Δρ. Αφροδίτη Χρ. Ραγιά
Καθηγήτρια Νοσηλευτικής
Πανεπιστημίου Αθηνών

Οικία:
Φραγκοκκλησίας 12
151 25 Μαρούσι
Τηλ.: 68 33 749, 68 11 033

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PSYCHIATRIC NURSING: A CONCEPTUAL APPROACH. A TEXTBOOK FOR GREECE.

Columbia University, Ed.D., 1975
Health Sciences, nursing

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This dissertation presents background for modern psychiatric nursing education in Greece and prepares a textbook of psychiatric nursing to be used by Greek nursing students in a basic university nursing program. Such background includes: (1) Speculation of nursing education in the perspective of Greek paideia, its evolution, and modern developments; (2) the beginnings and modern trends in psychiatric care in Greece and perspectives of psychiatric nursing within Greek nursing education.

A conceptual approach is selected for the presentation of the textbook in order to provide nursing students with a basic theoretical orientation to psychiatric nursing. The rationale is that a clear understanding of concepts may provide guidance for practice in a variety of nursing situations without limiting the imagination, the creativity, the choice of alternatives, and the responsibility of decision-making for nursing action.

The textbook does not include all available knowledge of psychiatric nursing. It presents only selective concepts of mental health and mental illness most applicable to a variety of psychiatric and general patient care settings common to Greek nursing practice. Concepts are traced not exclusively in the nursing field but also in other fields such as psychiatry, psychology, and psychosomatic medicine, in order to add depth, breadth, and richness to the content as well as to magnify
the educational value of the textbook. Nevertheless, nursing textbooks and other writings are consulted extensively. Accumulated nursing knowledge and experience and nursing projections into the future are acknowledged as a primary source and the most significant thesaurus to be used in developing a nursing textbook.

Greek religion and culture are considered and reflected throughout the textbook. Major themes developed in the textbook include:

- Presentation of the nursing profession as a treasury of values as well as the value orientation of Greek nursing.
- Modern prevailing values and trends in psychiatric nursing practice and education.
- Dynamics of mental health and mental illness.
- The family as a potential laboratory of mental health; description of the modern Greek family.
- Behavior as a personal expression in health and disease with special emphasis on selective pathological behaviors in mental illness and their nursing confrontation.
- Nursing as a science of dialogue and the significance of therapeutic interpersonal relations in mental health-psychiatric nursing.
- Man as a psychosomatic entity; the mystery of pain and suffering; illness as a crisis; and implications for nursing.
- Dimensions of personalized nursing care of the mental patient.

The textbook, although prepared for a specific nursing arena, namely, psychiatric nursing, places deliberate emphasis on the nursing of the whole person as a unique and intrinsically worthy being, to whom all nursing endeavors, either specialized or general, should be addressed. The study projects the position that the nurse in psychiatric settings,
in order to fulfill her psychotherapeutic role, should be able to see behind the disease to the whole person who may lose his productiveness but yet retain his dignity and ultimate worth, and thus deserves the most genuine, considerate, personalized, and scientifically sound nursing care. Furthermore, insight from psychiatric nursing may teach and equip the nurse in general settings — medical or surgical; pediatrics or geriatrics; intensive care units or chronic patient units — how to counteract the dehumanizing effects of technological automation and bureaucratic routine introduced into the care and treatment of the sick, by personalizing nursing care, namely, by practicing nursing of the whole person and not only of his malfunctioning parts or the disease which afflicts him.

The author suggests that in the development of future planned nursing textbooks, regardless of their focus area, this hallmark be reflected: the nursing of the whole person.
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the years of my doctoral studies and in the actualization of this
dissertation.

A.C.R.
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PART I

THE STUDY
CHAPTER I

INTRODUCTION TO THE STUDY

Need for the Study

Nursing education in Greece is changing. Contemporary rapid evolution in sciences and technology along with sociocultural changes have almost completely changed the approach to health problems in terms of prevention, diagnosis, and therapy of diseases, as well as promotion of health.

Greek society becomes more and more aware of its health needs, and it demands high quality professional nursing services. The nurses' roles and responsibilities are expanding particularly in the areas of holistic patient care, health counseling, research in clinical and community settings, participation in planning and administration of health services, and in interdisciplinary teamwork. To meet the challenges of the times, higher nursing education becomes imperative. The only type of the three-year schools of professional nursing has already proved inadequate to meet the health needs of Greek people.

Greece, the birthplace of sciences, and particularly of health sciences, has long ago felt the need for the establishment of higher nursing education. Toward actualization of this purpose, a considerable

1 Ελένη Παρινέλη. "Η Συμβολή της Διπλωματοδόχου Άδελφη στην Προαγωγή της 'Υγείας." Ομιλία από Ραδιοφώνου Δημοσιευθείσα είς Περιοδικόν ΕΛΛΗΝΙΣ ΑΔΕΛΦΗ, 41, Ιούνιος 1972, σσ.5-6.
number of Greek nurses, through state or private hospital scholarships, and sometimes by their personal savings, have attended advanced nursing educational programs at foreign universities in Europe, Canada, or the United States. These Greek nurses are now in leadership positions and are actively involved in the reorganization and expansion of the educational nursing programs in Greece.¹

Responding to this crucial need, the Hellenic National Graduate Nurses' Association, as the official representative of the body of Greek nurses, is intensively cooperating with the University of Athens as well as with the Ministry of Paideia for the establishment of a university basic school of nursing. Demetriadou, in her master's thesis, has already proposed a basic professional nursing curriculum within the University of Athens, which can be consulted in designing the prospective curriculum.²

The demand for higher nursing education in Greece, so far, was met only partially and temporarily through nation-wide organized nursing conventions, in-service educational programs, and through the official publication of the Nurses' Association: ΕΛΛΗΝΙΣ ΑΔΕΛΦΗ (Greek Nurse). However, only a few nursing textbooks exist. The need for them is being met in part through selective translations from foreign nursing textbooks, made available to nursing students in mimeographed form, and by using books from the basic disciplines with close guidance. These


² Ariste F. Demetriadou, "Meeting the Nursing Education Needs in Greece" (unpublished Master of Science degree field study, Boston University School of Nursing, 1964), pp. 80-82.
are the ways -- difficult, expensive, and time-consuming -- in which
Greek nursing keeps abreast of the increasing knowledge and international
progress in the field of health sciences.

As a consequence, in the intensive process of developing the first
university nursing program in Greece, one of the most crucial needs
identified is the need for Greek nursing textbooks, since only a few of
them exist. Greek is the only formal language in education and in every-
day life throughout the whole country. That is why the need for
indigenous nursing works is imperative. It is to this need of Greek
nursing education, undergoing a challenging and promising development,
that this textbook is addressed.

**Purpose of the Study**

1. To present background for modern psychiatric nursing education
   in Greece.

2. To prepare a textbook of psychiatric nursing to be used by
   Greek nursing students in a basic university nursing program.

**Title of the Textbook**

The title chosen for the textbook being prepared is: *Psychiatric Nursing: A Conceptual Approach*.

**Source of Material and Content**

Psychiatric nursing is a broad field which can draw concepts from
almost every other specialty or discipline and utilize them in relation
to a variety of situations. This study focuses selectively its
investigation on the following sources:
1. Literature representative of the fields of: (a) psychology; (b) psychiatry; and (c) psychosomatic Medicine.

2. Literature related to: (a) psychiatric nursing; (b) medical-surgical nursing; and (c) fundamentals of nursing.

The literature reviewed represents views and approaches of more than one country, mainly of Greece, United Kingdom, Switzerland, France, and the United States.

Criteria for the Selection of Concepts

This study uses a conceptual approach in order to provide guidance for practice in a variety of nursing situations, without limiting the imagination, the creativity, the choice of alternatives, and the responsibility of decision-making for nursing action.¹

The following criteria were used in the selection of concepts:
(1) that the concepts drawn from psychology, psychiatry, and psychosomatic medicine be related to mental health and mental illness in a general way and useful not only in definitely circumscribed disease-labeled intrapsychic processes; (2) that the concepts be the most frequently presented in the reviewed nursing textbooks within a ten-year period; and (3) that the concepts be universal enough to be applicable to a variety of nursing care situations.

Limitations of the Study

This textbook is prepared for Greek nursing students in a proposed university basic nursing program. Consequently, it must be adapted for use elsewhere.

¹See Appendix A.
This textbook does not include all the available knowledge and techniques of psychiatric nursing. It presents only selective concepts of mental health and mental illness most applicable to a variety of psychiatric and general patient care settings common to Greek nursing practice.

As primary nursing resources, psychiatric medical-surgical and fundamental nursing textbooks within a ten-year period were used. However, a few older books considered of classical value were also used as resource books. Journals and periodicals were consulted. Suggested further readings for the student are not designated in this study because of the limited Greek nursing literature on the subject. For the time being, the need will be met by the use of materials from the fields of psychology, psychiatry, and psychosomatic medicine available to medical students, and by selective translations from English psychiatric nursing literature planned for the near future and to be adapted to Greek nursing situations.

Consultation has been done only with members of the committee. This study is primarily a library study. Pictures were not included in the study; instead, narrative illustrations were used as pertinent. No suggestions for the use of the textbook are proposed. Study guides, questions, and summaries also are not included.

Methodology

As indicated above, this study is primarily a library investigation; the methodology used consists of two stages.
Selecting the Concepts to be Used in the Textbook

This category includes the following steps:

1. Reading selectively from the fields of psychology, psychiatry, and psychosomatic medicine, and drawing scientific concepts related to mental health and mental illness in a general way.

2. Reviewing the nursing literature in the areas of psychiatric, medical-surgical, and fundamental nursing for concepts related to mental health and mental illness most frequently presented and analyzed.

3. Identification of the prevailing and most universal concepts applicable to a variety of nursing situations.¹

4. Further screening of the identified concepts so that those which are taught and learned primarily in other courses, in Greek nursing education programs offered by the generic disciplines, are not presented in this textbook of psychiatric nursing.²

Developing the Content of the Psychiatric Nursing Textbook

This stage includes the following steps:

1. Organization of the presentation of concepts in two major units, each including chapters with further subdivisions.

2. Each chapter is preceded by a statement of purposes and content outline.

3. Concepts are presented separately or in a synthesis within the chapter.

4. A glossary and a bibliography are included.

¹See Appendix B.
²See Appendix C.
CHAPTER II

GREEK NURSING PERSPECTIVES

Nursing Education in the Perspective of Greek Paideia

Greek Paideia: Its Spirit and Character

Paideia has always been highly valued in Greece. Paideia is a broad and comprehensive concept. Its full content and meaning become clear only when one reads its history and follows its attempts to realize itself. Paideia is more than education. It includes modern notions such as civilization, culture, tradition, literature, and education. However, paideia is a unity beyond and above the sum of the foregoing aspects.

Greece first formulated a theory of education, including its aims and methods, and it is in that part of the world, where the foundations of the science of paideia (ἀγωγή) have been laid. Greek philosophy considers paideia as "the highest blessing bestowed on mankind"¹ (καλλίστων) as "a formative force" by which it is possible "to shape the living man as the potter molds clay and the sculptor carves stone into preconceived form,"² and, as such, deserving the name of culture. One


essential characteristic of Greek paideia that made it unique among the various conceptions of human education in other countries is, according to Jaeger, that "it not only contemplated the process of development in the human subject but also took into account the influence of the object of learning."\(^1\) Greek philosophy is characterized by the Greek contemporary philosopher Georgoulis, as the beginning of the true and genuine philosophical intelligence of the human race. He wrote that philosophy is also paideia for Greeks, it is the elevation of man to his true dignity.\(^2\)

Greeks believe so strongly in the civilizing effect of paideia that, in ancient times, they called Greeks all those who were educated in the Greek way. Isocrates states:

> And so far our city distanced the rest of mankind in thought and in speech that her pupils have become the teachers of the rest of the world; and she has brought it about that the name "Hellenes" suggests no longer a race but an intelligence, and that the title "Hellenes" is applied rather to those who share our culture than to those who share a common blood.\(^3\)

A number of educational concepts which are stressed and professed today as important to be incorporated in all types of education have their origin in Greek paideia. The concept of free and open education was held and practiced by Socrates. The theory of continuing education was stressed in Plato's *Academia*. As a result, great scientists such as the

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mathematician and astronomer Eudoxos, the physician Plistion, and the
famous politician Dion, were students of Plato. Dialectic was used as a
teaching strategy by all three Attic philosophers: Socrates, Plato, and
Aristotle. Furthermore, general education was considered as a requisite
for all, although special sciences were developing and being taught.
According to Plato, "the rightly educated prove what we mean by good," and "education is . . . that schooling from boyhood in goodness which inspires the recipient with passionate and ardent desire to become a perfect citizen. . . ." It became a general belief, and all Greek generations have been nurtured with the following precept: "All knowledge, when separated from justice and virtue, is seen to be cunning and not wisdom."

Another fundamental stimulant for the love of education, which has definitely influenced Greeks, is the Bible. The Old Testament declares that God inspired the love of knowledge and science, and presents religious persons broadly educated through the educational systems of their times. Examples of such persons are Moses, Daniel, and others. In Ecclesiastes we read: "And I applied my mind to seek and to search out by wisdom all that is done under heaven. . . ." In the New Testament we meet St. Paul, among others, who was broadly educated, and the Apostle

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2 Ibid., 643b, p. 1243.
3 Ibid., Menexenus, 246e, 247a, p. 196.
4 Acts 7:22.
5 Daniel 1:4.
6 Ecclesiastes 1:13.
St. Luke, a physician. These examples molded even more firmly the positive attitude of the Greeks toward education.

Since paideia was not in conflict with the ideal of Christian life and conduct, the Fathers of the Church were educated in the most famous schools of philosophy in Athens and in other educational centers. Large educational centers of that time also included the Museum of Alexandria; Antioch, known as Syriades Athens of the East; Carchedon, Rome, and Constantinople with its Auditorium or Pandidacterion (school in which all sciences were taught).

The three Fathers of the Church — St. Gregory the Theologian, Great Basil, and St. John Chrysostom — studied philosophy, rhetoric, and other sciences in Athens. All of the three deeply impressed their professors by their scholarship and wisdom connected with virtue and sainthood. They became eloquent preachers of the Gospel and writers of spiritual works in the Byzantine era. Today they are honored not only as Saint Fathers of the Church and models of educated men, but also as great teachers and patrons of the Greek-Christian paideia, by all Greek schools, including schools of nursing, and their special day of remembrance is observed as a school holiday. Greek universities organize educational seminars and lectures on the value and the meaning of Greek paideia in the perspective of the Greek-Christian ideal on this special day.

Under the convincing teaching that "nothing is more valuable than knowledge, because knowledge is light for the logic soul [and] ignorance..."
is darkness, the monasteries of Byzantium became famous centers of paideia, "schools of introduction to philosophy." Professor of Byzantine Art and History Steven Runciman, after a thorough study of the nature of paideia in Byzantium (330 - 1453 A.D.), concluded that "a good education was the ideal of every Byzantine. Apaideusia, a lack of mental training, was considered a misfortune and disadvantage, almost a crime."  

The history of Greek paideia proves the fact that Greeks value education very highly. They believe in its power to refine the human mind and enrich the human person. That is why Greeks do not neglect education, even under extremely restrictive national life circumstances. Greece survived a 400-year occupation by the Turks (1453 - 1821 A.D.), mostly because of the "Secret Schools" functioning under the aegis of the church. In these schools, Greek youth studied the Greek language, the Bible, Homer's Epics, mathematics, and other academic subjects. Hence the Christian Faith and the Greek tradition and civilization were transmitted from generation to generation and the ideal of freedom was nurtured. 

Soon after the liberation of Greece from the Turkish occupation, in 1834, the Government passed a law for the official re-introduction of elementary education.

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1 Ιωάννου Δαμασκηνού. "Πηγή Γνώσεως." Εἰς Ἰ.Ρ.Μίγνα, Πατρολογία Ελληνική, Κύκλος Κόλαμπτιος, 94, 529 A.B. 
4 Τρόφων Ε.Ευαγγελίδης. "Ελληνική Σχολή από την Άλωσις μέχρι Καποδιστρίου. Πέμπτη Α' και Β'" (Αθήνα: 1936).
and secondary education as well as for the establishment of a university in Athens.  

The foregoing information shows the development of Greek paideia mostly in the classical period of Greece (5th century B.C.), in the Byzantine era (330 - 1453 A.D.), and during the stressful occupation of Greece by the Turks (1453 - 1821 A.D.). It has become evident that Greek paideia is conceived as the civilization of the intellect and of the soul, consisting basically of the transmission of the Greek educational philosophy and of the spiritual thesaurus of Christian Faith. Also, it is loved zestfully and pursued even through misfortune and contradictory circumstances.

It is important to position nursing education in the perspective of Greek paideia; when and how nursing education evolved in Greece, what is its matrix and its special characteristics, and what are its horizons nowadays. This outlook, hopefully, will help the reader to understand and to feel the spirit and the structure of this textbook.

Evolution of Nursing Education in Greece

Modern excavations continually bring to light that, in Greece, the foundations of medical practice and therapeutics not only were free of primitive beliefs in demons and witchcraft, which was the case of other ancient peoples, but were also responsible for bringing new theories into life. It is known that in the ancient Aesclepeia, the pupils of the god of medicine, Aesclepios, and the followers of Hippocrates, taught anatomy and dissection of the human body and made use of treatments which the

1 Εφημερίς Κυβερνήσεως τοῦ Βασιλείου τῆς Ἑλλάδος.  
Αριθ.86. Νόμος τῆς 6ῆς Φεβρουαρίου 1834. Αθήναι 31.12.1836.
goddess Hygeia suggested. The first Aesclepeia, according to Aravantinos, served in a way as the first hospital in the world which promoted greatly medical practice and clinical observations.¹ Messolora writes:

Early expression of care of the sick was founded on the principle which governed the life of the ancient Greeks, i.e., worship of Xenius Zeus. The sick and needy were considered worthy of respect and were accepted as their guests. The kind care given in the Aesculapela was based on an open air life in beautiful natural surroundings and the cultivation of spiritual joy. Those coming for treatment not only listened to the advice of the goddess, given mysteriously by self-suggestion . . . but also visited the theatres, which were situated near the Aesculapela.²

One of these theatres is still preserved in Epidaurus. Moreover, rehabilitation of the convalescent patients was effected through physical exercise, occupational therapy, and athletics in stadia and other places of recreation.

Within the scope of Greek paideia, medicine was first founded as a science by Hippocrates, who was a contemporary of Socrates, native of Cos (born in 460 B.C.), and an Aesclepiad, that is, a member of a family which traced its origin to the god of healing. He studied medicine and philosophy and he was well known both as a practitioner and a teacher of medicine. Under Hippocrates, scientific medical knowledge and medical ethics grew and were disseminated side by side.

The great lesson given by Hippocratic writings is that medicine is an art, "of all the arts the most noble,"³ and one inseparable from the highest morality and the love of humanity. In his "Precepts"

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¹ A.Π.Αραβαντίνδς Ίατρδς. *Ασχληπεία (Ατηναϊκό Τύπος Β.Δρουγουλινοβ, 1907), σ.5.
Hippocrates made the point that "where there is love of man, there is also love of the art." Also, he held that knowledge of the body and ability to heal its illnesses or to maintain it healthy depends upon the knowledge of the whole man, from the philosophical point of view as well as from the vantage of natural science.

Hippocrates not only founded the science of medicine, but he also expressed a special interest for the nursing care of the sick. He assigned the care of the patients to medical students. Principles and technical descriptions of nursing procedures are taught in minute detail and with perfect understanding in his medical writings such as "Precepts," "Decorum," "Nutriment," and "On Fractures." His high ethics, and the generally fine standards of medicine under his influence, are embodied in his medical "Oath," known world-wide as the "Hippocratic Oath," which has had a marked influence on the ethical practice of medicine, and in extension on nursing ethics. Hippocrates' writings on medicine include precious implications for nursing education. They can be considered as a valuable nursing textbook, and in that sense we may say that Hippocrates opened the way toward a science of nursing.

2Hippocrates, Ancient Medicine, XX, 1-30, in ibid., pp. 54-55.
3Κ.Πουρναβδπουλος. "Περί τού Ιπποκράτειου Ἰατρού καὶ Γενικότερου περί Ὀρκου τῶν Ἰατρῶν." Περιοδικό ΙΠΠΟΚΡΑΤΗΣ 1, 2, Σεπτ.-Οκτ. 1972. Αθήναι, σ.98.
However, nursing had not developed as a learned health profession in the ages before Christ. Among the various reasons, the writer will discuss selectively only the low position of women in the ancient world. Plato sounds contradictory in his views about women. He considers the woman able and appropriate for the practice of medicine: "We shall rather, I take it, say that one woman has the nature of a physician and another not." Yet, according to Plato, women constituted a "flock" and the pursuit of men with reference to women should be that of guardians of the flock. Plato does not see the woman as the wife of one man and as the mother of her own children, whom she will love, nurse, bring up, educate, and relate with, over her life. How then would the women of Plato's "Republic," deprived of the opportunity to express tenderness and love to their husbands and children, be able to practice nursing, which requires an inexhaustible psychic repertoire of tenderness and love? Even though Plato's philosophic ideas about the republic were not materialized, still they revealed the attitude toward women during the era of the great philosopher.

Aristotle wrote that "among the barbarians ... the female and the slave occupy the same position." Even earlier than Aristotle, Hesiod was considering the house, the woman, and the ox as things serving the man. Furthermore, Euripides, "the philosopher of the stage" (ὁ ἀρχηγός φιλόσοφος), characterizes the woman as a miserable "herb":

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2Ibid., V, 451c, p. 690.
3Ibid., V, 460 bde, p. 699.
5Ibid., 1252b 5, p. 4.
Of all things upon earth that bleed and grow,  
A herb most bruised is woman.  

Even more tragic seems to be the position of the woman in Roman society. According to Roman Law, the "majestas virorum," that is, the major authority of men, regulated the relationships between men and women. Vis-à-vis Roman men, the women were "res," mere inanimate "possessions" over which men had absolute right of life and death, protected by the Law. Within such a society, how could ever a responsible professional body of nursing develop? A radical change was needed and it did not delay its appearance.

Christianity created a new spiritual climate which favored the development of nursing practice and nursing education. This favorable climate refers to the elevation of the woman's personality by the doctrine of the Gospel. The new position of woman in society is regulated by St. Paul's saying: "There is neither male nor female: for ye are all one in Christ Jesus." In the person of Virgin Mary, the mother of Christ, the feminine nature has been elevated even above angels, according to the Greek Orthodox Faith. Many names of women are listed in the Bible, and Christ accepted women and men equally among His followers. The Fathers of the Church distinguish one single difference between men and women which they call "difference in the curtains," that is, in the body's make-up. Clement the Alexandrian, stressing the equality between

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3 "Ἀδό γὰς Α’ Εἰς τὸ Ποιήσωμεν Ἀνθρωπον καὶ Εἰκόνα Ἡμετέραν καὶ Ὀμοίωσιν," Μίγη Πατρ. Ερ. 44, 276 A.C.
man and woman, stated that "women and men have the same human nature
... souls are neutral, neither male nor female,"¹ and above all
"grace and salvation are common to both ... they share a common name, anthropos."²

The reconstitution of only the woman's worth and dignity as a
human being in mankind's attitude was not enough for nursing to develop
as a social service worthy of educational preparation. It was mainly
through Christ's preaching of love, His innumerable miracles of healing
the sick, and His well-known parable of the "Good Samaritan" that the
spiritual and unshakable foundations of nursing were forever laid.

During the first Christian era, the care of the sick assumed a
christocentric character, which means care addressed to Christ Himself.³,⁴
Hospitals were erected and organized first by the Fathers of the Church,
and nursing was practiced as a form of prayer and as an expression of
love and devotion to God. Such a hospital was "Vassileias" in Kappadokia,
after the name of its founder, Great Basil, bishop of Kaisaria. It was
erected in 370 A.D. and included a hospital, a nursing home, a house for
the poor, and a nursery. It was the largest philanthropic institution of

¹ Κλήμεντος "Αλεξ. "Παιδαγωγός" Α'4, ΒΕΗΕΣ 7, 85.
² Κλήμεντος "Αλεξ. "Παιδαγωγός" Α'4, ΒΕΗΕΣ 7, 85.
³ Άλέξης Δημητριέβσκης. Περιγραφή των Λειτουργικών Χειρογράφων των Εν τας Βιβλιοθήκαις της Ουρομολού Ἀνατολάς Τηρουμένων. Τόμος 1, Ημερίδες (Κίεβον1895), σ.663.
⁴ Εδάγγελος Δ.Θεόδωρος. Η Χριστιανική Αγάπη: Αλ Διακόνισατο, Διά των Λόγων. (Αθήναι Βιβλιοθήκη Αποστολικής Διακονίας, Νο 17, 1949), σ.155.
those times in which Great Basil organized the nursing services and he personally cared for the sick.\(^1\)

There are valuable and magnificent writings teaching how to nurse the sick, and even though they are not categorized as nursing textbooks, nevertheless they constitute the nursing philosophical and educational guidelines which educated and nurtured a special nursing generation in Byzantium. This generation was composed of deaconesses, nuns, monks, noblewomen, and even world-known queens and empresses. History reports that Placilla, wife of the Emperor Theodosius I (d. 395 A.D.), visited the hospitals of the churches in Constantinople and "tended the bedridden with her own hands, herself taking hold of pots and tasting their broth, and handing their bowls, and breaking their bread and holding out morsels."\(^2\)

The spirit and the essence of nursing became the Christian love as defined by St. Paul:

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\begin{align*}
\text{Charity suffereth long, and is kind;} \\
\text{charity envieth not;} \\
\text{charity vaunteth not itself,} \\
\text{is not puffed up,} \\
\text{Doth not behave unseemly,} \\
\text{seeketh not her own,} \\
\text{is not easily provoked,} \\
\text{thinketh no evil;} \\
\text{Rejoiceth not in iniquity,} \\
\text{but rejoiceth in the truth.} \\
\end{align*}
\]

\(^3\)

This kind of love, expressed in nursing practice during the Byzantine era, was then defined as:


\(^3\) I Corinthians 13:4-6.
Impartial, undiscriminating, and generous care of the sick.\(^1\)

Compassionate, comforting, and supporting service to the suffering people.\(^2\)

Earnest desire and readiness to take pains in order to help the needy.\(^3\)

Ever "ought" duty to the fellow person.\(^4\)

Respect and brotherly affection for the sick, with therapeutic power.\(^5\)

Christian love actualized as nursing love is considered as the more excellent way to express one's faith and love to God, because He said: "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."\(^6\)

Among the Byzantine classical masterpieces which constitute a rich heritage of nursing education, there must be mentioned: (1) the description, by Dionysius the Alexandrian, of the magnitude of self-sacrifice of Christian nurses caring for the sick idolaters during a bad epidemic in Alexandria;\(^7\) (2) the perception of nursing as a way

\(^1\) Κλήμεντος Αλεξ., "Στρωματείζ" 2, 18. \textit{BEHEM}, 7, 339.

\(^2\) Ἰωάννου Χρυσοστόμου, "Λόγος περὶ Ἀγάπης." \textit{Migne Patr. Gr.} 1028 A.

\(^3\) Κλήμεντος Ρώμης. "Πρὸς Κορινθίους Α", 2. \textit{BEHEM}, 1, 3.

\(^4\) Ιωάννου Χρυσοστόμου. "Επιστολή ΡΑ." \textit{Migne Patr. Gr.} 52, 689.

\(^5\) Θεοδώρου Στουδίτου. "Ιαμβος ΙΖΈίς τε Νοσοκόμου." \textit{Migne Patr. Gr.} 99, 1789 D.

\(^6\) Matthew 25:40.

\(^7\) Διονυσίου Αλεξανδρείας, Πρὸς τοὺς ἐν Ἀλεξανδρείᾳ Ἀδελφοῖς Ἐσπεριστικὴ Ἐπιστολή, 2, \textit{BEHEM} 17, 217, 218.
leading to a philosophical outlook on life, by St. Gregory the
Theologian; and (3) the famous 17th Iambus of St. Theodore the Studite,
head of a large monastery. The Iambus is dedicated to the monk "nurse"
and sounds like a lesson on fundamental principles in nursing. Theodore
Studite highlighted the schedule of a nurse's day, gave selective prin­
ciples of a nurse-patient relationship and the healing potential of com­
munication, and, finally, he characterized nursing as a sacred endeavor
which would be appropriately recognized and rewarded by God. 2

The foregoing highlights of historical evidence show not only
that there was a certain kind of nursing education taking place in medi­
cal centers of different epochs such as in Aesklepeia, in Hippocrates'
era, and in Byzantium, but, also, that valuable writings, like text­
books, were educating the Greeks how to nurse the sick and care for the
health needs of people. These writings transmit to us the spirit and
the content of nursing at different points of Greek history.

For the purpose of following the thread of Greek nursing education
through the ages, it should be mentioned that, during the 400-year occu­
pation by the Turks, Greek nurses were distinguished for their intelli­
gence, courage, and resourcefulness in caring for the sick and the wounded
soldiers in the midst of extreme deprivation of food and supplies. Their
heroism, reaching even to the sacrifice of their lives in the service of
their country, 3 constitutes a great lesson for succeeding generations.

1 Γρηγορίου Θεολόγου, Επιστολή 178, Migne Patr. Gr. 37, 292 A.
2 Θεοδώρου Στουοίτου, Ιαμβός ΙΖ'Είς τόν Νοσοκόμον, Migne Patr. Gr. 99, 1765 L.
This lesson teaches one of the dimensions of nursing heroism which Lanara investigated in her dissertation.1

Greek nursing had already reached a point of readiness and kept an openness for the development of a systematic scientific education comparable to the education of the physicians, for better and more comprehensive health care of the people.

**Modern Developments, Insights, and Visions**

Greece is included among the first countries which imitated the example of Florence Nightingale in initiating the systematic education of nurses. Greece, a small and poor country since ancient times,2 but great in the history of sciences and paideia, could indeed be expected to grasp the challenge, and it did. It established a school of nursing within three years from the emergence of the world's second school of nursing (in the New England Hospital, Boston, Massachusetts, in 1872).

In 1875, Queen Olga of Greece, well known for her Christian love and genuine concern about the sick, founded the first school of nursing in Athens.3 Soon after, Queen Olga founded Evangelismos hospital for the clinical practice of nursing students, based on scientific principles.4

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3 Οργανισμός Νοο-νομομετρικοώ Παιδευτηρίου από 23.1.1875 ατ Εσωτερικός Διοργανισμός αυτοῦ από 5.2.1875.
4 Βασιλικόν Διάταγμα 20 Μαρτίου 1881, Αθήναι.
It is interesting, and perhaps unique in the history of nursing, that the primary goal of the hospital was the education of nurses. This is also written on the foundation stone of the hospital, laid by the King of the Greeks, George A, on March 25, 1881, and it is mentioned in Queen Olga's will. To honor the founder, the school is named: School of Nursing "Queen Olga" of Evangelismos Hospital, Athens. Since then, many schools of professional nursing have been established in Greece.

Today, professional nurses are educated in three-year schools of nursing, either independent or hospital affiliated. The worthiness of specialization in various nursing areas, during a fourth year within the same schools is a question of some debate. However, it is tried by a few schools only for the preparation of public health nurses. All these schools are controlled by the department of nursing education at the Ministry of Social Services. The control consists of determining the curriculum content and standards, of confirming the diplomas awarded, and of issuing licenses for professional nursing practice. Practical nurses are prepared in one-year nursing programs.

Contemporary Greek nurses feel very honored and privileged; they bear a noble heritage, a tradition of Greek nursing made up with the spirit of ancient Greek philosophy and paideia as well as with Christian faith and love. In their endeavor not only to respond to the increasing and changing health needs of society, but also to refine, develop, and further the frontiers and perspectives of Greek nursing, they feel deeply the need for higher education established within the country and they

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1 See Appendix D.
2 See Appendix E.
demand it. This need is intensified by the scarcity of Greek nursing textbooks. The efforts to meet these needs temporarily and the systematic movement toward the establishment of a university basic school of nursing have already been highlighted.

A significant number of Greek nurses already possess bachelor's degrees, some of them have acquired master's degrees, and still others have earned different foreign university titles. Recently, Miss Vassiliki Lanara became the first Greek nurse to be awarded the Doctor of Education degree from Teachers College, Columbia University, New York City. These nurses constitute the nursing leadership group today. They are pooling ideas and joining efforts in studying the changes and trends of Greek society as well as in forecasting and planning in both nursing arenas, education and service, in order to meet the challenges of the times.

The proposed textbook endeavors to make a contribution to this effort of uplifting Greek nursing education and positioning it within the university.

**Psychiatric Nursing in Greece**

*Beginnings and Modern Trends in Psychiatric Care in Greece*

In Greece, the birthplace of philosophy and science, psychiatry appears as early as in the pre-classical era. Mental disorders were considered diseases attributed to supernatural and supercosmic diseases or believed to be God's punishment for man's sins. Before the time of Asclepios and Hippocrates, it is reported that the empiric doctor Malambus cured through psychotherapeutic methods and psychopharmacological agents the daughters (Ifinoi and Ifianassan) of the King of Argos,
Fritos, who suffered from mania.\textsuperscript{1,2} During the Homeric age (12th century B.C.), people had some advanced medical knowledge. However, the cure of patients was sought through prayers and religious rites.\textsuperscript{3}

Organized care and application of therapeutic measures were found in Aesclepeia, the temples of Aesclepios. Mental patients were treated by a kind of psychotherapy (dialogues, baths, music, athletics, theatrical plays, recreational activities). They were cared for in the midst of picturesque and serene natural surroundings. Aesclepios based his therapeutic regime on his father Appolon's axium: "Psychic strength dominates physical weakness." As a consequence, he was trying to increase physical defenses through nurturing psychic dynamism.\textsuperscript{4}

Hippocrates (460-377 B.C.) promoted the knowledge in the domain of psychiatry through systematic observation and description of clinical syndromes such as puerperal psychosis, mania, melancholia, toxic delirium, and others. He characterized mental illness as "dyscrasia" (chymopathology),\textsuperscript{5} which, in today's terminology, could be disturbance of biopsychological homeostasis. Hippocrates considered the symptoms of

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\item Γ.Δημ.Γρέγορος. Ιατρική Φύσικη Φιλοσοφία Μνημονικόν Πανεπιστημιακών Παραδόσεων. ('Αθήναι: 1971), σ. 5.
\item Γεώργ. Π. Φιλιππακκόπουλος. Αναπαραστατική Φυσική Φυσική. ('Αθήναι: Εκδόσεις Α. Καραβία, 1971), σ. 6.
\item Άνδρεάς Κ. Παπαρηγα. Ιατρική Φυσική Φυσική. ('Αθήναι: Εκδόσεις Α. Καραβία, 1972), σ. 6.
\item Ανδρέας Κ. Γεωργαρας. Στοιχεία Φυσικής Φυσικής. ('Αθήναι: Εκδόσεις Α. Καραβία, 1972), σ. 6.
\end{enumerate}
mental diseases as related to disturbances of behavior, of affect, and of intellectual functioning, namely, of the speech, orientation, attention, and memory.  

Aristotle (384-322 B.C.) created an empiric psychology emphasizing the meaning of music and of a kind of catharsis in the treatment of mental patients and particularly of those suffering from melancholia.

The role of emotions in the genesis of psychic disturbances was first discussed by Aesclepiades (1st century B.C.), descendant of Aesclepios, in his work about "Psyche and Phrenitis." He was treating his mental patients by music, psychotherapeutic dialectic, and recreation.

Finally, Galinos (130-200 A.D.) described mental disorders in psychological terms, and he is well known for his humane and genuine treatment of psychiatric patients.

The foregoing information shows that very early in Greece, mental disorders were considered diseases. Mentally disturbed people were treated as sick, and the applied therapeutic measures imply a very good understanding of the impact of caring, of involving the patient in his treatment, of good human relations, and of the environment, on the restoration of mental health.

During the Byzantine era (330-1453 A.D.), in the Byzantine empire, that is, in the East, the whole medicine, including psychiatry and the care of the sick, was exercised, socially organized, and greatly

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1 Αυξέσσος. 'Ιστορική Φυσιολογία. σσ.5-6.
2 Γεωργαράς. Στοιχεία Φυσιοτρικής. σ.6.
3 Φιλιππόπουλος. Αναλυτική Φυσιοτρική. σ.ή.
4 Ibid.
promoted under the influence, inspiration, and leadership of the Church. Thus, while in the West, during the same period (Middle Ages), the mental patients were flogged, fettered, scourged, and starved because of the superstitious beliefs that devils and witchcraft which possessed the patients could be driven out by these methods, in Byzantium the mental patients were receiving tender, loving care within a prevailing strong, diffuse, and generalized religious-nursing climate. History reports that in the Byzantine times (330-1453 A.D.), mental patients were cared for in psychiatric wards belonging to general hospitals organized and run by monasteries. Such an establishment was the Hospice of the Monastery of Allmight (Σκόπο τῆς Μονῆς τοῦ Ἡλευτροκόρτους ), the best and most complete hospital of Byzantium and of all Middle Ages. Physicians who studied and described mental diseases in that epoch are Theodorus Pricianus, Alexander Oribasius, and others.

The presented beginnings of scientific description and categorization of mental diseases, as well as the care of mental patients, are recognized worldwide as the elemental foundations of psychiatry as well as psychiatric nursing.

During the 400-year occupation of Greece by the Turks (1453-1821 A.D.), psychiatry and the care of psychiatric patients, similarly to general medicine, were practiced mostly within the monasteries, upholding

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2 Πούρναρόπολος, Συμβολή τῆς Ιστορίας τῆς Βυζαντινῆς Ιατρικής, σ.117.
the Byzantine humanistic health care tradition. Soon after the liberation of Greece, namely, in 1836, the first movement for the hospitalization of mental patients started and the first mental hospital was established in Corfu (1833 A.D.) under the direction of the Greek psychiatrist, Christos Tsiriotis. The latter, in his writings in the form of statistics of the hospital, was defending the rights of the mental patients to considerate care and to full health services. Furthermore, he was attributing the phenomenon of mental illness to the secular upbringing of the children, which fed in them the egoism and the contempt of religious and moral principles, resulting in inner conflicts and mental disturbances.¹

Today, Greek psychiatry is no different from the world's psychiatry in terms of basic knowledge and scope of practices. What makes a difference is the cultural context in which it is practiced, and which determines the shift of emphasis, the targets to be conquered, and the methods of application of knowledge.

Mental patients are treated either in their homes, when they are not acutely ill, or in the mental hospitals, state or private, as well as in private clinics. As to the prevalence of mental disorders in Greece, schizophrenia seems to be higher than the affective or other mental disorders.

Cultural attitudes toward mental illness interfere with the early detection and treatment of mental patients. There is an element of social stigma attached to mental disorders, a stigma that the family also must bear, so that the first reaction to signs of mental illness is either to

¹ Γνώσες Χριστ. Τσηρινωτής, Ο Πρώτος Ελλην Ψυχίατρος, σσ. 5, 26.
deny them or conceal them or to consult with a doctor of some other specialization and not a psychiatrist. Furthermore, the public tends to consider merely precipitating factors such as poverty, worries, strains of modern life, as etiological of mental illness. Social or occupational maladjustment, marital difficulties, school difficulties are not considered problems requiring special psychiatric help. The foregoing attitudes show that the Greek public needs systematic educational orientation as to what mental illness is and who is mentally ill. Moreover, all health professionals, other than psychiatrists and particularly nurses, need to be well informed on psychiatric matters because they are the first to be consulted and, very often, the first to diagnose mental health problems.

A recent law referring to mental health and psychiatric care of the sick provides for the development of community mental health and psychiatric centers. However, no state-wide organized community mental health centers or institutions for intermediate stages of rehabilitation for mental patients, such as halfway houses or day and night hospitals, are yet established. Also, no state medical and financial assistance during psychotics' first steps in the community and work provision or

protected workshops have been developed. Nevertheless, there are remarkable private efforts initiated by psychiatrists either within the community or launched from the mental hospital services.¹

One community center is "The Athenian Institute of Anthropos," the purpose of which is stated by the founders as follows:

The overall purpose of this center would be to sensitize, trigger, and speed up developments, conduct research, prepare manpower, consult or assist in the formulation of action programs, and experimentally launch small-scale programs, staying away from large resource-consuming action programs in order to be able to remain a catalyst, a small, independent outfit able to scrutinize and evaluate critically even its own ideas and proposals.²

Other agencies of private initiative are the Institute of Medical Psychology and Mental Hygiene, and the Center for Mental Hygiene and Research. In addition, a number of organizations, with partial or without state support, conduct child guidance clinics and counseling centers (Ιατροπαιδαγωγικοί και Συμβουλευτικοί Σταθμοί ΙΚΑ, ΠΙΚΠΑ).

A representative example of a project conducted by a mental hospital service is that of the first clinic of "Dromokaition" Mental Hospital. It was initiated by its medical director, Associate Professor in Psychiatry of the University of Athens, G. Lyketsos. It constitutes the development of a system of after-care by the family of the patient under the supervision of the hospital.

The aim was to reintroduce the patient into the family unit by a constant and ever increasing contact between the family, the patient, and the psychiatric team and by every other possible means of communication; i.e., correspondence, questionnaires, alternative visits


²Ibid., p. 282.
of the patient to his home and his family to the hospital, followed by reports and, [finally, by] family, patient, and psychiatric staff interviews. In some cases, the patient's outings developed into a regular working day in the community or into night family visits so that the Dromokaition was informally transformed into a day or night hospital according to the case.  

At the end of the first year of the study (1962-1963), the result showed that when the families are not able to assist in their patient's rehabilitation and when the patient does not work at all or does not offer any help in the family, there was a high readmission ratio. On the other hand, when the patient's role in the family was useful and accepted, and when he works either outside home or, in the case of housewives running their own homes according to social standards, seldom did a patient return to the hospital.  

The foregoing project became policy followed by all departments of Dromokaition Mental Hospital up to this day, and tends to be initiated by almost all mental hospitals and private mental clinics. This effort is an initial step toward a more comprehensive social planning of community mental health delivery systems.

A still more recent development is the experimental psychiatric unit of day care set up in Salonica, the second largest city in Greece, by the Center of Mental Hygiene and Social Psychiatry. It constitutes a

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1 George Lyketsos, M.D. "After Care of Chronic Psychotics in a Community Orientated Mental Hospital." Νευρο-Ψυχιατρικά Χρονικά, 4, 1, Ιανουάριος 1965, σ.2.

2 Lyketsos, "After Care of Chronic Psychotics in a Community Orientated Mental Hospital," p. 8.

preliminary study toward planning formal out-patient services. The reported therapeutic results on the patients and their families and the identification of some inhibiting socio-cultural factors are impressive.

The insights gained by the described efforts imply that the services of the mental hospital alone are not sufficient to help the patient achieve an acceptable and efficient familial and social life when he returns to the community. Furthermore, the community needs to become thoroughly informed on matters of mental health and mental illness in order to assume a responsible participant role in the care and rehabilitation of its mental patients.

In contemporary literature it is emphasized that the rehabilitation of the mental patient can be achieved only within the social context itself because it is society which forms, deforms, and reforms.¹ Concurrently, a number of studies have been conducted in Greece with the purpose of collecting data about the socio-psychological characteristics of modern Greece and the personality of Greeks, about Greek family (family roles, role behavior, role demands, attitudes toward children, and so forth).² Other studies have yielded data on the attitudes toward and prejudices against the mental patient,³⁻⁴ on the modern perceptions

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² G. Vassilou, A Preliminary Exploration of Variables Related to Family Transaction in Greece (Athens: The Athenian Institute of Anthropos, 1966), P.
of and perspectives on the psychological problems of the elderly, and on the psychiatric phenomena as they develop in the Greeks, i.e., the phenomenon of anxiety, the content of paranoid delusions, and other phenomena. In addition, systematic epidemiological studies are conducted by the State mental hospital in Athens and other institutions.

The foregoing studies are indicative of attitudes toward mental health and mental illness and explain, to some extent, the degree of readiness to use community mental health services either for guidance or for early detection of psychiatric problems. In addition, the findings of these studies offer a basis for planning mental hygiene educational programs, in Greece, specific to the existing needs as well as to check the effects.

Through gathering data on variables interfering with mental health in Greece, and through continuing feedback between training, research, planning, action, and evaluation, Vassiliou and Vassiliou say:

We expect to contribute to the increase of the country's therapeutic potential and to the formulation of more effective preventive efforts. These steps accomplished, we will be able to plan, propose, or experimentally try comprehensive community programs for treatment and prevention that will be milieu-specific, tailored to the concrete needs of our country, based on the firm foundation of data, and executed in controlled ways with constant follow-up research.

1 Γ.Π. Αλεξίδης και Γ.Κ. Λυκέτσος, "Σύγχρονοι Άντιλήψεις και Προοπτικές των Φυσικοϊνων Προβλημάτων της Γεροντικής "Ηλικίας," Ελληνική Ιατρική, 37, 2, 1968, σσ. 3-9.


5 Vassiliou and Vassiliou, op. cit., p. 298.
Psychiatric Nursing Care Practices in Greece

Registered professional nurses, graduates of basic schools of nursing, are caring for mental patients within the psychiatric hospitals as well as through the public health agencies in the community. Of course, under their supervision and on-the-job teaching, a number of practical nurses with one year of training, as well as people with no previous training, also work in the wards of mental institutions.

There is no educational nursing program providing advanced study and specialization in psychiatric nursing in Greece. Beyond the basic knowledge, attitudes, and skills acquired during their nursing education, nurses working in mental health-psychiatric nursing arenas continue to learn, to refine their skills, and to keep pace with the changes and the trends, while caring for the mental patients. They continue to learn mostly through their close collaboration with psychiatrists in the wards, through attending and participating in patient group therapy, in doctor-patient or doctor-patients meetings other than individual psychotherapy sessions, and through establishing nurse-patient relationships. In addition, nurses participate in the various research studies conducted by the psychiatrists, as observers, reporters, collectors of data, and by cooperating in creating and maintaining certain kinds of environments required by the studies. Their input counts and is respected. Psychiatrists rely heavily upon the nurses' observations of and reports about the exhibited behaviors and the life of the individual patients in the wards and on this basis, usually, they prescribe or modify the therapeutic regime.¹

¹ Κρατικού Θεραπευτήριον Ψυχικών Παθήσεων 'Αθηνών. "Εκθέσεις Ηκτατήρων 1972, σσ.30, 32, 77.
Greek literature specific to psychiatric nursing is very limited. Thus nurses become quite knowledgeable by exchanging information, experiences, and ideas with one another, the younger with the senior ones, and vice versa, within the same institution and on a larger scale during the Panhellenic Nurses' Conventions. Furthermore, they keep up with medical psychiatric publications, and they are always invited and frequently attend conferences and conventions of the Greek psychiatrists as a means of deepening and expanding their understanding of mental health, mental illness, and the mentally sick. Those who know a foreign language, usually English, read psychiatric nursing literature in English, and they are well aware of what goes on in other parts of the world. Organized in-service educational programs in the large mental hospitals, though of varied length and scope, help nurses promote the quality of psychiatric nursing care.

Concerning the issue of independent functions of psychiatric nurses, it is interesting to mention that Greek nurses working in psychiatric settings function in many respects independently from medical orders and control, and they are positively reinforced, when they do so, by the doctors themselves. For example, nurses are expected, through their own initiative, to set up and constantly readjust the environment — natural, material, and human — which they consider appropriate and potentially therapeutic for individual patients and for the whole group of them. They are encouraged to establish and maintain supportive helping relationships with patients individually and collectively. They approach the patients' families during their visits to the hospital with the purpose to insure and/or impart information about the patient's needs or to help them express their feelings and revise their negative attitudes. Nurses are responsible
for creating and nurturing the therapeutic milieu in their wards, they conduct ward meetings and activities, recreational or occupational. Sometimes they decide also on the ground privileges of the individual patient according to his changing condition, even though the doctor’s prescription might have been different.

In view of these developments in psychiatric nursing care, there is an increasing demand on the part of the medical directors in mental hospitals, as well as on the part of the nurses, for the establishment of educational programs leading to specialization in psychiatric nursing. The Department of Nursing Education at the Ministry of Social Services is already studying the possibility for the actualization of such a program, but no official steps have been taken as yet.

The general trends in psychiatric care in Greece, as well as the expanding roles and functions of the nurses in the corresponding field, have been presented. It remains to discuss the psychiatric nursing component in the educational nursing programs in Greece, to speculate on the needs for promoting this specific part within Greek nursing education, and possibly to venture some projections through this textbook.

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1 Κρατικόν Θεραπευτήριον Ψυχικών Παθήσεων 'Αθηνών. "Εκθεσίς Επετειόμενων 1972, σ.51."
Psychiatric Nursing within Greek Nursing Education Perspectives

Following the general requirements for nursing curricula set up by the Department of Nursing Education at the Ministry of Social Services in Athens, all basic schools of nursing include one course of psychiatric nursing with concurrent clinical experience in psychiatric facilities. The clinical experience usually extends over a 12-week period while the theory teaching hours vary from school to school.

The psychiatric nursing unit included in the curriculum of the Evangelismos Medical Center, 3-year school of nursing, in Athens, is identical to that of three other schools of nursing and is no different from that offered by other schools.

The purpose of the course is:

To assist the student to acquire or develop basic knowledge, skills, attitudes, and concepts essential to the nursing care of patients with psychiatric conditions, with an emphasis on communication and interpersonal skills. It is designed to broaden, refine, and deepen understanding of socio-psychiatric nursing problems encountered in all nursing situations.\(^1\)

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\(^2\) Αφροδίτης Χρ. Ραγίδα. Σημειώσεις Ψυχιατρικής Νοσηλευτικής (Αθήνα: 1968), σ. 1.
The specific goals of the course are to assist the student to:

1. Acquire concepts of psychiatric nursing within the framework of the disciplines of psychology and psychiatry, constructed in the corresponding courses.

2. Define the various roles -- social, professional, student -- in working with patients.

3. Realize the nursing contributions to specific psychiatric therapies.

4. Know the principles of communication in psychiatric nursing.

5. Develop the ability to identify patient behavior through observation of and communication with the patient, and construct a nursing care plan for the individual patient based on the analysis of behavior.

6. Begin to exercise the skill of therapeutic intervention in response to specific pathological behavior of the patient.

7. Cultivate skills in creating, maintaining, and promoting the therapeutic environment for the patient.

8. Gain an appreciation of the impact and adjustments that long-term psychiatric illnesses have upon the patient, his family, and the community.

9. Become aware of the community resources and programs available for the prevention of mental illnesses as well as the care and rehabilitation of the mentally ill.

10. Develop the ability to observe, understand, and study the dynamics of human relations in groups.

11. Acquire an appreciation of mental health-psychiatric principles as they apply to all areas of nursing and to daily life.
12. Enrich, hopefully, her equipment to continue to grow throughout life in personal stature, professional service, and useful citizenship.¹

Even though not all of these objectives are measurable, they constitute teacher goals with the hope that pursuit of these objectives — i.e., Nos. 6, 7, 12 — will create insights and will foster understanding leading to the development of relevant measurement tools.

In this particular program and in a number of others, the course is placed in the second year so that students early in their nursing education learn about mental health and mental illness and are able to understand the interrelationship of physical and psychic factors within man, and thus integrate the relative concepts in giving total patient care, in identifying the health needs of people, and in contributing to early case finding.

The theory teaching covers about forty hours plus another twenty to thirty hours of clinical conferences and guided group case discussions.

The teaching-learning methods include lecture-discussions, individual and group conferences, demonstrations, guided clinical experiences, role-playing, audio-visual presentations (films, etc.), establishing a student-patient relationship and reporting it in written, group projects presented orally during organized multidisciplinary sessions held in the mental hospital, and field trips to community mental health-psychiatry-related centers and programs. In addition, students attend and participate in patient group therapy sessions followed by discussion of the dynamics involved.

¹Objectives of the Course of Psychiatric Nursing in the Basic School of Nursing of Evangelismos Hospital, Athens, Greece.
The subject matter of the course covers mainly the following areas:

1. Basic concepts of mental health-psychiatric nursing.
2. The therapeutic role of the nurse — planning, implementing, and evaluating nursing care of the individual mental patients.
3. Creating and maintaining a therapeutic environment.
4. The counseling, teaching, and mothering role.
5. The art of communicating — nurse-patient interpersonal relations.
7. Group dynamics.
8. The contribution of the nurse in prevention of mental illness, in restoration and promotion of mental health in various nursing settings and areas.
9. The role of the family, the church, the school, and the community at large in prevention, care, and rehabilitation concerning mental health problems.
10. The functions and goals of the modern mental hospital.
11. Modern international trends in community mental health-psychiatric care and in psychiatric nursing, including practice and education.
12. Applications of psychiatric nursing concepts in all nursing situations.

The outline presented earlier of the basic psychiatric nursing course, in the three-year diploma schools of nursing of Greece, is similar and comparable to basic courses of psychiatric nursing in many
other parts of the world. What makes it different and unique is its adaptive modeling according to the value system, the nursing and medical philosophy and practices, the nature of the Greek family, the socio-psychological characteristics of the national character of the Greek, and, in general, the tradition and culture of Greece.

The foregoing illustration of the basic psychiatric nursing course provides Greek nurses with the elemental knowledge, skills, and understandings to begin with, in their professional practice in mental health-psychiatric settings, if they choose to work in this field, or in any other nursing field. However, the recent developments in mental health-psychiatric practices and the increasing demand for the acceptance of the expanding role of the nurse in the relative field, makes the broader education of the nurse an imperative need. Although this basic course is constantly modified, enriched, and adapted to meet the emerging and changing needs, it cannot be changed that much, within the boundaries of the structure of the existing three-year curriculum, in order to prepare the nurse for a more therapeutic role and more complex functions in psychiatric settings. A new educational program must be built.

The issue of the expanding role of the nurse in Greece proved to be of a universal type and it does not refer solely to the psychiatric nursing field. As a consequence, new designs for a university basic nursing program are under study. The implications of this future planned development of nursing education in Greece will touch considerably upon the teaching content and the instructional strategies with reference to psychiatric nursing. For example, nurses must be prepared to function comfortably in a variety of settings -- medical, surgical, psychiatric, public health, and others; to define flexibly and
situationally their roles and functions in relation to the nursing priorities and to the range of professionals available in the work scene, at a point of time, to readily exchange roles on certain multidisciplinary settings and yet not to lose their nursing identity. Furthermore, nurses must be educated to be able to use the mental health-psychiatric nursing concepts in assessing and interpreting a variety of nursing situations as well as in health teaching, in health counseling, in restorative, and in therapeutic nursing interventions.

Another dimension of concern is the educational preparation of the nurse to be able to work therapeutically with individuals and groups to understand the sociocultural factors and systems as potential contributors to or inhibitors of mental health and cultivate a sense of responsibility to participate in the building of a saner society.

At this point in time, with Greek nursing education at the crossroads and with the prevailing mental health-psychiatric trends already discussed, this textbook endeavors to make a contribution to the broader and more comprehensive education of the basic university Greek nursing student, to meet the challenge of the expanding role of the nurse within the perspective of mental health-psychiatric nursing.

A Conceptual Approach - Rationale

Concepts are used increasingly in modern nursing education as a framework for curriculum or as content matter in individual

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A conceptual approach is selected for the presentation of this textbook in order to provide the nursing students with a basic theoretical orientation to psychiatric nursing. The conceptual psychiatric nursing framework will prepare professional nurses to function in any setting — psychiatric or other — in which they may find themselves, because concepts are abstractions and relate to a variety of situations. Thus, they allow for transference of knowledge.

Concepts are like patterns, composed of many parts, which can be reorganized and used in various combinations and in new ways, and they can always acquire new depth and dimensions through clinical experience. Concepts are also subject to revision and rejection or to refinement and re-use in the context of new knowledge. Thus, they assist in meaningful incorporation and systematization of new knowledge and experiences.

This intellectual approach is chosen instead of the pragmatic approach describing techniques and procedures, in order to foster the development of the nurse as a creative thinking person rather than a follower of orders and performer of delegated tasks. Through a clear understanding of concepts, the nurse will be able to relate and fit the knowledge to the situation and to reach decisions for responsible nursing action.

Finally, the concepts presented in this textbook may serve as a framework for the exploration and identification of new concepts toward a theory development in the arena of psychiatric nursing in Greece.

3 See Appendix A.
The study of concepts related to mental health and mental illness applicable to a variety of nursing situations, in the context of Greek culture, led this writer to the organization of the present textbook. It includes two units. The first unit is entitled "Modern Horizons of Mental Health-Psychiatric Nursing." The second unit is entitled "Dimensions of Mental Health-Psychiatric Nursing."

The first unit sets the perspective in which the textbook considers psychiatric nursing. It encompasses two chapters. Chapter 1 introduces the value system of the whole of nursing as the foundation and the orientation to psychiatric nursing. The chapter opens with a speculation on the role of beliefs and values in human life; it includes the presentation of the nursing profession as a treasury of values as well as the value orientation of Greek nursing shaped mainly by the Christian Faith; the chapter closes with a consideration of the modern prevailing values in all nursing and particularly in psychiatric nursing.

Chapter 2 explores the contemporary trends in psychiatric nursing care; it presents the psychiatric nursing component in the basic education of nurses and considers psychiatric nursing as a baseline to all nursing.

The second unit illustrates selective dimensions of mental health-psychiatric nursing in Chapters 3 to 7. Chapter 3 endeavors to foster understanding of the dynamics of mental health and mental illness; the role of the family as crucial in mental health and mental illness including a description of the modern Greek family; and the dimensions of prevention of mental illness in modern times.
Chapter 4 discusses nursing as the science of the dialogue. It highlights the significance of skillful communication and therapeutic interpersonal relations (nurse-patient and nurse-patient group) in mental health-psychiatric nursing, within the conceptual perspective of all nursing being an interpersonal process.

Chapter 5 describes the dimensions of personalized nursing care of the mental patient, as a unique person with a personal expression of his illness. It includes (1) nursing assessment of the patient's level of health; (2) planning nursing care; (3) actualization of the nursing care plan within a therapeutic environment; and (4) evaluation of its effectiveness. The nursing care is discussed as the core and the essence of the interpersonal nursing process, based on a continuous nurse-patient interaction and committed to help the mental patient to move in the direction of health.

Chapter 6 presents the psychosomatic approach within the context of conceiving man as a psychosomatic entity, who experiences the disharmony produced by illness as a whole. It encompasses a speculation on the mystery of pain and suffering, illustrations of illness as a crisis of psychological stress and anxiety, and implications for nursing intervention.

Chapter 7, finally, studies behavior as a personal expression in health and disease with special emphasis on selective pathological behaviors in mental illness and their nursing confrontation. It includes, also, a discussion of behavior problems exhibited by physically ill elderly patients, and suggestions for nursing intervention.
The textbook reflects in perspective the possibilities for nursing the person, regardless of the diagnosis and care setting; these possibilities may be actualized if the mental health-psychiatric nursing concepts are integrated in all nursing situations.

**Summary**

The textbook is addressed to Greek university basic nursing students. Thus, the cultural dimension is considered, incorporating variables such as Greek religion, philosophy, tradition, history, and the national character of the Greek. This is to alert the non-Greek reader.

The textbook builds upon, as well as illustrates, nursing perspectives on the basis of conceived values projected as ideal hallmarks to guide nursing practice. These are: (1) the belief in the intrinsic worth of man; (2) the holistic view of man; and (3) service to man, by Christian Love. The author is aware of the gap between conceived values and operative values in everyday practice. However, conceived values are deliberately highlighted as nursing ideals in the textbook, with the hope that they will challenge nursing students to develop a commensurable personal axiology and pursue its actualization in the nursing arena.

Finally, the role of the nurse is considered mostly in its psychosocial dimension. The nurse's function in milieu is speculated as a strong therapeutic potential of her expanding role nowadays.
PART II

THE TEXTBOOK
INTRODUCTION

This textbook is but a small contribution to Greek nursing education. The author acknowledges the burden of responsibility in daring to write a textbook for Greek nursing students. This is due to an awareness that modern Greek nursing students are inheritors of, and assigned to enrich and extend, the spirit, the essence, and the "thesaurus" of Greek paideia as well as of Greek nursing tradition. The endeavor is undertaken mainly as a learning experience for the author, who considers herself a lifelong student of nursing.

This textbook aims to reveal to the contemporary nursing generation the psychiatric nursing perspective as one of the infinite dimensions of general nursing. Caring for and about man as a bio-psycho-social unique person was first discovered by the Greeks. The textbook will no doubt raise many more questions than it will provide answers to the readers. It will analyze and synthesize selective psychiatric nursing concepts applicable in a variety of nursing settings. It is hoped that application of these concepts will enlist the critical thinking, the creative mind, and judgmental powers of nursing students. The textbook is intended to serve as a stimulus to learning for nursing students, as a challenge for developing interest in the subject, and an opportunity for independent inquiry and broader study in the field.

For the teachers of nursing, this textbook can be a tool of communication in the teaching-learning process, a guide in selecting course content, a bibliographic source for further search in the domain of psychiatric nursing, and an encouraging appeal for better and more systematic writings in the field.
UNIT I:

MODERN HORIZONS OF MENTAL HEALTH-PSYCHIATRIC NURSING
Chapter 1 introduces the value system of the whole of nursing as the foundation and the orientation to psychiatric nursing. The purpose is to enhance understanding of the philosophical perspective in which this textbook will consider psychiatric nursing. The presentation refers primarily to the value orientation of Greek nursing, shaped mainly by the Christian Faith. However, there will be included a selective and comparative overview of modern international formulations of the value system of nursing as well as of psychiatric nursing.

The chapter opens with speculation on the role of beliefs and values in human life and closes with a consideration of the prevailing values in psychiatric nursing.

Content Outline

Beliefs and Values: The Essence of Human Life
- Man's Need for Values
- Value Crisis in Present Times

Modern Nurses and the Issue of Values

Nursing Profession: A Treasury of Values
- Values: The Living Substance of Nursing
- Value Orientation of Nursing in Greece

Modern International Conceptions of Nursing Values
Overview of general nursing literature with reference to values

Overview of the psychiatric nursing literature with reference to values
Beliefs and Values: The Essence of Human Life

Man's Need for Values

The search for meaning, for an axiology, constitutes a prevailing theme in contemporary thought. Man needs a framework of beliefs and values to live by and to understand, in the same sense that he needs food and love.

Values, usually, are developed "as a part of the learning process by observing and by associating with people, ideas, and institutions in society ... in the home, the church and the school. ...". Values are estimates of the intrinsic worth of people, things, relationships, life, and happiness. Man uses values as criteria for choices and as guides for selecting from available modes, means, ends, and courses of action. Allport observes that "personal values are the dominating force in life, and all of a person's activity is directed toward the realization of his values.".

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2 Ibid.
Contemplating the human destiny, Lecomte du Noüy makes the point that:

If intelligence alone should rule, all the human traits of which we are proudest, the sense of duty, of liberty, of dignity, of the beauty of disinterested effort, would disappear little by little and fade out into oblivion, until civilization would vanish without even an afterglow. On the other hand, if the moral law dominates, it will not oppose itself in any way to the free development of the mind . . . true progress is internal and depends solely on the sincere passionate desire to improve in the strictly human sense of moral and spiritual values.

Indeed, values give meaning and purpose to human life, as well as foster the development of the spiritual dimension of man.

Value Crisis in Present Times

In the midst of so much world conflict and rapid social change in which we live, many people are unable to keep any enduring faith, any basic value orientation, which provide the ground for a unifying philosophy of life. As a consequence, they conclude that life is futile and purposeless, and they give up searching for meaning. This is a distressing phenomenon in the 20th century, the richest century in scientific inventions and applications, and in the variety of opportunities in which man may fulfill himself. The inability of people to find values and meaning in their life is considered "fertile ground for mental disorders."

There is an increasing consciousness of the "value-illnesses" in our days, holding for conditions like apathy, hopelessness, and cynicism.

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Maslov expresses deep concern about the consequences of this phenomenon when he writes:

Character disorders and disturbances are now seen as far more important for the fate of the world than the classical neuroses or even the psychoses. From this point of view new kinds of illnesses are most dangerous, e.g., the diminished or stunted person, the loss of any defining characteristics of humanness or personhood, the failure to grow to one's potential valuelessness.  

The diagnosis of the contemporary value crisis is speculated on by Livingstone from another vantage, as follows:

The real cause of our malaise is the absence . . . of an "ethical ideal." We do not know what we believe; therefore, we do not know what we want. We become the slaves of our material civilization and not its masters. No steady mind and purpose fills the sails of our ship. The modern world has no definite view of life. . . . Without a clear and accepted view of life, men waste and misuse material resources and are lost in their rich profusion as travelers in a tropical forest who have neither guide, map, compass . . . . It is the confusion brought by the collapse of a spiritual ideal.  

Modern educators admit the failure of education to deal adequately with values at this particular point of history, and engage in real crusades for humanizing curricula, educational systems, and school environments. Indeed, the education does not fulfill its purpose as human development facilitator by merely transmitting cognitive information, but also by providing each student with opportunities to broaden and deepen a developing philosophy of life. "Knowledge and values, or epistemology and axiology, are separable only conceptually, never behaviorally."  

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More and more it becomes evident that only the man who grasps the demands of the world of values, exemplifying truth and goodness, and is capable of lasting response to values, can really overcome the daily adversities and disappointments and survive real-life crises. "He who has a why to live for can bear with almost any how." It is written that "man shall not live by bread alone, but by every word that proceedeth out of the mouth of God." Only the man with faith cannot lose sight of the ultimate meaning and worth of his life even when he is enslaved in a concentration camp or working in the darkness and hardship of the mines.

Indeed, beliefs and values constitute the essence of life. They contribute to building, sustaining, and promoting healthy personalities; that is, personalities open to experience, accepting, understanding, caring, supporting, loving, zestful for life, risking involvement, daring to encounter others as well as themselves.

Modern Nurses and the Issue of Values

Contemporary nursing faces the value crisis, in this age, with increasing concern. Science and technology have opened limitless opportunities for nurses to extend and expand their roles in the health-care field; but in the meantime they encourage cold objectivity, detachment, and depersonalization. Professional nursing is at the crossroads.

1 Victor Frankl, Man’s Search for Meaning: An Introduction to Logotherapy (New York: Pocket Books, 1963), p. 121.
2 Matthew 4:4.
Will it be capable of utilizing the advents of civilization and yet not leave aside its commitment to a value system which nurtures its transcendent meaning and humanizes the ideal? What direction nurses choose now will determine not only the future of the profession but also, to a considerable extent, the future human resources for a holistic health care of society.

McAttee, commenting on this issue, writes:

The future is unlimited, and we have just begun to explore the possibility of maximizing learning through curriculum development. Greater emphasis on human values in the nursing curriculum along with increasing academic standards will enable nurses to move into responsible positions in society. . . . If human values are left out of our curriculums, we can produce only insensitive, automatic practitioners. . . .

The crucial need, especially in our era, for a value-oriented nursing curriculum is emphasized by Sister Roach, writing that the ideals of love, respect, and reverence must become meaningful to nursing students. She also says:

It seems apparent that educators are charged with facing the reality of the need for integral human values, values which embrace the whole man and his relationships with other creatures and with God. Such a commitment calls . . . for a more direct focus on affective learning without prejudicing the cognitive and conative outcomes.²

It is encouraging to see that nursing faculties express officially their concern and willingness to assume responsibility for helping students to develop a value system. The philosophy of the Department of Nursing of Columbia University, New York City, includes the following statement:

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"The Faculty accepts the obligation to provide knowledge and stimulate learning, serve as resource persons and innovators in nursing, act as professional role models and contribute to the development of human values.\(^1\)

Anderson, speculating on the issue of values, stresses the point that "every person needs a system of values to guide his life and conduct. ... Philosophy can bring deeper meaning into nursing practice and the lives of those who practice it."\(^2\)

In a society which is undergoing a value crisis, it is the writer's view that blessed and privileged are the nurses who will choose to live and to nurse by faith and values. They will taste the spiritual essence and the fullness of life, and they will be able to transfuse it to the needy. The nursing profession, like a school of philosophy, can provide the favorable climate conducive to the search of the ultimate truth for those willing to engage in it. If the nurses become involved, they will discover answers to the philosophical questions: Who is man? What is life? Why suffering? Why death? What is after death? Such nurses can really determine the dimensions and the horizons of the nursing profession.

**Nursing Profession: A Treasury of Values**

**Values: The Living Substance of Nursing**

Concern for human values has always been a permanent inhabitant of the heart of nursing. The nursing profession has a rich history of

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\(^1\)Department of Nursing, The Faculty of Medicine, "Philosophy," Columbia University Bulletin, 1972-1973, p. 18.

dedication, self-sacrifice, and whole-hearted commitment to promoting the health and well-being of individuals, families, and communities. Tracing through the depths of centuries we can witness from the very beginning of nursing that it was born out of human values, was nurtured and grew by human values, and its survival may be better understood by its devotion and attachment and continuing response to human values.

Nursing in any part of the world holds and expresses, in its own ways, certain beliefs and values about the nature of man and about the worth and meaning of human life and health. Let us examine these beliefs and values.

Value Orientation in Nursing in Greece

The value orientation of Greek nursing is influenced by the medical and philosophical ancient Greek spirit, shaped by the Christian Faith, and conceptualized during the Byzantine era. It encompasses the holistic view of man, the belief in the intrinsic worth of the person, and the commitment to the service of man by Christian love. This value system is not a matter of historical evidence and mere inheritance from the past, but it stands for the Greek nursing ideal today, and inspires all modern developments and aspiration in the fields of nursing education and service.¹

The holistic view of man originated in the Hippocratic medical thought² and it was accepted and elaborated by Plato as follows:

¹ ΕΛΛΗΝΙΚΗ ΑΔΕΛΦΗ. Πανηγυρικόν Τεύχος Ἐπετειακοῦ εἰς τὴν ἹΜΕΡΑΝ Τῆς ΑΔΕΛΦΗΣ, 12 Μαΐου 1972, Τεύχος 41, Ἰούνιος 1972, Αθήναι.

I dare say that you have heard eminent physicians say to a patient who comes to them with bad eyes, that they cannot undertake to cure his eyes by themselves, but that if his eyes are to be cured, his head must be treated too. And then again they say that to think of curing the head alone, and not the rest of the body also, is the height of folly. And arguing in this way they apply their regime to the whole body, and try to treat and heal the whole and the part together . . . the part can never be well unless the whole is well. For all good and evil, whether in the body or in the whole man, originates . . . in the soul.¹

This view of man has, as a whole, acquired a deeper and higher meaning within the Christian anthropological perspective. In the latter, man is considered as a bio-psycho-social and spiritual being, a distinct, unrepeatable, irreplaceable, and incomparable person with a unique soul which cannot be exchanged for the whole world.² Thus, nursing does not condition services according to man's social privileges and "accidental" characteristics such as family origin, education, profession, wealth, skin color, and so on. Nursing is one in quality for all people, following the teaching of the Bible: "Ye shall not respect persons in judgment: but ye shall hear the small as well as the great."³ And because of the intrinsic worth and dignity of the recipient of nursing care, the smallest service done to the lowliest possesses an eternal value and contributes to the nobility and grandeur of the nursing profession.

The third aspect which constitutes the essence of the value orientation of Greek nursing is service to man by Christian love, as defined by St. Paul,⁴ with its nine elements:

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¹ Plato, "Charmides," 156b, c, d, e, The Collected Dialogues of Plato, pp. 102-103.
² Mark 8:36-37.
³ Deut. 1:17.
⁴ I Corinthians 13:4-6.
Patience  "love suffereth long"
Kindness   "and is kind"
Generosity  "Love envieth not"
Humility   "Love vaunteth not itself; is not puffed up"
Courtey    "Doth not behave itself unseemly"
Unselfishness  "Seeketh not her own"
Good temper  "is not easily provoked"
Guileless  "thinketh no evil"
Sincerity  "rejoiceth not in iniquity, but rejoiceth in the truth"

This kind of Christian love composing the nursing ideal is founded on the belief that "God is love; and he that dwelleth in love dwelleth in God, and God in him." This kind of "nursing love" is considered as the more excellent way to express one's faith and love to God, because He said: "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me." \(^1\)

In conclusion, the value orientation of Greek nursing, presented above, standing as a projected ideal to be sought and actualized, will be used by the writer as a framework of this textbook.

Modern International Conceptions of Nursing Values

Overview of general nursing literature with reference to values.

Modern nursing begins with Florence Nightingale (1820-1910), who introduced a new system of nursing education and contributed to the development of nursing as a profession. It is interesting, therefore, to see

\(^1\) John 4:16.
\(^2\) Matthew 25:40.
what this pioneer molder of contemporary nursing believed about the place of values in the formation of a nurse. In many different ways (and repeatedly) she expressed and defended her position that "the nurse must have method, self-sacrifice, watchful activity, love of the work, devotion to duty, the courage, the coolness of the soldier, the tenderness of the mother, the absence of the prig..." ¹ Also:

Every nurse... must be no gossip, no vain talker... she must be... strictly sober and honest; but more than this, she must be a religious and devoted woman; she must have a respect for her own calling, because God's precious gift of life is often literally placed in her hands; ... she must be a woman of delicate and decent feeling.²

From this point on, continuing the search in the works of nursing writers, we find interesting positions concerning the issues of values in nursing. Harmer, one of the first to write a nursing textbook, stresses the point that "nursing is rooted in the needs of humanity and is founded on the ideal of service..." ³ Chaptal presents the nursing profession to French nurses as a high mission which requires a moral education of the nurse beyond her scientific and technical preparation. Her entire book is an analysis of the virtues that a professional nurse must cultivate, such as sincerity, loyalty, goodness, sympathy, tolerance—all stemming from the great virtue of charity.⁴

Goodrich\(^1\) expresses the concern about the importance of values in nursing. The question of the nature of nursing has been raised by many nursing leaders at various points of history. Let us see what answers have been given, and whether they include explicitly and implicitly notions on the issues of values.

Effie Taylor responds that "the real depths of nursing can only be made known through ideals, love, sympathy, knowledge and culture, expressed through the practice of artistic procedures and relationships."\(^2\)

A group of nursing educators defines nursing in the following way:

Nursing, in its broadest sense, may be defined as an art and a science which involves the whole patient—body, mind, and spirit; promotes his spiritual, mental, and physical health by teaching and by example; stresses health education and health preservation as well as ministration to the sick; involves the care of the patient's environment—social and spiritual as well as physical; and gives health service to the family and community as well as to the individual.\(^3\)

Another nursing author says: "The art of nursing is the fulfillment of an ideal through the application of principles which have been discovered by science... A serviceable and inspirational force for good."\(^4\) Nursing is considered by Dalloni as a mission of serving the patients as images of God. She suggests that the nurse examine continuously her axiology of values, to make certain that charity \(\text{la virtu-}\)

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\(^2\) Effie Taylor, "Of What is the Nature of Nursing?", *American Journal of Nursing*, 34 (May 1934), 476.


ing (the virtue queen) possesses constantly the higher rank when she cares for her patients.¹

Nursing as a profession is considered to embrace more than an art and a science by a considerable number of nursing leaders. "It is a blending of three factors," Price says. "Art, science, and the spirit of unselfish devotion to a cause primarily concerned with helping those who are physically, mentally or spiritually ill."² This "spirit" of nursing is otherwise characterized as "the desire to help people ... compassion and understanding."³ Wiedenbach emphasizes the need for a philosophy of nursing and epitomizes the essence of such a philosophy in three concepts: "(1) Reverence for the gift of life, (2) Respect for the dignity, worth, autonomy, and individuality of each human being, (3) Resolution to act dynamically in relation to one's beliefs."⁴

The description of the nurse by Henderson, included in her definition of nursing, looks very impressive. The nurse "is temporarily the consciousness of the unconscious, the love of life for the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the infant, knowledge and confidence for the young mother, the 'mouthpiece' for those too weak or withdrawn to speak, and so on."⁵ Among the

qualifications and abilities of the professional nurse, Spalding and Hotter include: "Faith in the fundamental values, respect for the individual dignity of every human being, practicing self-sacrifice for the common good ... to accept and understand people of all sorts, regardless of race, religion, or color."¹

In her systematic inquiry for the development of a nursing theory, Martha Rogers has formulated many statements defining nursing. One of these says: "Nursing is a humanistic science dedicated to compassionate concern for maintaining and promoting health, preventing illness, and caring for and rehabilitating the sick and disabled. ... Nursing's central concern is with man in his entirety ... Man is a unified whole."²

McManus also sees professional nursing as "an art and a science dominated by an ideal of service." She makes the point that "skillful care embraces the whole person -- body, mind and soul -- his physical, mental and spiritual well-being."³

Today, when nursing education presents such a variety of programs and directions, Bailey makes the point that nursing education must foster self-development will, in turn, widen the nurse's tolerance and understanding and will strengthen her interest in people, namely, in knowing about them and in feeling for them.⁴

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Finally, the overall international nursing horizon proves to be value-based and value-oriented by the existence of an official international code of ethics for nurses. One of its articles states: "The need for nursing is universal. Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status."

The foregoing selective presentation of extracts from general nursing literature makes evident that nursing profession definitely has a value system, which appears to be operating in all nursing endeavors, either in education or in service, and even in the more frontier strivings for the conceptualisation of a nursing theory. Basically, the prevailing transcendental values, mentioned in the nursing literature, refer to the spiritual dimension and the intrinsic worth of man and to the ideal of nursing service represented mostly by unselfish, compassionate, and non-discriminating care of the whole man.

What does not appear explicitly expressed in most of the cited philosophical statements is the notion of absolute values, namely, of the ultimate source of man's intrinsic worth and of all the transcendental nursing values. The concept of love also is scarcely mentioned while isolated attributes of it are stressed frequently. Is it because the absolute values remain still to be discovered by most of the nurses or are they so unanimously shared that there is no need to mention them but only to imply them? In any case, what matters is the involvement in the search of the ultimate truth, because "he that seeketh findeth."

Overview of the psychiatric nursing literature with reference to values. Psychiatric nursing as a distinct and developing nursing specialty is based on the general nursing values. However, in related literature, certain values are emphasized and analyzed as particularly applicable and useful in the field of mental health and psychiatric nursing.

The belief that "man is a unity, a complex, physical, intellectual, emotional, and spiritual organism,"1 with "innate worth and dignity,"2 is declared repeatedly as fundamental in understanding the psychiatric patient.3,4,5,6,7 Ackner stresses the point that it is not the diseased part but a disorder of the whole person which finds expression in psychiatric illness and emotional difficulties. Each person has his own unique background, life history and personal problems. He cannot be regarded as just suffering from a disease to be cured, but must be approached as an individual who needs to be understood.8

2 Illinois State Psychiatric Institute, Philosophy of Nursing (Chicago: The Institute, 1967), p. 4.
Sister Kathleen Black also emphasizes that

Although to himself the patient may seem to be a non-person, an alienated uncommitted thing among things, the nurse perceives him as a person who, however deprived or despairing, still has a potential for authenticity. She views him as much more than a collection of behaviors to be identified and labeled, or a subject to be measured against theoretical criteria and influenced to calculate degrees by the use of calculated techniques.  

Even in the revision of current practices in mental health, the issue of the worth of man is brought up as the touchstone against which the quality of services can be estimated. Morris raises the question: "Do we establish and develop relationships that respect the worth and dignity of every individual? ..."  

However, very few try to speculate on and express belief in the source of the intrinsic worth and dignity of man. Manfreda does. She declares:

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The aims and objectives of medical and nursing care stem from the high value placed upon the creations of God. In dignifying man, we dignify God who created him and ministered to his needs. Nurses who believe in this concept harbor a value and respect for human beings as they minister to their needs during health and illness.  
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She elaborates further how this concept may be woven into nursing care by giving examples such as helping the underprivileged person without injuring his pride, showing attention to the less attractive and less talented individual, preventing unnecessary exposure of the patient's

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1 Sister Kathleen M. Black, "An Existential Model for Psychiatric Nursing," Perspectives in Psychiatric Care, 6, 4 (July-August 1968), 180.


body, sharing the satisfaction of a person's achievement, and so on. In this perspective, Manfreda considers keen sensitivity, charity, loving care, genuine acceptance, and protection as therapeutic elements of the nurse-patient interaction.¹

There is an overall consensus in the literature reviewed that psychiatric nursing and the means of its provision with a therapeutic potential is the nurse-patient relationship.²,³,⁴,⁵,⁶ This notion originates from psychiatry itself in which the personal relationship of therapist and patient is considered to be the most effective therapeutic force.⁷ Thus, most of the values presented refer to the personal attributes of the nurse which count for the quality of this relationship. What are they?

Peplau defines nursing as "a significant therapeutic interper-
sonal process . . . a maturing force that aims to promote forward move-
ment of personality."⁸ In her analysis of the therapeutic elements of
the nurse-patient relationship she emphasizes warmth and acceptance of

¹Manfreda, Psychiatric Nursing, pp. 61, 182, 207, 222-223.
²Peplau, Interpersonal Relations in Nursing.
⁵Poletti, Aspects Psychiatrques des Soins Infirmiers, p. 40.
⁸Peplau, op. cit., p. 16.
the patient as he is. She admits that "a nursing practice can be improved when such words as 'love,' 'respect for the patient,' and 'nursing the whole patient' are clear to those nurses who find those symbols useful in communication." However, she has the feeling that the operations which denote showing love, showing respect, and rendering care to the "whole patient" have not yet been adequately identified nor the relationships to the references clarified in the minds of nurse practitioners.\(^2\)

Despite Peplau's reservations, Lisa Robinson presents love as an element of the therapeutic nurse-patient relationship and defines it as "a warm positive regard for the patient . . . [enabling] the nurse to respond to the needs of the patient in a consistent, interested, helpful manner."\(^3\) Alice Robinson proposes the concept of love as "a specific and potent nursing tool and a skill which can be developed with warmth and understanding" and which has a positive, constructive influence as a therapeutic agent in the individual nursing care of the schizophrenic.\(^4\)

Love is also mentioned as a therapeutic attitude in the nurse-patient relationship, along with empathy, acceptance, kindness, sincerity, availability, and respect, by Gagnon and Lamothe.\(^5\)

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1 Peplau, Interpersonal Relations in Nursing, pp. 186-187.
2 Ibid., p. 298.
5 Gagnon and Lamothe, Soigner C'est Vivre le Défi Quotidien, pp. 33, 60-62.
Holmes and Werner suggest that "the golden rule can be interpreted to give a useful guideline to therapeutic nursing." In their description of the basic humanistic qualities of the psychiatric nurse, which sounds like an interpretation of the "golden rule" suggested in their introduction, they state: "The nurse should be able to like many kinds of people, accept all kinds of feelings, tolerate very primitive behavior, be interested and warm and accepting." In another place, Holmes seems to attribute the elements of love to the substance of nurse-patient involvement, when she defines it as "the interest, the feeling of compassion, the concern, the desire to help..." and when she points out that "a professional relationship need not be cold and detached..." [the nurse] must be able to give something of herself, her time, her concern, her interest -- without demanding anything in return.3

The patient's need for love is emphasized repeatedly by Poletti, who suggests as a therapeutic nursing response: chaleur humaine (= human warmth), respect, availability, acceptance, reassurance, patience, genuine interest, and kindness.4

Irving makes the point that the patient because he is a person of essential worth and dignity deserves the nurse's love and respect.5

2Ibid., p. 76.
4Poletti, Aspects Psychiatriques des Soins Infirmiers, pp. 32, 104-105, 117.
Elaborating on this point, she expresses her conviction that the nurse cannot help the patient unless she cares enough about him to risk personal involvement and commitment and unless she has a willingness to invest and give of herself, yet feeling that giving replenishes rather than depletes her inner supply. Love is emphasized also by Schue as therapeutic in the nurse-patient relationship, along with knowledge, patience, kindness, understanding, acceptance, and empathy.1

It is interesting to read how Weiss considers love as the basis of attitude therapy in psychiatric nursing:

And the most unreachable patient begins to react favorably when he recognizes that you are interested in him. He has a little bit of faith in himself again, and that tiny morsel of self-respect, or esteem, or dignity, can be the vital spark in resocialization or rehabilitation. . . . And [the nurse's] basic tool is love. . . . That is why we say love is the basis of attitude therapy. . . . "If we can love: — This is the touchstone". . . .2

In her lyric monologue on the nurse-patient relationship, Gould says:

I must be . . .
one who loves
for
one who suffers.
Only love
can compel me
to compassion
Love is not a luxury.
Love is life saving.3


The presentation of the concept of love by Georgianna Hoffman reveals more vividly the therapeutic potential of love as a nursing clinical power. Even though she raises the question: "Where does love originate?", she does not go too far in answering it. Rather, her focus is on exemplifying love in the nurse's role, in a psychiatric setting.

Hoffman maintains:

Through "mothering" the nurse offers the patient a second chance to experience what he has missed in childhood in the hope that he will be able to develop an affirmative attitude toward himself. . . . By listening to him with concentration. . . . By guaranteeing a resilient response to the expression of negative emotions. . . . By extending a love that imposes a minimum of conditions, the nurse offers an atmosphere of safety that provides . . . the sick person with the crucial knowledge that he is acceptable. . . . This understanding lies at the heart of the healing process, for it enables him to become acceptable to himself.

Of course, one must note that this author fails to report that one cannot as a therapist give anyone what has been missed in childhood. Hoffman stresses the point that because the nurse exercises professional judgment and focuses on the needs of the patient, she may not always approve of the patient's behavior. However, her actions spring out of the matrix of love, are informed by her loving concentration on the sick person, and are motivated by her intense desire to see him grow toward health and wholeness. The art of loving, according to Hoffman, is "a process which requires discipline, concentration, patience, and acceptance of the possibility of pain."2

Horris analyzes the concept of "respect" and of "tenderness" in a way that projects the spectrum of love, though not put explicitly in this

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2 Ibid., p. 690.
Writing about reassurance depending on a basic philosophy of respect for another person, and about acceptance as a therapeutic element in the nurse’s role, Gregg implicitly becomes an advocate of the therapeutic use of love by the nurse. Similarly, a considerable number of writers in the field, such as Mereness, Matheney and Topalis, Brown and Fowler, Tremblay, and others, though not dealing with the concept of love directly, they do emphasize the elements of love as therapeutic agents in the nurse-patient relationship. Representative elements of love prevailing in their writings are: acceptance of patients as unique and important human beings, warmth and genuine interest, understanding, respect, empathy, and support.

The selective review of psychiatric nursing literature revealed a great emphasis on beliefs and values referring to the intrinsic worth of man and to the loving care of the psychiatric patient. The primary sources of these values, however, were mentioned by only a few writers.

Opposing views were not identified, except a feeling of uncertainty and no unanimous orientation as to what values, if any, should be inherent in the practice of community mental health nursing. The Report of the Third Work Conference on Graduate Education-Psychiatric Mental Health Nursing includes the following statement: "There appeared to be no group consensus on questions pertaining to the necessity for absolute values in developing a philosophy for practice or which values ought to be considered." Nevertheless, the fact that a group conference of this caliber chose to consider philosophical issues in relation to community mental health, though terminated with a ferment of opinion and disagreement, creates the impression that values in nursing continue to be sought as important. And, perhaps out of the ferment, a constructive momentum will result; namely, a redefinition and enrichment of nursing values may emerge as the task by privilege of group conferences of modern nursing leaders.

In conclusion, this writer believes that a value orientation can definitely contribute to the fuller, better, and most meaningful use of all available scientific knowledge, as well as of all gained clinical experiences and insights, for making mental health and psychiatric nursing truly therapeutic.

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1 Conference held October 7-9, 1970, Pittsburgh, Pennsylvania, p. 45.
Purpose

This chapter aims (1) to explore the modern trends in psychiatric nursing practice, (2) to present the psychiatric nursing component in contemporary basic education, and (3) to consider psychiatric nursing as a baseline to all nursing.

Content Outline

Modern Trends in Psychiatric Nursing Care

Major Psychiatric Clinical Developments Affecting Nursing

Developments and Issues in Psychiatric Nursing Services and Functions

Basic Educational Preparation for Psychiatric Nursing in Selective European Countries and in the United States

Psychiatric Nursing Concepts Applicable in General Nursing Settings
Modern Trends in Psychiatric Nursing Care

Major Psychiatric Clinical Developments Affecting Nursing

There have been major changes in care and treatment of the psychiatric patient as well as in the organization of psychiatric facilities which have influenced nursing in many ways. These changes not only are a matter of better engineering and organizational planning, but also they represent a combination of evolving values, beliefs, and practices. They are enhanced by recent developments of social psychiatry and the concept of community mental health.\(^1\)\(^2\)\(^3\)

An increasing emphasis is given to the importance of events which precipitate the explosion of emotional disturbances and, respectively, a renewed interest is developed in early case findings and possible

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2. Κ. Στεφανής, Η Φυγιατρία Η μεταμόρφωση της Φυγιατρικής, Τέμος Α', Τέμος Α', Γενικό Μέρος, Αθήνα: Επιστημονική Εκδόσεις, 1973, σ. 337.

prevention. Furthermore, systematic observations have led to the discovery that many patients viewed as hopeless inhabitants of wards designed for custodial care may show marked and efficient changes in behavior when they are given the opportunity to participate responsibly in planning and implementing the arrangements for their own care.

Furthermore, the effectiveness of new psychotherapeutic drugs in helping even severely ill patients to keep contact with people in their environment allowed early discharge from the hospital, possible treatment in the context of family, and the establishment of new ways for continuity of care at different stages of rehabilitation. Subsequent developments of psychiatric clinical practices are highlighted as follows:

1. Increased conception of mental illness as social in origin and facing it as a social issue.

2. Reorganization of the physical structure and psychosociological systems of the hospital; for example, open doors, disappearance of physical restraints, therapeutic milieu, patient government,

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1. Audrey L. John, Maria O'Leite-Ribeiro, and Donald Buckle, The Nurse in Mental Health Practice, Public Health Papers No. 22 (Geneva: World Health Organization, 1963), pp. 75-76.


and diminution of legal restrictions.1,2

3. Expansion of psychiatric services within general hospitals.3

4. New approaches to therapy, such as psychopharmacology, individual psychotherapy, milieu therapy, group therapy,6 behavioral therapies,7,8 and family therapy.9

5. Emphasis on prevention, early detection, and treatment in the community.10,11

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1John, O'Leite-Ribeiro, and Buckle, The Nurse in Mental Health Practice, pp. 75-76.


7. Awareness of the value of continuity care throughout the patient's illness, involving a variety of coordinated services and necessitating the multi-disciplinary team approach to psychiatric practices.

8. Increase of psychosomatic diseases necessitating an integrated psychosocial as well as psychosomatic orientation of all health care, be it physical, psychiatric, or social.

The foregoing trends have precipitated respective developments in psychiatric nursing care.

Developments and Issues in Psychiatric Nursing Services and Functions

The prevailing concept of community mental health in the frame of social psychiatry and the concurrent re-conceptualization of mental illness and of the mental patient in the interpersonal perspective have fostered the extension of nursing roles and functions, in Europe as well as in the United States, along the following lines:

1. There is an increasing variety and complexity of settings for psychiatric nursing practice, such as mental or general hospitals of

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various kinds (day-care, night-care, emergency units), outpatient clinics, mental health centers, and so on. All of these call for flexibility and adaptability, but with a clear purpose and defined framework for nursing functions. The nurse participates actively and responsibly in multidisciplinary teams. This implies problems of overlapping roles and functions, of identifying role and function, and of communication within the team. And "of all recommendations, interdisciplinary collaboration may be the most difficult to accomplish."

2. The nurse is more and more involved in primary assessment of psychiatric problems and in direct psychotherapeutic patient care, wherever this takes place.

The trend of treating mentally ill patients in their own surroundings makes use of the nurse's professional expertise, not only in the care of the patients but also in educating the family and the public in matters of acceptance and helpful relationships, or even in making the decision to admit the patient, should the therapeutic intervention with the community fail. Nurses appear to be "the only professional group who actually give practical help at once, and they have ready access to other agencies whose resources can be tapped when needed. Nurses could carry

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3 Catherine Norris, "The Trend Toward Community Mental Health Centers," Perspectives in Psychiatric Care, 1, 1 (January-February 1963), 38.

4 Altschul, Psychiatric Nursing, pp. 18-19.

whose function is conceived as follows: "The nurse must be committed to function professionally in meeting health needs. This means that she must lay claim to the parts of health care which she defines as nursing, and that she must take full responsibility for her own functioning and her own decisions." Furthermore, a great deal of experimentation and investigation is going on in the domain of mental health-psychiatric nursing by nurse researchers, and there are a number of impressive psychiatric nursing publications, books and journals, which report on the developments and the achievements, the issues and the concerns, as well as the perspectives of this field in the future.

Exploring the dimensions of community mental health nursing, Morris points out that "we in nursing must extend our vision beyond the treatment of the individual to include the development of community integrity ... if our contribution is to be made out of a sense of responsibility to the common good..." Indeed, the possibilities for nursing to act as a positive social force, jointly with other positive forces, are infinite. The issue is: Have modern nurses the adequate education, the psychological and spiritual resources, and the heroism to grasp the challenge?

Basic Educational Preparation for Psychiatric Nursing in Selective European Countries and in the United States

Modern trends in psychiatric nursing care in Europe and the United States, as reviewed in the previous section, seem to follow the same


out such work from a hospital base, or they might be employed wholly to work in the community.  

Working with families and groups therapeutically is an evolving role of the nurse which positions her as a therapist and co-therapist among other professionals in the area of psychotherapy.  

American psychiatric nurses, in comparison with nurses in other countries, do not only work as clinical specialists in in-patient psychiatric services and as community mental health nurses, but they also have conceptualized and developed more sophisticated specialization either in some particular content or functional area. In the content area, for example, there are child, adolescent, or geriatric nursing specialists as well as specialists in a particular method of therapy such as crisis therapy, drug therapy, family therapy, and so forth. Functional specialists include psychiatric nurse consultants to schools or other agencies, specialists in primary prevention of mental disorders, researchers, and educators. One of the most recent developments in the changing role of the American psychiatric nurse is that of the independent practitioner.

1Altschul, Psychiatric Nursing, p. 23.


general direction, though the approaches and the rate of development differ. A brief discussion of the educational preparation for psychiatric nursing, as influenced by the general trends in the field, is considered relevant in order to set up the contemporary frame of reference within which this textbook will be developed.

In Sweden, in the basic nursing program (2½ years), the psychiatric nursing unit covers 10.5 weeks, including theory and clinical practice. A small part of theoretical instruction is placed in the first term and the remainder in the fourth term, concurrently with the clinical practice. The content of the course is a composite presentation of mental diseases and their treatment as well as of principles of psychiatric nursing.¹ Teaching consists of lectures, demonstrations, laboratory work, group conferences and seminars, bedside nursing, field trips, and supervised practice.²

In Finland, the psychiatric nursing course is somewhat shorter in length but similar in content and teaching methods to that of Sweden. One remarkable difference is that in Finland there is a systematic effort toward integration of psychiatric nursing principles throughout the whole program.³

In England, basic educational preparation for psychiatric nursing is quite different from that taking place in Scandinavian countries. In the general basic three-year programs for state registration (SRN), the

³Programme Guide for Basic Nursing Education in Finland (Helsinki: National Board of Health, 1966), pp. 7-11.
A psychiatric nursing course is optional, which means that general professional nurses are not required to take courses in psychiatric nursing and thus may not have any background in it. However, there are separate basic three-year programs for psychiatric nursing, leading to registration as a mental nurse (KAN). These programs cover three broad fields of study:

(i) A systematic study of the human individual, both mind and body, relating normal development and behaviour with the effects of mental disorder and physical illness.

(ii) The various skills in dealing with mental disorder and bodily diseases associated with or occurring in psychiatric patients.

(iii) Concepts of mental disorder, psychiatry and psychopathology.

Nevertheless, recent developments in England tend toward integration of psychiatric nursing into general education. The most appealing program of this type seems to be the four-year program at the Princess Alexandra School of Nursing of the Hospital of London, which leads to double registration: as a general and as a mental nurse. It sounds promising from the point of view of multidisciplinary and integrative teaching of psychiatric nursing, in hospital and community settings, throughout the program, which potentially can prepare broad-minded nurses able to function in a variety of nursing settings.

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Another country which has basic psychiatric nursing programs apart from basic general nursing programs is Switzerland. These are three-year programs which prepare psychiatric nurses to function mainly within mental hospitals with a special emphasis on the therapeutic environment and on the occupational, recreational, and social therapy. In comparison with the equivalent British programs, these seem to include a broader component of general education and basic sciences, and to be more concerned with the development of the nurse as a person.¹

The separate basic education of psychiatric nurses and of general nurses is already considered inadequate by Swiss nursing leaders, and one of the efforts to bridge the gap between the two types of programs is Poletti's book.²

So far, the psychiatric nursing content in basic nursing programs of selective European countries has been discussed. It is interesting to see what psychiatric nursing approaches are used in basic nursing education in the United States. Since baccalaureate degree nursing programs are the basic programs which prepare professional nurse practitioners,³ only these will be discussed here.

In America, there is a great deal of experimentation going on, with various methods in teaching psychiatric nursing for a more effective use of the ever-increasing information from behavioral and social sciences.

¹Croix-Rouge Suisse, Directives pour les Ecoles d'Infirmières et d'Infirmiers en Psychiatrie Reconnues par la Croix-Rouge Suisse (Bern, 1966), pp. 7-15.
²Poletti, Aspects Psychiatriques des Soins Infirmiers, p. 11.
in order to prepare students for work in the expanding psychiatric
facilities and new concepts of care and prevention.

The psychiatric nursing content in baccalaureate nursing programs
in the United States seems to keep up with the overall trends in psychi­
atric nursing care. However, the objectives of the psychiatric nursing
Teaching unit tend to be broader than those found in Europe, in terms of:
1) fostering awareness of and developing ability to deal also with the
patient's family and the community; 2) stressing the role of the nurse
as a therapeutic agent; 3) helping the student to understand herself
and engage in the realization of her full potential.

Another point is that there is a lot of experimentation resulting
in variability and differences among schools, with reference to teaching-
learning methods and strategies. The multidisciplinary approach to teach­
ing this course is more and more used in order to insure a more compre­
hensive view of the person with psychiatric problems. On the other hand,
the systematic efforts toward integration of psychiatric nursing concepts
throughout the entire curriculum are significant in terms of broadening

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1 Margaret Larson, "From Psychiatric to Psychosocial Nursing," 
Nursing Outlook, 21, 8 (August 1973), 520-523.
2 National League for Nursing, Integration of Psychiatric Nursing
Concepts in Baccalaureate Basic Programs, Report of a Work Conference
3 Loretta Heidgerken, Teaching and Learning in Schools of Nursing,
4 E. Mumford and E. Pouslne, "Multidisciplinary Group Teaching in
Psychiatric Nursing," in B. Schoenberg, H. Pettit, and A. Carr (eds.),
Teaching Psychosocial Aspects of Patient Care (New York: Columbia
the perspective in which general nursing views man.\textsuperscript{1,2,3} This approach is based on the notion that the nurse's contribution to the mental health of her patient is not confined to the psychiatric settings but extends into any situation in which "the nurse helps the patient with his immediate need" because in this way "she helps to restore his disturbed sense of adequacy or well-being."\textsuperscript{4} The idea of integration is found also in England, but it is conceived and implemented differently.

There is no specialization in the basic American nursing programs. They are offered only in post-basic programs leading to master and doctor degrees.

In conclusion, contemporary basic nursing education includes an overall orientation to psychiatric nursing and enhances the development of basic skills in dealing with mental health-psychiatric nursing problems. Few countries have established separate basic psychiatric nursing educational programs. However, following the general trend of specialization in nursing for a better mastery and use of specialized scientific knowledge and realization of broader nursing goals, psychiatric nursing has developed as a clinical specialty as well. It is studied as such, in

\textsuperscript{1} Alice J. Gifford (ed.), Unity of Nursing Care: A Report of a Project to Study the Integration of Social Science and Psychiatric Concepts in Nursing (Chapel Hill: University of North Carolina School of Nursing, 1960).


advanced or post-basic programs which vary in length, content, and scope, in the different countries. The discussion of such programs lies beyond the scope of this study.

Psychiatric Nursing Concepts Applicable in General Nursing Settings

Besides the actual symptoms and discomforts of physical illness, being sick has very profound psychological effects and nursing intervention cannot be successful unless it acts psychotherapeutically. As a consequence, basic psychiatric nursing concepts are relevant to all nursing situations and actions whenever nursing is practiced.

Primarily, the nature of man makes psychiatric nursing concepts useful in all of nursing.\(^1\) Man is a unit, a physical, intellectual, emotional, and spiritual being. As a consequence, when he experiences a health problem or an illness in one of his parts, he is wholly affected as an indivisible organism. Miropoulos-Bailas, discussing "Psychiatry in the General Hospital," points out that the continuous interaction between organic and psychological factors in the development of any kind of illness, which is observed daily in the wards of the general hospital, along with the relative frequency of psychiatric problems exhibited by medical and surgical patients, creates the need for a composite approach to the patient, that is, an integrated psychophysical approach.\(^2\)

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\(^2\) Μιροπούλου-Μπάιλα, "Η Ψυχιατρική είς τά Πλαίσια τοῦ Γενικού Νοσοκομείου," s.343.
Illness today is not conceived of as the result of only one factor (i.e., physical, chemical, microbial, etc.) acting upon man, but it constitutes the result of a complex system of variables, dynamically interrelated, which can be distinguished on three levels: the biological, the psychological, and the social. The spiritual dimension is particularly discussed by a number of medical writers as a variable significant in the manifestation of illness as well as in the recovery process. Furthermore, physical illness does not affect only bodily functions but very often influences negatively the patient's self-esteem, his competence to deal with life, his social status, and his ability to function according to the requirements of his roles: professional, familial, social. In addition, physical illness frequently decreases one's potential for adjustment to changing circumstances, increases psychological vulnerability, and sometimes precipitates an emotional crisis. The latter may occur particularly when the body image is mutilated or a developing career is damaged, or death is impending. At these times, mere confrontation of the physical symptoms cannot be considered nursing care.

1. Παυλός Κυμίσης. Διερεύνησις Κοινών Ψυχολογικών Μεταβλητών Εκείνων στη Κλινική Μεσολογγία της Διατριβή (Αθήνα: 1972), σ. 15.
4. Μ. Γερουλάνος. Φυσικός Επιδράσεις των Φυσικών Παράγοντων. (Αθήνα: Κ. Κακουλίδη, 1944), σ. 98.
Many studies have shown that various psychological problems emerge every moment in the practice of surgery concerning the doctor-patient contact, the operated site of the body, the way in which the patient interprets it, and all the reactions up until the reintegration into normal life. These problems make the surgical intervention, and consequently the surgical nursing care, a psychosocial event.\(^1\)

In addition to the fact that many physical diseases precipitate psychiatric reactions such as excessive anxiety,\(^2\) changes in behavior, and others, "physical illness and psychiatric disorder co-exist in many patients, especially the middle-aged and the elderly, and for this reason an exclusive preoccupation with either the physical or the psychiatric symptoms may be harmful."\(^3\) As a consequence, every professional nurse, regardless of the special nursing field in which she works, needs to use in everyday practice certain basic skills in caring for patients with psychiatric manifestations.

Moreover, any patient who becomes hospitalized, for whatever health problem, does not leave his fears, doubts, worries, attitudes toward self and others, prejudices, beliefs, and aspirations, at home. He brings all these to the hospital, and he responds to the hospital, the nurses, the doctors, and to his disease, not as a broken limb, a paralyzed member, a congested heart, but as a whole person, and obviously he needs to be

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nursed as such. Hence, personalized nursing care requires the nurse to be able to recognize and respond not only to the general and more superficial needs of the patient but to the deeper psychological needs as well.\(^1\)

Another significant factor which indicates the usefulness of psychiatric nursing concepts in all of nursing is the fact that man is an integral part of his family, his particular social milieu, and his subjective culture. He cannot be understood apart from his context. Psychiatric nursing concepts facilitate the nurse's understanding of enculturation as part of the process of growth and development, and of the cultural influence on patterns of behavior, values, attitudes, and beliefs of people. Furthermore, psychiatric nursing concepts provide the nurse with a framework for viewing interpersonal and social relations as important variables affected by and affecting the patient and the course of his illness.

To illustrate the foregoing point, examples are drawn from the Greek cultural context.

The Greek man, in normal everyday life, possesses a place of power, and he is the decision-maker not only in his own personal affairs but also in the affairs of his family. When he becomes ill and is hospitalized, he is forced into a subordinate role. He stops regulating the schedule and the details of his life. He is asked to report his health history which sometimes necessitates revelation of the most secret folds of his life. He will be further submitted to diagnostic tests and procedures suggested by the doctor and performed by unknown persons. He may

be connected to strange machinery, such as a monitor, respirator, artificial kidney, upon which his life may depend. Finally, the nurse, younger than he and female, plans his nursing care, however cooperatively, with him, imposing another role of dependency upon him.

In reality, a discontinuance of his previous independent role occurs, which decreases his self-esteem, precipitates frustration and stress, and mobilizes a number of defense mechanisms, including hostility. This hostility usually is addressed toward his wife, and in extension toward the doctors and nurses, according to Kimisis' findings in his study of the sociopsychological variables intervening in hospitalization of Greek patients.¹

In caring for a Greek male patient, the nurse, in addition to assessment of his nursing needs and planning the respective nursing intervention, should take steps early enough to prevent the vicious cycle which is likely to occur by the decrease of the patient's self-esteem leading to hostility toward others, which causes reactions further diminishing his self-esteem.² This vicious cycle may result in still other vicious cycles, since the discontinuity of the patient's usual independent and superordinate role adds more stress to the stress of illness, which may precipitate psychosomatic symptoms and retard recovery. Thus, the nurse must always find ways to elevate the patient's self-esteem, to provide him with alternatives in his care so that he can choose for himself and realize that his personal worth is realized and respected. Also, he may be encouraged to talk about his work, his achievements, his social status, and so on.

¹ Κομίσης. Διερεύνησις Κοινωνιολογικών Μεταβλητών Υπεισερχομένων εις τὴν Ἐν τῇ Κλινικῇ Νοσηλείαν. σ.42.² Ibid.
on, and in this way the stress caused by the change in his role can be decreased. Especially the Greek nurse, who is always female, may intensify the patient's feelings of hostility by forcing him to become subordinate in relation to her, if she has not developed the specific social consciousness that, for example, she is not caring for a cardiac patient, but for a Greek cardiac patient.

On the other hand, the Greek female hospitalized patient does not undergo considerable change in her usual role because this is ordinarily characterized more or less by submissiveness and dependence. She accepts and she adapts more easily to the condition of hospitalization. However, separation from home, leaving behind a family, especially if she is the mother of young children, may become a cause of worry, anxiety, and depression, and may complicate seriously the actual health problem. This is commonly noted in large Greek urban hospitals where patients from other parts of the country are treated.

It is extremely important that the nurse recognize the patient's sensitivity, be resourceful in facilitating any possible continuity of communication between the patient and her family, and be considerate toward the patient's visitors, who may have come from far away for just one short visit and who may make the difference between recovery and prolongation of the illness.

A third point to consider as making psychiatric nursing concepts important and applicable in all nursing situations, refers to modern trends in nursing toward primary care, total patient care, and health teaching. Assessment of the health state of a person, now becoming a nursing responsibility, demands that the nurse be able to view man in his totality, that is, his physical and mental health as well as his illness. She is
expected to explore and recognize relationships among a wide range of variables and assess coping abilities within the biological as well as the sociopsychiatric framework. In Greece, this is the expanding role for the public health nurse. In addition, because of her strategic position within the community, her knowledge and use of psychiatric nursing concepts help her to contribute to the following:

1. The prevention and early detection of mental illness.
2. The appropriate care of a number of mental patients within their own families.
3. The familial, occupational, and social rehabilitation of discharged mental patients.
4. The dissemination of information about the principles of mental hygiene.

The Greek public is to a large extent uninformed about mental illness, remains unalarmed at and tolerates for long periods of time the development of psychiatric disturbances, and is unwilling to seek psychiatric care because visiting a psychiatrist has a socially bad connotation. Thus, the public health nurse has to play an important part in reducing the social stigmas attached to mental illness in the Greek society, through formal and informal education. In this way she may not only ensure early diagnosis and treatment of mental patients, but also lessen the danger

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that the discharged patient will be shunned or isolated because of the
fear of the family with regard to threatened social implications.

A last-but-not-least aspect to mention is the increasing need of
the contemporary nurse to master interviewing techniques as well as to
establish and maintain a sound interpersonal relationship with any person
who needs nursing care. It is through an interpersonal encounter that
the outpatient clinic nurse makes the first health assessment of a
patient; the bedside nurse determines the patient's reaction to his ill-
ness and hospitalization and his need for psychological help; the public
health nurse gives emotional support and health counseling to the young
mother as well as detecting and preventing impending psychological crises
within families. Interviewing skills are mostly mastered and refined with
a thorough understanding of psychiatric nursing concepts.

The foregoing illustrations of selective nursing situations show
how psychiatric nursing concepts are useful and applicable in a variety
of nursing settings. The nature of man, the relation of man to his sub-
jective cultural milieu, and the modern trends in nursing, make this
application feasible and imperative in all nursing. In this perspective,
psychiatric nursing can be considered as an outlook on all nursing.
UNIT II:

DIMENSIONS OF MENTAL HEALTH-PSYCHIATRIC NURSING
Outline of Chapter 3

MENTAL HEALTH AND MENTAL ILLNESS

Purpose

To enhance understanding of (1) the dynamics of mental health and mental illness; (2) the role of the family as crucial in mental health and mental illness; and (3) the dimensions of prevention of mental illness.

Content Outline

Mental Health

Indicators of Mental Health

The Family

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The Greek family

Family-centered nursing approaches

Mental Illness

Theoretical Approaches to Mental Illness

The pathological or medical approach

The statistical approach

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Speculations on modern society - Focusing on Greek society

Prevention of Mental Illness in Modern Times: A Philosophical Outlook
Mental Health

Indicators of Mental Health

Mental health is more than just the absence of disease. It is a positive, dynamic condition and a part of a more comprehensive state of health in which there is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."\(^1\)

Health means wholeness of function and being. It "touches every action, thought, feeling and hope that man has. Understanding health demands an understanding of the human organism in its totality."\(^2\)

Mental health, according to Sullivan\(^3\) is the adequacy and appropriateness of action in interpersonal relations or the interpersonal adjustive success, as well as knowing oneself, realistic self-evaluation, inner security, increasing knowledge, and insight through new experiences over the total life span. Adequacy in interpersonal relations is


highlighted by a number of authorities in the field. In sociological terms it is referred to as the optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized in a particular society.4

The dimension of love and affection as an ability indicative of mental health is particularly emphasized by many psychologists.5,6,7

Mental health is also considered from the vantage point of homeostasis and adjustment. It is discussed as the continuous internal and external adaptation to ever-changing conditions by the organism ensuring his bio-psycho-social vital balance for an effective level of living.8,9

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3 Ε.Παπαθωμάκος. "Γονείς και Παιδί: Ψυχιατρική Κατανόηση των 'Ενδοοικογενειακών Προβλημάτων." Ελληνική Ιατρική, Β/37, 10, 'Οκτώβριος 1968, σ.1469.


The foregoing position is in some ways challenged because it seems to ignore or negate (1) the possibility of achieving homeostasis by psychopathology and by compliant or unethical conformity\(^1\) and (2) the notion that man's growth and continuous achievement results from imbalance and potentially constant crisis.\(^2\) Those who take a different stand reflect that "mental health is based on a certain degree of tension, the tension between what one has already achieved and what one still ought to accomplish, or, the gap between what one is and what one should become."\(^3\)

As a consequence, any definition of mental health "must allow for serviceable imbalance within personality and between person and society."\(^4\)

A philosophic orientation in life is considered by many psychologists and psychiatrists as a hallmark of mental health. It is postulated in various ways such as meaning orientation or awareness of a meaning worth living for -- including the potential meaning of suffering -- and pursuing its fulfillment;\(^5\) a unifying philosophy of life;\(^6,7\) a

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\(^{6}\) Allport, *op. cit.*, p. 162.

subjectively satisfactory frame of orientation and devotion;¹ a set of personal values to live by.²,³,⁴

Health is a quality of life, Tournier reflects, a physical, psychical, and spiritual unfolding, an exaltation of personal dynamism; it is the harmonization of the whole personality. As such, it cannot be acquired once and possessed forever. The same author points out that "he who does not go forward, goes back. Physical, psychical and spiritual health is not a haven in which we can take refuge in a sort of final security, but a daily battle"⁵ in which we are constantly at stake.

Cornarakis speculates mental health as the harmony between one’s way of life and his personal conscience.⁶ He makes the point further that spiritual life makes possible the transcendence of internal and external unhealthy factors and constitutes the foundation of psychic harmony and mental health.⁷

Most Greek psychologists, psychiatrists, and general physicians hold a holistic view of mental health. Vassiliou and Vassiliou maintain

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¹Fromm, The Sane Society, p. 64.
³Coleman, Abnormal Psychology and Modern Life, p. 618.
⁶Ιωάν.Κ.Κορναράκης. Ποιμαντική Ψυχολογίς. Πανεπιστημιακές Παραδόσεις (Θεσσαλονίκη: Εκδόσεις ΩΜΕΓΑ Δημ.Ι. Κοριαχίδης, ), σ.19.
⁷Ιωάν.Κ.Κορναράκης. "Η Νεύρωσις ως "Αδαιμον Μέγη": Υμνολογική τούς Ειρηνικής Θεολογίαν. Διατριβή επί Τρητησία (Θεσσαλονίκη: 1986), σ. 98.
that mental health is the successful completion of developmental tasks according to one's age, the unfolding of the personality's potential, the actualization of its synthetic functions, the acquisition of refined and adequate techniques in interpersonal relations, and the successful entry into social life as a fully participating member of one's primary and secondary groups.¹

Mental health is stressed as the harmonious functioning of the psychosomatic unity of the human personality by Geroulanos² and Philippopoulos.³

Today mental health is conceived as a multi-dimensional phenomenon and as such it is described in terms of multiple criteria. Inventories of such criteria have been formulated by many writers.¹,²,⁵,⁶,⁷ Spetsieris seems to encompass in general terms what is proposed by other authors in his own set of indicators of mental health. These are:

1. A philosophical outlook on life serving as a compass for life.
2. Broadness of one's horizon of values, wideness, congruence with reality, and clarity of perception regarding self, others, and the world.

²Geroulanos, Φυλακτική Επιθετική Αποδοτής Μονάδας Παράγωγ,
⁵Allport, Personality and Social Encounter, p. 162.
⁶Maslow and Mittelman, Principles of Abnormal Psychology, p. 15.
3. A right and virtuous way of living, including moral, intellectual, aesthetic, and religious inner living experiences.

4. Fullness of life and variety of interests, hierarchically ordered, leading to higher degrees of psychic integration.

5. Self-knowledge, self-transcendence, and self-actualization through social participation.

6. Finding meaning in suffering and through it achieve spiritual personal development.

7. Happiness derived from contemplation of beauty, moral and virtuous life, creative activities, constructive group participation, self-transcendence and devotion in loving care for others, and pursuing personal growth.¹

The foregoing information has been derived from the fields of psychology, psychiatry, and general medicine. A review of the nursing literature reveals that nursing approaches to mental health do not differ basically from those expressed in the disciplines under consideration. As a matter of fact, they stem essentially from them. However, it is interesting to see how they are formulated. The criteria of mental health most frequently presented in nursing literature are the following:

1. Effective interpersonal relations in which personality needs are met and the expression and productive use of one's capacities are fostered.²,³,⁴

¹ Κωνσταντίνος Σπετσιέρης, Η Φυσική Ζωή του Ανθρώπου (Αθήνα: Εκδόσεις Τύπος Ιατρικής, 1960), σσ. 354-367.
² Peplau, Interpersonal Relations in Nursing, p. 15.
2. Ability to love and to express genuine concern for others.1,2

3. Active inner-directed adjustment and the achievement of equilibrium between internal and external forces and demands.3,4,5

4. Effective handling of stresses and crises to the point of strengthening inner resources.6,7

5. Wholesome philosophical outlook on life.8,9,10

6. Positive and dynamic bio-psycho-social and moral well-being.11,12

The major themes regarding the characteristics of mental health which have been traced through the foregoing literature and which will

1. Matheney and Topalis, Psychiatric Nursing, p. 4.
serve as a frame of reference in the proposed textbook are presented in diagramatic form.¹

In concluding, the writer wishes to emphasize the following point: The identification of specific indicators of mental health aims only at helping the nursing student, through inductive thinking, to achieve a deeper understanding that mental health (1) is a multi-dimensional lifelong process, variously and uniquely expressed in each life situation, stage, and context of interrelated variables; (2) constitutes one part of an indivisible whole made up of the bio-psycho-social, moral, and spiritual health; and (3) means wholeness of function and being.

The Family

The family: A potential laboratory of mental health. The family, based on marriage, blessed by the Church,² and accepted by society, represents a biological, psychological, social, and cultural unit, destined to procreate and enhance humanity.

Within the family, a wide range of the needs of the spouses are satisfied, from the biological sexual drive to personal growth and self-fulfillment. The family as a unit of interacting personalities nurtures the courage to love which trusts in the creative wholeness of the "we."³ If the meaning of the sacred bond through marriage is grasped by the couple, then a transcendence of each self takes place toward penetration

¹See Figure 1, following page.
²Ephesians 5:32.
### The Person in Relation to the Universe

<table>
<thead>
<tr>
<th>Search for and commitment to ultimate meanings and values</th>
</tr>
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<tbody>
<tr>
<td>Unifying philosophical outlook on life</td>
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<tr>
<td>Ability to envision ideals</td>
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### The Person in Relation to His Environment:

#### People and Conditions
- Correct perception of the world
- Socially considerate behavior
- Appropriate interpersonal relationships
- Giving and receiving love
- Full participation in primary and secondary groups
- Sense of considerateness and responsibility toward others
- Love for creative work
- Active confrontation—adjustment, adaptation, mastery—of the environmental conditions
- Use of internal and external resources

### The Person

- Maintenance of inner integration
- Relative tolerance of stress and suffering without incapacitating psychic disorganization
- Realistic self-perception
- Self-acceptance
- Striving toward self-actualization
- Readiness for self-transcendence
- Involvement in full living

**Figure 1**

Indicators of Mental Health
of the other self, resulting in mutual discovery in communion, and in
the affirmation of their life, happiness, growth, and freedom.

In the depths of such a relationship, love develops as a power
and as an act of giving, implying inclusion of elements such as caring,
responsibility, respect, and knowledge. This syndrome of interdependent
attitudes, cultivated and expressed by the mature spouses, prepares the
favorable, healthy, and nurturing climate for the birth and growth of
their oncoming children. Indeed, such a climate not only fosters the
children's growth but also makes of the family a school of values, an
institution educating free persons, a human laboratory forging cultures
and living civilizations, a nursery bringing up great men and women,
scientists, artists, heroes, saints.

The family is the first society that any person can become aware
of, and it acts, particularly in relation to the young, as a declared
representative of the community as a whole.

The family is a multipolar dynamic ground of transactions between
the intrapsychic interpersonal, intergroup, and social variables. Therefore it is potentially a natural primary mental health center, where
health education, prevention of illness, restoration, preservation, and
promotion of health may be achieved. The mental health aspects of the
family are studied and discussed by representatives of various disciplines,
including nurses, from the vantage point of their positive as well as
negative potential.

1963), p. 22.

2 Jack H. Kahn, "Mental Health and Family Life," World Health - The

3 Γεώργιος Βασιλείου, Διερεύνας Μεταβλητών 'Υπερπαθοικών
εις τὴν Ψυχολογίαν τῆς 'Ελληνικῆς Ὀικογενείας, Τεχνική Εκδοσιάς
('Αθήνα: Αθηναίων Ινστιτούτον τοῦ 'Ανδρέα, 1966), σ. 21.
There appears to be general agreement as to the decisive influence of early experiences on laying the foundations of mental health or developing vulnerability to mental illness.\(^1,2,3,4\)

Healthy human development requires a home in which children consistently experience love, security, acceptance, and respect for what they are and what potentially they may become, as well as where they are given opportunities for growth and self-fulfillment.\(^5\)

The family represents the chief environmental factor in the socialization of the child and in molding the development of his personality. Through the process of family living, roles are learned, attitudes formed, feelings nurtured, and values developed.\(^6,7,8\)

Sullivan illustrates how early stages of life are crucial in the unfolding and the development of a healthy personality for adequate


\(^2\) Jahoda, Current Concepts of Positive Mental Health, p. 3.


\(^5\) Φιλιπποςφολογούλος. Δυναμική Φυγιατρική. σ. 121.

\(^6\) Ackerman, The Psychodynamics of Family Life, pp. 23, 339.


interpersonal relations in the progression from birth toward mature
compentence for life. The infant-mother relationship is the child's first
interpersonal experience through "emotional contagion or communion." If
this is an experience of interpersonal security and of reflected positive
appraisals, the child develops self-respect, self-security, and a similar
positive attitude toward others. In this way, the foundations for success-
ful interpersonal adjustment of the person in his life are laid. On the
other hand, if the reflected appraisals were chiefly derogatory, the
self-concept will itself be derogatory, positive attitudes toward others
will be inhibited, and thus only hostile and negative attitudes toward
others will develop. Therefore, "inadequate and inconsistent accultura-
tion limits the self and impoverishes the whole personality" and becomes
a fertile ground for the development of mental illness.¹

Many authors discuss and emphasize the mother-child relationship
as crucially important for the healthy development of the child's person-
ality.²³ This position is held by most of the Greek authorities in the
field. The points frequently stressed include the significance of a warm
and consistent mother-child relationship encompassing positive attitudes
toward the child such as unconditional affection, devotion, protection,
understanding, acceptance, and active adjustment to his changing needs.

³Fromm, The Art of Loving, pp. 41-42.
through the various stages of his growth. The presence and influence of the mother during the first years of life are considered as the basic levers for the whole bio-psycho-social development of the child, by providing adequate stimuli for aesthetic, kinesic, and interpersonal experiences. In a study of the mental disorders of blind children and adolescents, it was found that the attitudes of the family and, mainly, the quality of the mother-child relationship constitute the cornerstone of the whole formation of the personality of the blind, not so much the handicap itself.

Furthermore, emotional problems in childhood and even the development of future psychotic syndromes are attributed greatly to inadequate or disturbed early interpersonal relations with parents. Psycho-traumatic experiences in early stages of life, such as separation from the mother, rejection, overprotection, or inconsistent handling of the child's reactions, parental conflicts, instability or breakdown of the

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1 Λυκέτσος. "Η Πρόληψη των Ψυχικών Νοσημάτων." σ.258.
2 Ν.Κ.Ρασιδάκιος. Στοιχεία Ψυχιατρικής. (Αθήνα:1967), σ.34.
3 Παπαθωμπούλου. Συγγραφή Ψυχιατρική, Τόμος Α' Τεχνική Ψυχιατρική, σσ.465-466.
4 Σ.Δοξιάδης, Συντονιστής. "Η Πρόληψη Διαταραχών της Ψυχικής." Συζήτηση Στρογγυλής Τραπέζης. Τομ. Α' Ιατρική, σσ.465-466. "Ελληνική Ιατρική." 19, 4, Ιανουάριος 1971, σ.120.
5 Ευάγγελος Δημητρίου. Συμβολή τής Μελέτη των Ψυχικών Προβλημάτων των Τυφλών Παιδιών και Εφήβων. Διατριβή επάνω του Διδακτορία. (Θεσσαλονίκη: 1971), σ.84.
There are a number of studies referring to the effects of mother-child separation. The state in which an infant or a young girl do not experience a warm, intimate, and continuous relationship with the mother (or a permanent mother-substitute) is called maternal deprivation.

Of course, a child may be deprived even though living at home if his mother is unable to give him the loving care he needs, for example, in the case of a mentally ill mother or a working mother who is not at home except during the child’s sleeping time.

The detrimental effects of deprivation vary with its degree. Partial deprivation may precipitate acute anxiety, excessive need for love, strong feelings of revenge leading to guilt and depression. The consequent psychological disorganization may cause disturbance of the intellectual process (i.e., retardation or fixation of perceptual and conceptual development, language problems, symptoms of neurosis, and instability of character, or it may completely cripple the capacity to make

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relationships. Not only behavioral but also somatic catastrophic consequences, such as inhibition of physical growth and increased incidence of illness, may follow the loss of the mother without suitable replacement of a mothering figure, as in the case of hospitalized or institutionalized babies.

Of course, maternal deprivation is only one among the various kinds of deprivation which, experienced in early life, may influence detrimentally the later development of personality. For example, paternal deprivation is also discussed as precipitating delinquency; sensory deprivation is studied as preventing the formation of adequate models and strategies for dealing with the environment, and so on. Furthermore, divorce which disrupts family life has a dramatically negative impact on young children. Family histories of mental patients almost


always include an unhappy or deserted childhood, a disturbed or broken home, an absence of loving maternal care, among other contributory causes of psychopathology.  

It constitutes a discouraging fact that the modern family, as a bio-psycho-social unit and as a sacred institution with ultimate meaning and purpose, undergoes a serious crisis with nation-wide and world-wide consequences. However, this does not negate its latent potential for being the psychological laboratory and the most important front line where prevention of mental illness and promotion of mental health can be worked out and actualized, if appropriate education and socially organized professional help can be provided, as needed.  

The Greek family. The institution of family in Greece is very strong. It is established through marriage, which is one of the seven sacraments of the Greek Orthodox Church. It is considered socially as an agency through which happiness in life may be secured as well as

2 Caplan, An Approach to Community Mental Health, p. 146.
5 Π.Σιφναίος, "Ο Ρόλος του Εκπαιδευτικού και του 'Ιερέως δι' Εργασίαν Ψυχικής Υγιεινής," Νευρο-Ψυχιατρικά Χρονικά, 1, 3, 1962, σ.223-224.
6 Σκέτερρης, "Η Ψυχική Ζωή του 'Ανθρώπου," σ.350-351.
fulfillment of the ideal sexual role. This social perception of family becomes a strong variable, motivating individuals toward establishing a family.¹

The Greek family tends to be nuclear, particularly in the large urban centers. Intrafamilial life is based to a great extent on the expression of emotions. Family members are very communicative among themselves.

Family roles are well delineated, complementary, with little overlapping. The father has a superordinate role. He is the household provider, the supporter, the guide and leader of the family. The mother’s role is that of nurturing and caring. Once a mother, the wife becomes almost holy. She is given unconditional love and respect. Thus motherhood for her becomes highly meaningful and important.

The mother has a primary role in child-rearing. The child becomes her main concern. She is very sensitive in anticipating and gratifying the child’s needs. Breastfeeding is the predominant pattern. The discipline of the child is almost exclusively the mother’s duty. Furthermore, she is the one who intervenes in the child-milieu interaction, functioning as mediator and transformer.² The child is loved and respected as an autonomous and worthy individual.

The Greek family is child-oriented, future-oriented, and achievement-oriented. There is a common interest in the child’s future, hoping that he is going to realize goals and dreams which will elevate

¹ Βασιλείου. Διερευνήσεις Μεταβλητών Υπερηφανείων ελίς τήν Φυσικονομικήν τήν Ελληνικήν Οικογένειαν. σ.149.

the socioeconomic status of the family. It is evident that there are no individual interests, only family. There is no individual achievement. The achievement of any member becomes a family affair. In this perspective, the son is more preferred than a daughter because he is more likely to achieve social mobility for the whole family. The daughter is expected to honor the family either by studying and becoming a career woman or through a successful marriage.

The child, brought up in this way, feels trusted and destined to complete a special task with uplifting implications for his family or his in-group. Within the family, he learns the norms of in-group behavior and how to relate to out-group people.

Parents closely supervise the child's school work and almost always expect excellence from him, even if he is intellectually limited. The child's success in school is enjoyed by the whole family and the in-group milieu because it reflects the success of the adults in assisting him. Especially, it means good motherhood.

Neglect of children or hostility toward them, extreme punishment and frustration of his basic needs to the point that a community agency is needed for protection of children against maltreatment -- these do not exist in Greece.

Children are greatly encouraged to play, both indoors and outdoors. Toys do not have to be expensive, especially for the poor families. Children are very resourceful in making their own toys with materials available at home and not useful for anything else. They may even play

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1 Περοδιακόνου, "Ο Ρόλος της Οικογενείας στις Ψυχοπαθολογικές Εκδηλώσεις της Ηπιοπάθειας "Ηλικίας," σ.99.
with little stones or tree branches chipped appropriately, or they engage in games equivalent to athletics.

Within the Greek family and in-group, a malfunctioning person usually is sheltered, protected, and cared for with concern. As a consequence, his basic human rights are safeguarded, even by depriving him legally of certain civil rights, in order to protect him. In the Greek view, positions like this — a malfunctioning, suffering person has the right to be schizophrenic — are not accepted as implying detachment and depersonalization. On the contrary, it is stressed that "the most basic human right is the right of each one of us to count on his fellow human beings for his well-being."¹

The mental health implications with regard to the psychodynamics of the Greek family may be speculated as follows:

1. The clear delineation of the roles of the spouses provides for complementarity and reciprocal satisfaction of needs and aspirations. Love is considered as a duty and as the spontaneous and natural atmosphere of the home.

2. The value of parenthood as an ideal to be pursued strengthens the institution of family and secures adequate love and support for the child through his developmental stages.

3. The emotional expression as well as the giving and receiving of psychological support, encouraged so much within the family and the in-group milieu, provides for ventilation of tensions and catharsis, which in turn helps in regaining inner balance and security.

The family is assisted and supported by the in-group members, including relatives, neighbors, friends, colleagues, and whoever shows concern for it. Above all, the church through the parish priests is a constant resource of support, guidance, consolation, and actual help if needed.

Discord and misunderstandings within the family are expected to be resolved by reciprocal efforts and, as a last resort, by the wife's compliance. Intervention of the in-group usually consists in encouraging and supporting reciprocal understanding. This approach, in most cases, safeguards the unity of the family and divorce is avoided.

The rate of divorce in Greece is reported as low. As far as delinquency is concerned, it is less frequent than in other comparable and geographically close cultures. Addictions are reported as non-existent. The latter is attributed by Ayoutandis, professor of medical law and toxicology at the University of Athens, to the Greek character which, confronted with life's problems (economic, emotional, social), does not yield and does not seek escape into the world of dreams. On the contrary, he takes a stand in order to face these problems, even if this consists in an effort to transfer the problem.

This type of family, molded through the ages, has succeeded in transmitting the Greek Orthodox Faith, the Greek spirit and tradition,
and the "Greek way" of life, even during extreme pressures for the de-
hellenization of Greece, such as the 400-year occupation by the Turks.

Even though human phenomena cannot be adequately understood by
the linear cause and effect approach, the family, conceived as one of
the interrelated variables constantly in process and transition, influ­
ences the development of the person and his health through the various
stages and phases of life.

The very patterns which keep the family united and reasonably
stable may overtax certain persons emotionally and cause real stresses
and conflicts. For example, the Greek mother may become overprotective
and may foster such dependency upon her by the child that his develop­
ment toward autonomy and independence may be seriously inhibited. Also,
parents may become so unrealistic in their expectations in terms of high
achievement from their children that failure is very likely to occur,
precipitating feelings of guilt, inadequacy, and hopelessness in the
child. Another point is that family loyalty and allegiance, strong emo­
tional ties, as well as the tolerance developed among the members, may
become the dominant factors for delaying decision-making with regard to
referring a mental patient to the psychiatrist and subsequent
hospitalization.¹

Recently, increasing industrialization and urbanization have
necessitated certain changes in family life, which in turn cause stresses
and role conflicts. For example, the tendency toward nuclear families
derives the young couples and the children of the elderly parents and

¹ George Lyketsos, "Report of a Research Concerning the Environ­
mental Influence Delaying Diagnosis and Treatment of Mental Patients in
Greece," in Excerpta Medica International Congress Series No. 150,
Proceedings of the Fourth World Congress of Psychiatry, Madrid, 5-11
September 1966, p. 1475.
grandparents as primary learning resources about religion, tradition, mores and customs, and as sources of affection and support, counseling and guidance. The other side of the same problem is the fact that elderly people stay alone in their homes, be it in a village or a town, and thus are more likely to have mental health problems such as feelings of uselessness and helplessness, loneliness and depression. Until recently, the young developing families living with the elderly parents had the responsibility of detection, reference, and care of such problems whenever they arose. Now, however, community health services have to take over early case-finding and health care of the elderly.

Another change with mental health implications is the movement of families from smaller to larger urban centers; hence the separation from the in-group milieu. In the in-group environment, families always find assistance and support during various difficulties or crises, and they become enculturated in clearly established behavior norms regarding lateral and vertical transactions. Families newly settled in large cities feel like strangers among strangers, and struggle alone to maintain their identity, to transcend serious stresses and difficulties, and to survive. They are left only with their own resources and they are not adequately educated and accustomed to seeking professional assistance from community resources. As a consequence, mental health breakdowns constitute a real hazard.

Children growing up in small apartments do not have enough space in which to play and develop creative projects of their own, and they cannot make intimate friends with strangers living in other apartments in the area since close emotional ties between families are not easily and frequently established. As a consequence, children have limited
alternatives with regard to activities and they usually relate superficially to temporary friends, which may cause nervousness and, later, interpersonal difficulties.

Furthermore, the increasing rate of working mothers precipitates child-rearing problems because grandparents and in-group people are not around to help and because community day-care centers are not numerous enough and adequately staffed and organized to meet the emergent needs. Not only are the children somewhat neglected, being cared for by different and in many ways uninvolved mother-figures, but the mothers also experience serious role conflicts. They have to divide their commitment between their families and their work and very often they feel inadequate in both and thus guilty and unhappy.

Forecasting the later mental health of the modern generation undergoing such radical changes and role conflicts, if compared with other countries, is not optimistic. However, Greeks do not necessarily need to repeat what happened in other western cultural settings, namely, the increase of mental health problems subsequent to depersonalization and alienation in addition to industrialization and urbanization. They may profit from the good things these changes bring to people and plan to face the resulting problems in such ways that higher psychic reintegration and continuing growth may be achieved. The history of Greek culture has much to say about cases in which strains and extreme difficulties forge strong characters, keep families together and the people united, and contribute to increased mental health.

Greek nurses share with other professionals the responsibility to help families live safely through contemporary changes from the mental health standpoint. Suggested nursing practices are discussed in the next section.
Family-centered nursing approaches. It is interesting to note that nursing as a social service started first as family nursing through home visits, and then developed into organized public health and hospital nursing. Nowadays family nursing is developing, in certain countries, as a specialty with special educational preparation, while the traditional maternity-child and public health nursing co-exist in the nursing area. Moreover, psychiatric nursing is increasingly orienting and extending its study and services to families in all its practice settings: hospital care or community mental health.

The conception of the family as a decisive variable in the development of mental health and the speculation of the clinical picture which the "identified mental patient" presents as the manifest result of disturbed family transaction provides modern nursing with the essential, basic knowledge for a deeper understanding, a systematic study, and a holistic mental health-psychiatric care of people.

Family-centered nursing care involves helping the family, not as a collection of individuals, but as a bio-psycho-social unit. It aims to promote the mental health of the family which, in turn, influences positively the mental health of each of its members. Because, just as the family provides the basic context of growth and experience, so does it provide the context for health or illness. Furthermore, the dynamic


balance of the individual and the group may act as an influential factor for the precipitation of illness, the course of illness, the possibility of recovery, and the danger of relapse.\(^1\) It holds true also that when one member of the family becomes ill, the whole family suffers from a degree of psychological disturbance and a certain amount of readjustment has to take place in the family so that it can play a valuable part in the patient's therapeutic program. A discussion of implications and applications of family-centered approaches in various nursing situations will follow.

Nursing looks at parenthood as a crucial developmental stage which may either precipitate a crisis or become a maturing experience. Thus, it is a situation calling for nursing intervention. The goal of the intervention is to assist in developing the growth-enhancing potential of parenthood and in reducing its disorganizing effects.\(^2\) This intervention may consist of setting up programs for expectant parents, in order to foster the development of positive feelings about the anticipated birth of a child, and a readiness to handle the change in roles and patterns of interaction which will be necessitated by the arrival of the child. Also, parental responsibility to the child may be cultivated and guidance for healthy child-rearing can be provided. In past times, such intervention was actualized by the parents of the young couple and by the in-group people. Nowadays, young couples, who live apart and very often far away from their own milieu, need professional help to deal with critical aspects of their life, one of which is parenthood. Nurses who work in

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\(^1\) Ackerman, *The Psychodynamics of Family Life*, p. 10.

maternity-child, in "medico-pedagogical stations," in public health or in mental health psychiatric nursing settings, are in strategic positions to initiate relative programs.

Child-bearing is a bio-psychological strain which may precipitate a mental health problem such as a neurosis, or even a psychosis. The nurse, more than other professionals such as obstetricians, pediatricians, nutritionists, psychiatrists, psychologists, and social workers, holds a special position in relation to her "patient" during pregnancy, delivery, and entrance into motherhood. The main characteristic of this position is closeness, including spatial, temporal, and psychosocial closeness. The nurse, in addition to physical and psychoprophylactic hygiene teaching, may provide opportunities for talking out, and adequate emotional support, so that impending feelings of fear, anxiety, insecurity, and similar reactions to pregnancy can be worked through in a healthy way.

Adequate nursing care during pregnancy, delivery, and post-partum periods not only may protect and, hopefully, promote the mental health of the maternity "patient," but also prepare the appropriate atmosphere for the development of the mother-child relationship which will contribute to the shaping of the emotional development of the growing child. It is obvious that physical or mental illness in the mother will prevent her from responding affectionately to the needs of the child. Thus, the

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1 Caplan, An Approach to Community Mental Health, pp. 176-177.
nurse, working with the mother or any other members of the family who form the child's emotional and cultural environment, does indeed nurture the mental health of the child.

The nurse has a significant role to play when she cares for an unmarried Greek maternity "patient" because of the social stigma attached to pregnancy and motherhood out of wedlock, and because it is considered a sin. This woman frequently is rejected and abandoned by her family, which feels dishonored and ashamed. Nobody in her family nor in her in-group milieu accepts the child or is willing to help the mother in raising him. Because no Greek milieu accepts the unmarried mother, she cannot raise her child by herself unless she marries right after the delivery. Usually she signs her consent that the child be adopted, which means that the child will be taken away from her immediately after the birth and will be institutionalized in an infant center from which adoption may be realized. It is evident that this circumstance is a high risk for the mental health of the mother. The nurse first has to identify her own feelings, which are likely to be derogatory and judgmental, so that she may reject the action on the basis of her cultural norms and accept and care for the mother. Usually she encourages and supports the unwed mother toward marriage, if possible, and toward confession in order to be liberated from feelings of guilt, to profit spiritually from the suffering experience, and thus maintain her mental health.

If the nurse has an opportunity to care for the foundling, she must understand her responsibility not only for his physical comfort and survival, but also for the emotionally healthy development of the child. She is called to function as a mother-substitute, to develop a consistent, supportive, responsive, warm, close relationship with him. This type of
nursing care provides for the child the right to continuous, loving care, the right to satisfaction of basic needs. From this vantage point, mental health nursing care of the child might also be called "developmental" care, and indeed it constitutes a great contribution to the mental health of the family.

The nurse's role is of paramount importance when a handicapped child is born in the family. She realizes that the parents need time to recover from the emotional shock and must be allowed to suffer grief for their loss — the perfect child of their expectations — as well as to prepare their minds and hearts for the burden that will be with them as long as they live. The nurse is understanding and supportive to the parents, with empathy and a willingness to help, counsel, and guide, if needed.

The overall goal of nursing intervention in such a case is to help the parents maintain their own mental health; to see the handicap of their child not as a disease but as a problem of adjustment and as a special way of life; to become involved in helping the child develop the will to struggle and unfold his latent potentialities; to protect and foster his physical and mental health within his limitations.

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Nursing of any sick hospitalized child places upon the nurse a tremendous responsibility for the protection and promotion of the mental health of the child and hence of the family. A primary nursing goal is to preserve the mother-child relationship to the greatest possible degree, and by any means. Even when the hospital regulations have limited visiting hours for parents, the nurse may devise a number of ways to ensure continuity in the mother-child relationship. Some of these ways may be: regular telephone calls, exchanging cards, keeping the child informed about life at home, explaining rationally the reasons for his mother's absence, intermediate visits of the child at home while hospitalization continues, and so forth.

Small children, as with all patients, are entitled to sense that they stand at the center of the nurse's interest. According to their developmental stage, they need to be given explanations and reasons for what they are going to experience, as well as given time to prepare themselves for the experience they are anxious about, before it happens, especially before surgery.¹

Moreover, the nurse must keep in mind that, whatever the situation, it is damaging to the emotional well-being of children to be told something that is not true, such as that the injection will not hurt. However, with the information that the injection will hurt should go also the notion that the pain will not last.

The nurse who plans the nursing care of the child, not as a detached designer but committed to help the sick child toward physical recovery and healthy psychological development, can transform the traumatic experience

of illness and hospitalization into a satisfactory, positive, educative experience. In this way the nurse can influence the future intellectual and affective development of the child much more than his future teachers will be able to do in years of teaching him sciences and humanities.1 Furthermore, the nurse may be, by example, a teacher of healthier ways of child-raising to the parents. In this perspective, modern nurses play a responsible part in molding not only current but also oncoming generations and in preparing the world of tomorrow.2

In the care of any patient, child or adult, the nurse cannot wholly understand and help him unless she sees him in relation to his whole family. In her assessment of the patient's needs, she should include an assessment of the family's potential, positive or negative. She should care as much for the preservation or restoration of equilibrium in the mental health of the patient as for that of his family. She should plan her nursing intervention in such a way that it incorporates steps to counteract the disrupting effect of illness and hospitalization of one member by loosening or blocking his relationship with the family which, in some cases, causes psychological distance. The family should not only be allowed but welcomed and encouraged to express feelings of worry and concern, to ask questions, and even actively to participate in the care of the patient.

If the nurse who cares for maternity or other hospitalized patients in so many ways support and promote the mental health of the family,

1Dalloni, Sous les Armes de la Charité, p. 193.

The nurse who works in public health centers really has infinite opportunities to foster the family's potential to become a laboratory of mental health. Very often a physically or mentally sick person, a handicapped or an elderly person with nursing needs, will necessitate home visits by the nurse.

During home visits, the nurse sees the patient in his human and physical environment. She can then actually observe the transactions between the family members which hours of history-taking could not reveal. In this way the nurse may identify critical situations and recognize environmental hazards to the interpersonal relations of the patient and his family; she may contribute to early case-finding; she may strengthen the mental health potential of the family through health teaching and providing emotional support. Furthermore, the nurse, by knowing the family, can motivate it to seek professional help in the case of a mental health problem, and she can interpret the patient to the doctor and the doctor to the patient and his family.

The family may be helped by the nurse to respond constructively to the psychological needs of their patient and may become more receptive to mental illness and the mentally ill if they experience a relative situation. Thus, the nurse contributes to reducing the social stigma attached to mental illness and to increasing the community's willingness to care for its mental patients.

If the sick member of the family is hospitalized, the family-centered nursing approach may minimize the length of hospitalization and the emotional distance likely to be created between the patient and the family. Also, hospitalization may be prevented, especially when the interpersonal stress of the family and negative attitudes toward the
patient are not assessed as mental hazards, and as inhibitors to the patient's recovery. Finally, the discharged patient may have a better readjustment and reintegration into the family circle.

Specifics about the nursing approach to the family of the mental patient will be presented later in this textbook. The foregoing illustrations do not cover the entire range of possibilities available to the nurse for constructive work with families to attain or retain mental health. They only open the stage for thinking, raising questions about, and discussing relevant issues.

In concluding, it must be stressed that the modern family undergoes critical changes and needs special nursing attention, understanding, and support. It is, indeed, within its fortress that the struggle to improve man's mental health can be won and persons can continue to grow and achieve, with self-identity and dignity, even in the mechanized and dehumanizing world in which we live.

Mental Illness

Theoretical Approaches to Mental Illness

Mental illness is a complex phenomenon which has been approached at different levels and can be speculated upon in various perspectives: medical, personal, interpersonal, social, and cultural. An idea of the multiple views of mental illness may be drawn from the following illustration:

On a behavioral level . . . [mental] disorders could be conceived of as a complicated pattern of responses to environmental stress. Phenomenologically, they could be seen as expressions of personal discomfort and anguish. Approached from a physiological viewpoint,
they could be interpreted as sequences of complex neural and chemical activity. Intrapsychically, they could be organized into unconscious anxiety and conflict.

Mental illness is discussed in three dimensions.

The pathological or medical approach. Sickness consists of disturbances and conflicts in the manner one perceives, reacts to, and solves the main problems of life, including the manner of satisfying one's needs. In other words, mental illness is viewed as an intrapsychic malfunctioning with outer symptoms. This approach encompasses a standard psychiatric classification and the underlying assumption of separate disease entities, initiated by Kraepelin (1856-1926), and, although constantly changing, is still in use.

Today there is an expressed dissatisfaction by a number of writers in relation to the strict separation of mental disease entities. For example, it is suggested as most convenient to distinguish only major nodal collations such as neuroses and psychoses, and allow for a wide variety of combinations of symptoms to be enveloped by these two major entities. Some writers are in favor of a unitary concept of psychopathology, according to which differences are considered, only in the

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1. Millon, Theories of Psychopathology, p. 2.
severity and not in the quality of the disturbance, among the various psychiatric syndromes.\(^1\) The latter standpoint is further supported by research findings that there is an increase in the numbers of patients seen by physicians who have undifferentiated health aberrations. They suffer from combinations of mental, physical, and social distress which are ways of life, diseases that cannot be diagnosed or treated by modern technological medicine.\(^2\) This notion holds true also for Greece, according to observations reported by the Department of Psychiatry of the University of Athens at the Aeghinition Hospital.\(^3\)

Furthermore, some authorities in the field conceive mental illness as the one extreme on a continuum, the opposite extreme being mental health. In other words, they consider mentally disturbed reactions as different in degree only, and not in kind, from the emotional and mental experiences and modes of expression of so-called healthy people.\(^4\) The strongest empirical evidence in favor of this view may be the occurrence of borderline cases. However, in opposition to this view stands the point that "the continuum pertains only to symptoms, to appearances. The processes, or mechanisms, underlying these appearances are not continuous."\(^5\)

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\(^1\) Menninger et al., The Vital Balance, p. 63.


\(^5\) Allport, Personality and Social Encounter, p. 163.
Indeed, the world of the mental patient is a qualitatively different world. Although it can be understood, we cannot participate in it, and it differs intrinsically from the world of the normal person. The communality of the "living world" is lost in mental illness.¹ ²

The statistical approach. Any psychological traits or behavior that depart from the average are considered abnormal. This approach is of value only if its limitations are recognized. The main problem with this standpoint is that it is not yet known qualitatively and quantitatively how the average or normal person feels.³ For example, we do not know how many people live with feelings of pervasive anxiety; neither have we appropriate tools for measuring anxiety. This approach sounds too mechanical and materialistic to be used in describing mental illness, which involves the human personality with its intangible dimensions.

The sociocultural approach. Psychopathology may be understood in many respects with reference to the sociocultural background of the person. This implies the relativity of normality. In this perspective, mental illness is viewed as an interpersonal deviation from socially accepted norms of behavior or as a breakdown in the performance of social

² Παπαδημητρίου, Σύγγραμμα Παιδατρικής Τόμος Α' Γενική Παιδατρικής σ.146.
Hence the conception that mental illness is social, and the development of social psychiatry rather as a view of psychiatry than as one of its subspecialties. Indeed, the importance of subjective culture is paramount, especially in the field of psychiatry, because it influences man's perceptual responses, cognitive processes, behavioral reactions, and attitudes.

An example showing the need to know one's subjective culture in order to understand his ways of perception and cognitive processes might be the following: While the American distinguishes his in-group statistically as "people like me," the Greek perceives his in-group functionally as "people concerned with me," which can change abruptly the moment one is perceived as "not showing concern." The implication is that a foreigner may interpret as alienation one's perception of a close relative as an out-group member, while this is quite normal in the context of Greek culture because the criterial attribute of in-group membership is "being concerned" and not kinship.

The foregoing illustrations evidence the fact that there are multiple approaches to describe the nature of mental illness. To recapitulate, mental illness generally is conceived as entailing both a

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disturbance of psychological processes and a deviation of behavior from social norms.¹

Indicators of Mental Illness

Most Greek psychiatrists consider as indicators of mental illness the disturbances in psychological processes manifested in behavior. The following disturbances are discussed as indicative of mental illness: disturbances of perception, affect, thought, attention, judgment, will, orientation to space and time, consciousness, communication, and behavior.²,³,⁴,⁵ Another formulation of the criteria of mental illness emphasizes the disturbance of the person's intrapsychic homeostasis, of his interpersonal relations, and of his adjustive competence with regard to his familial, social, and occupational environment.⁶ As indicators of mental illness are also pinpointed the degrees to which behavior becomes undesirably symbolic and the extent to which problems are tackled, not logically but with distorted perception of reality.⁷

¹William A. Scott, "Research Definitions of Mental Health and Mental Illness," Psychological Bulletin, 55, 1 (1958), 34.
³Α. Κωστάκης. Επικράτεια Ψυχιατρικής (Άθηνα: 1966), σ.17α.
⁴Παπαδημήτρου. Σύγχρονη Ψυχιατρική. Τόμος Α' Τεχνική Ψυχιατρική. σσ.683-699.
⁵Φιλιππάκους. Δυναμική Ψυχιατρική. σ.3-35.
⁶Άνδρέας Κ. Γεωργαρδς. Στοιχεία Ψυχιατρικής. (Άθηνα: 1972), σ.55.
⁷Ρασιάκης. Στοιχεία Ψυχιατρικής. σ.40.
A recurrent theme in Greek psychiatric literature is the calling of attention to the danger of fragmentation of the patient in the event one tries to study one by one his psychological processes. It is particularly stressed that the mental patient experiences his illness as a psychosomatic unified whole and his behavior constitutes a synthetic expression of his psychic processes. Therefore, he can be studied and understood as a whole, with his unique personal history, only in the context of his relations with himself and with his environment. 1,2,3

It is important to see how other authorities in the field describe the criteria of mental illness. A number of psychiatrists see mental illness in the perspective of interpersonal relations and maintain that it covers the whole field of inadequate and inappropriate relations like a tent, 4,5,6 because intrapsychic equilibrium can in no way be divorced from interpersonal equilibrium. 7

Psychological disturbed processes as indicators of mental illness are referred to as failure of man to develop into full integrity according to the characteristics of human nature, 8 lowering of personality

1 Γεωργαρδς, Έστοιχεια Ψυχιατρικής, σ.55.
2 Φιλιππόπουλος, Δυναμική Ψυχιατρική, σ.3.
3 Στεφανή, Ιστορία Ψυχιατρικής: Μέ Στοιχεία Ψυχολογικάς.
4 Τεύχος Α, Ηγεμόνια Άνθρωπος, σ.4.
8 Ackerman, The Psychodynamics of Family Life, p. 79.
9 Fromm, The Sane Society, p. 23.
integration in the cognitive, emotional, and motivational level, \(^1\)
impaired reality discrimination, \(^2\) conflicts in self-concepts, \(^3\) and ego
rigidification and impenetrability. \(^4,5\)

Maladjustment, as inability to adjust or indiscriminate adjustment
through passive acceptance of environmental conditions, or even as
extreme deviation from established group norms, is considered by a number
of authors as one of the major indicators of mental illness. \(^6,7\) Even
though the notion of social maladjustment is open to question because of
the varying requirements of different social systems and the diversity of
criteria for adjustment employed by community members, it still can be
and is used as a criterion of mental illness, particularly conceived as
a form of disorientation between the personality and society.

The foregoing presented criteria are grouped and formulated by
Page in a way applicable transculturally for differentiating abnormal
from normal behavior. They have to do with:

1. The relative proficiency of psychological functioning.
2. The relative appropriateness of social behavior.

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\(^1\) James C. Coleman, Abnormal Behavior—Introduction to General
Psychology: A Self-Selection Textbook (Dubuque, Iowa: Wm. C. Brown

\(^2\) Offer and Sabshin, Normality: Theoretical and Clinical Concepts
of Mental Health, p. 36.

\(^3\) Maslow and Mittelmann, Principles of Abnormal Psychology, p. 169.

\(^4\) William Glasser, Mental Health or Mental Illness? (New York:

\(^5\) Allport, Personality and Social Encounter, p. 164.

\(^6\) Hilgard and Atkinson, Introduction to Psychology, p. 532.

\(^7\) George L. Engel, Psychological Development in Health and Disease
3. The degree of voluntary control.

4. The degree to which the behavior is seen and estimated by society as desirable and beneficial, or as unacceptable and destructive.

5. The degree to which the behavior is perceived by the person as satisfying or distressing.¹

Even though it is true that some cultures may, more than others, tolerate particular forms of deviant behavior, no society would consider as normal a person whose behavior is so impaired, disturbed, and uncontrollable that he constitutes a threat or a source of undue distress to himself or to his social milieu.

Finally, a number of psychiatrists and psychologists regard mental illness as a loss of courage and a failure of heroism stemming from doubts about one's immortality; the abiding value of one's life, and a lack of conviction that one's having lived really makes a cosmic difference. In other words, loss of the meaning of life due to a decline of active religious faith is considered as one indicator of mental illness.²

The indicators of mental illness are discussed in psychiatric nursing literature mostly in terms of exhibited behavior problems.³,⁴ However,

¹Page, Psychopathology: The Science of Understanding Deviance, p. 73.
⁴Matheny and Topalis, Psychiatric Nursing, pp. 53-54.
the notion of difficulties in adjustment, and the impairment of personality functioning, are stressed by some authors of nursing texts. Poor and inappropriate interpersonal relations are also discussed frequently as indicative of mental illness.

Bernard, in a lengthy list of criteria of psychopathology, includes among others:

1. Denial of existence.
2. Withdrawal from relations with others.
3. Delusional and hallucinatory projections.
4. Systematization and displacement of anxiety (obsessions).
5. Changes in consciousness: lack of insight, loss of contact with reality.

Travelbee, after a brief discussion of the contemporary approaches to describing mental illness, concludes that "a mentally ill individual is to some extent unable to demonstrate the behaviors exhibited by the mentally healthy person, namely, the ability to love oneself, transcend self and love others; to face reality; and to find a meaning or purpose in life."

References:

The foregoing criteria referring to feelings, thoughts, and behaviors indicative of mental illness, objectively studied one by one cannot help us understand any mental patient. It is essential to speculate on the inappropriateness of the behavior, to estimate the degree of impairment in functioning, to evaluate the consequences of the behavior on the given individual and his society; that is, to study the total situation with all the interrelated variables under play, and, above all, to know the whole person who is affected by mental illness.

The indicators of mental illness are summarized in a diagrammatic form.¹

Factors Precipitating Mental Illness

Mental Illness is a multifactorial phenomenon. It has no clear outline, no specific pathogen to be isolated. What we know is that in any individual case multiple factors interacting in complex situations and environments are predisposing for, or precipitating, psychopathology, but are not in themselves sufficient to bring about the condition of disease.

No etiological factor can be studied in the abstract, but only in relation to the system and the circumstance upon and within which it is operating.² Moreover, the amount of impairment a person manifests at any point in time is an outcome of the interaction of his personal resources, experiences, perceptions, supports, and developed modes of adaptation.³

¹See Figure 2, following page.
²Engel, Psychological Development in Health and Disease, p. 255.
**The Person and His Outlook on Life**

Inability to find the meaning or purpose in life

**The Person**

- Intrapsychic disequilibrium and/or disorganization
- Withdrawal from or loss of contact with reality
- Disturbed or incongruous affect
- Feelings of pervasive anxiety
- Disturbance in cognitive functioning (comprehension, judgment, reasoning)
- Impaired perception (delusions, hallucinations)
- Motivational disturbances
- Lack of insight and self-acceptance
- Conflict in self-concepts
- Inability to transcend self and love of others

**The Person in Relation to His Environment: People and Conditions**

- Distorted perceptions of the world
- Disturbed communication
- Inadequate or inappropriate performance in interpersonal relations
- Falling off in interest in people
- Deviation of behavior from social norms
- Marked decrease, increase, or distortion of function in daily living and in working conditions
- Maladjustment to life conditions and situations
- Inability to face reality

**Figure 2**

Indicators of Mental Illness
Vassiliou characterizes the linear cause-and-effect models as inadequate for understanding mental health and mental illness. He suggests "a holistic, systems approach where phenomena are perceived and examined as the outcome of the multilateral transaction of all interrelated and interdependent processes involved in the development of each phenomenon,"

including mental illness.

A discussion follows with reference to some factors believed to increase the probability of occurrence of mental illness, keeping in mind that in reality these factors are intermingled in a transaction of processes in relation to each other.

**Genetic and biological considerations.** Every individual has a unique genetic endowment which determines his biological and behavioral individuality. Other sources of biological individuality include brain damage incurred during the birth process; nutritional deficiencies, particularly during infancy and early childhood; toxic substances produced within or taken into the body; and debilitating physical diseases. As far as deviant behavior is concerned, the influence of genetic endowment seems to be in the area of temperament, reflected in activity, prevailing mood, adaptability, and intensity of reactions.

It has been observed that subtle brain damage of the fetus, prenatal toxemia in the mother, bleeding during pregnancy, and infectious diseases may lead to varying degrees of behavior abnormality.

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The major assertions, however, about hereditary factors in behavior disorders were based on studies of identical twins, brought up in different environments and yet manifesting psychosis with a high concordance rate.\(^1,2\) The reports of these studies have been challenged by other researchers.\(^3\)

While there is increasing support for genetic predisposition to mental disorder, particularly schizophrenia, discrete genetic mechanisms and their consequences on human behavior have not yet been isolated by research.\(^4\) Furthermore, the manifested outcome of a genetic predisposition is considerably influenced by the facilitating, modifying, or neutralizing interaction of nongenetic variables such as the developmental process, family relations, social opportunities, and so forth.\(^5,6\)

In concluding, it must be pointed out that there is no available knowledge about what the genetic predispositions are, how they constrain


behavior, and under what circumstances, so that constructive environmental regimens can be designed to prevent mental illness.

**Psychological factors.** The following considerations highlight certain points of practical importance for the understanding of the psychogenesis of psychiatric disease.

Practically all theories of psychogenesis imply or explicitly state that much of psychopathology is acquired through inadequate acculturation and defective family interaction. Hence the concept of family discussed separately. However, all through life, environment acts as an agency mobilizing different facets of the personality. There are in every person many latent possibilities which may be favored alternately or inhibited by the external world and under various life circumstances.

Sullivan maintains that "not the earlier stages only, but each and every stage is equally important in its own right, in the unfolding of possibilities for interpersonal relations in the procession from birth toward mature competence for life in a fully human world."¹

A person reacts in life situations in terms of (1) his biopsychological equipment up to the time, (2) his fields of consciousness at the time, and (3) his perception of the current situation and the actual influence exerted upon him by the situation. Accumulated unresolved conflicts, chronic stress, and traumatic situations or experiences sustained over a long period of time often militate against learning from later experience. Furthermore, they form a reservoir of potentially pathogenic intrapsychic influences determining illness.² On the other hand,

²Engel, *Psychological Development in Health and Disease*, pp. 311, 312.
psychological deprivation in terms of inadequate stimulation and opportuni­ties to learn during any of the critical periods of development may result in subsequent failures to master intellectual and other psychic competencies essential for effective social adjustment.¹

Another critical determinant is considered to be the person's self-perception built up over the years, which in turn molds his perceptions of others.²,³ If a person has distorted or unrealistic views about himself and others, he is not free to make a realistic selection of the potentials and limitations within the self and in the outer world, those alternatives available for living a fuller and more meaningful life.⁴ For example, an unrealistically high level of aspiration held by oneself or demanded by others may place the individual under severe pressure for achievement. Thus, disturbances in identity and self-concepts, as well as distorted perception of others, become sources of frustration, conflict, and incapacitating pressure.

The presence of important motivational systems in dissociation constitutes another weak aspect of the self-system, which impairs the person's ability to deal with difficult situations. It has been observed that "healthy development of personality is inversely proportionate to the amount, to the number, of tendencies which have come to exist in

¹ Coleman, Abnormal Behavior—Introduction to General Psychology, p. 6.
dissociation. Such dissociations may cause reality distortion, split parts of the personality, and impair flexible adaptation or realistic assessment of the gamut of changing demands and needs which life usually entails. Kornarakis reflects that repression of guilt feelings to avoid dealing with them and bearing their consequences consciously limits the person's psychic freedom and adjustive ability, and may lead him to mental illness.

Not only the psychological endowment and the "fields of consciousness" that a person brings to a current situation determine his coping ability, but also his interaction with the forces -- imaginary or real -- operating in the situation. Indeed, psychological trauma, as it occurs in real life -- deprivation, separation, loss, failure, overstimulation and temptation, harsh and inconsistent behavior of others, and a variety of threats including those of disease, injury, pain, and dysfunction -- often constitutes a real risk to mental health.

Sociocultural factors. The general outlook seems to be that modern psychiatry has reached the stage of a theoretical approach which links the sociocultural dimension with the genetic, biological, and psychological interpretation of mental illness. The interrelationship of abnormal psychological states and the sociocultural milieu constitutes the central theme of many studies. Epidemiological studies related to the ecology of...
city life, to social stratification, to occupation, and to ethnic groups, have been carried out by psychiatrists and social scientists. Another important development has been the study of whole communities in which the factors of community social structure and culture were brought into direct relation with mental health. Still another path of research has been the study of the beneficial as well as harmful aspects of the hospital environment in the therapeutic process.

The social environment contains both pathogenic and eugenic factors which may intensify or neutralize the nosological significance of certain biological or intrapsychic factors. A sane society fosters the person’s capacity to love his fellow men, to work creatively, to develop reason and objectivity, to develop a self-concept congruent with the experience of his own skills and powers. On the other hand, an unhealthy society creates mutual hostility and distrust, and transforms man into a machine or an automaton.

3Ibid., pp. 102-191.
4P. M. Yap, "Mental Disorders Peculiar to Certain Cultures: A Survey of Comparative Psychiatry," Journal of Mental Science, 97 (1951), 313.
6Engel, Psychological Development in Health and Disease, p. 316.
7Langner and Michael, Life Stress and Mental Health, p. 6.
8Fromm, The Envirn Society, pp. 71, 72.
Culture, social system, and personality are considered connected variables, and the uniqueness of any given person is conceived as a product of interrelated personal, social, and cultural factors. Even though sociocultural factors may not directly cause mental disorders, there are manifold ways in which social and cultural contexts and processes influence mental illness, its manifestations, its meaning, and its effects upon society. It has been written that social conditions may create or favor a predisposition for a disease; they may transmit the causative factors of disease; and they may have an impact on the course of disease. Philippopoulos maintains that socio-economic and cultural factors may not only precipitate but often shape the psycho-dynamics of mental diseases in a homogeneous population. He also sees the person's social environment as the psychological laboratory where the hatching of psychiatric problems takes place.

An almost general consensus exists among the various authorities as to the notion that sociocultural factors have considerable influence on man's mental health and mental illness. What about modern society and cultural patterns with regard to mental illness?

Speculations on modern society—focusing on Greek society.
Speculating on the nature of modern society as creating problems of adjustment for its members, it is stressed by a number of writers that

1 Opler, Culture and Mental Health, p. 9.
2 Rogers, Human Ecology and Health, p. 167.
3 Φιλιππόπουλος, Αναλυτική Ψυχιατρική, σ. 513.
Industrialization, urbanization, and mass communication have introduced a number of changes in family and social living with a negative impact on mental health. Modern technological advancement causes rapid social changes which result in role dislocations, depersonalization, and frustration of the socio-relational needs. Toffler describes the threat of future shock as the disease of accelerated change in our time; that roaring current of change which overturns institutions, shifts people's values and shrivels their roots.

Caught in the turbulent flow of change, called upon to make significant rapid-fire life decisions, [man] feels not simply intellectual bewilderment, but disorientation at the level of personal values. As the pace of change quickens, this confusion is tinged with self-doubt, anxiety and fear. He grows tense, tires easily. He may fall ill.

In Greece, industrialization and urbanization are receiving great impetus. The development of industry is planned on the basis of non-human requirements such as availability of raw materials, electric energy, market availability, and ground areas for plant establishment. The areas of Attiki, Piraeus, and Salonica have become the largest industrial centers, to the point that they are expected in the near future to attract 50 percent of the country's population. However, socio-cultural processes and changes necessitated by these technological advances were not taken into account in the overall planning. They developed in a random, unplanned way.

Changes in the socio-cultural domain which have particular significance for people's mental health and mental illness include consequences of urbanization such as the increase in the density of settlements, the disintegration of the traditional neighborhood, the evolvement of new forms of recreation, which almost exclude the intimate transaction characteristic of the traditional forms of recreation. Greek families more and more abandon their private houses surrounded by flower gardens and fruit trees, providing opportunities for contact with nature and for natural activities for both adults and children. They move to apartment buildings where children have no space to play, noise becomes unbearable, and there are no neighbors to talk with. People living in the next apartment are strangers. Furthermore, the in-group relationships, intimate and highly supportive, are loosening because of the geographical distances. Face-to-face transactions are replaced by telephone calls.

Greeks, who were accustomed to working rather independently and cooperating only with their in-group people, now are employed in large organizations. Instead of cooperating, they compete with their colleagues and they cannot easily share goals and plans for future achievement with them. Also, working in a large corporation is seen by many Greeks as dealing with an impersonal material environment because they can no longer find the affectionate and comforting frame of the in-group where intimate relations usually are developed.

Greek women are confronted with still more intense role conflicts. As they become working women — more than one out of three financially active Greeks today is a woman — they find themselves in a social vacuum because they lose the usual ways of meeting their social-relational needs through the transactions with in-group and neighborhood people. In the meantime, no role descriptions fitting the new occupational life are available to them.

Furthermore, the traditional value-orientation transmitted and reinforced to a great extent by the in-group norms now becomes loose, blurry, easily intermingled with imported values, and somehow undergoing a crisis stage. One key value in the Greek milieu is *philotimo* (love of honor), which regulates appropriate in-group behavior and secures interdependence through concern for others and utmost cooperation. Concern should be manifested with actually expressed love, care, active interest in the other person's life, readiness to give help and continuous availability. The relationship developed is characterized by absolute honesty and loyalty, trust, and unlimited giving. Relationships with out-group persons are competitive. Conceptually, *philotimo* is associated with honesty, respect, love, conscientiousness, morality, and duty. On the other hand, *philotimo* leads to respect and obedience, honesty and sincerity, success and progress, and, above all, to humaneness.

With social change, however, as milieu complexity, education, and social as well as occupational involvement increases, the antecedents and consequents of *philotimo* change. As a person moves toward a more highly complex milieu within Greece, his social conduct ceases to be regulated by in-group norms, and role perceptions become more important. Thus, *philotimo*, becoming more of an abstraction associated with honesty,
needs to be interpreted individually, depending on the social context which is ever changing. As a consequence, social changes in Greece necessitate changes in social relationships and social behavior, which in turn influence changes in social value orientation. This period of transition causes a great deal of frustration, insecurity, and anxiety, and taxes the person psychologically.

The foregoing social and technological changes in Greece expose the Greeks to psychological stress, to role conflicts and frustration of their social-relational needs as well as they test their potential for active and creative adjustment and for reintegration of a higher order.

This is the time for appropriate nursing intervention, in planning and delivering community health services with mental health educational and preventive goals. The field is virgin and the arena open. Were the Greek nurses to grasp the challenge and join efforts with allied health professionals, they would not only help prevent mental malfuctioning but also help the socio-cultural and spiritual civilization to proceed coincidentally with the technological development. Then man's personality would not be split and fragmented; he would remain unified and whole in his struggle to transcend and overcome pathogenic adversities, to keep his inner freedom and choice of action, even if he has to proceed contra torrentum; that is, against the downward current of the

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technological society. After all, "personality is effort and conflict, the conquest of self and of the world, victory over slavery, it is emancipation."¹

Greeks as a people have suffered traumatic deprivations, barbaric invasions, disintegrating pressures and persecutions, wars and occupations, and they have not only survived physically and emotionally, but they have also sustained and strengthened the Greek spirit through the ages. It constitutes common fact in Greece that in wartime, in periods of occupation by enemies and strenuous deprivation, as well as in times of socially and politically unsettling troubles, morale becomes higher, resistance movements attract people's commitment, and psychological breakdowns as well as psychosomatic diseases diminish considerably. Nevertheless, nursing preventive intervention is imperative so that Greeks are not left alone and at random in their confrontation with industrialization and urbanization and the subsequent depersonalization and conflictual stresses, but are helped and supported in a planned and substantial manner to preserve their mental health and, if possible, even to promote it.

For purposes of better understanding, the foregoing discussion has focused separately on biological, psychological, and sociocultural factors affecting mental health and mental illness. The nurse, however, should always keep in mind that the life process is a field of events in which inner and outer processes make up a complex totality.² Therefore,


all efforts, either therapeutic or preventive, in the field of mental health require overcoming reductionism and analysis. We need not merely to understand the biological, psychological, and sociocultural variables interfering in the process one by one, but also to become able to grasp their transaction.¹

Prevention of Mental Illness in Modern Times: A Philosophical Outlook

¹ Every man embodies countless cultural patterns in a unique configuration. He functions almost always in a sociocultural context, actual or imaginary. His psychological field at any particular situation encompasses the person himself, his life space, and his environment in a dynamic and unique interdependence. Therefore, stressful external conditions may act as potentially limiting boundaries of his psychological field; may influence his world outlook and his way of life; and may even influence critically his accessibility to health education and, if he becomes mentally ill, the health care he will receive. However, environmental forces do not stand alone in their influence on the cause and course of mental illness, nor can particular changes in these forces eliminate mental illness. There are cases -- one of which is Greek history, already mentioned -- when the same conditions that cause emotional breakdowns may mobilize powerful social counteractions and individual strengths and defenses that prevent breakdown.

Therefore, the issue is: Is there no spiritual freedom in relation to behavior and reaction to any given environmental realities? Is man only a product of conditional and environmental factors, bound to tread

the path determined for him by biological, psychological, and socio-cultural forces? But what about man's freedom and choice of action?

Man is created a free being by God. And he is that even if he were born in chains, even if the whole world wished to enslave him. He is created a being who surmounts and transcends himself. This does not imply a simple escape from reality or the rejection or distortion of reality. It implies free choice of action, not on the periphery but in the center of reality, be it contradictory or ambiguous or the cause of unhappiness and stress.

In each of the personal dialogues included in the Bible, the Word of God poses questions to man. Thus He makes of him a being who should respond, a responsible person. The Bible underlines the crucial character of this choice. For example, we read, "No servant can serve two masters," and "thou art neither cold nor hot: I would thou were cold or hot." Of course, freedom is a difficult thing. Spiritual liberation is conflict and independence may be a torment to man. It seems more secure to conform, to surrender to powers which may relieve man from the necessity for making decisions, taking risks, and having responsibilities. In this sense, slavery may be preferred. However, it is questionable whether this kind of security can be an equivalent of mental health. Decisions always imply a risk of failure, otherwise they have not been decisions in the true meaning of the word. This type of insecurity rather than

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2Revelation 3:15.
security, gained by passive acceptance of what is imposed externally, is a sign of mental health.¹

The experiences of concentration camp life show that almost everything can be taken from a person except his freedom to choose his attitude in any given set of circumstances.² Indeed, man can preserve a vestige of spiritual freedom, of independent thought, even in such awful conditions of extreme psychic and physical stress, because such unfavorable experiences may take on the meaning of suffering, which in turn adds a deeper and richer meaning to life.

The point is, how can man be better prepared to live in modern society with the multiple pathogenic factors and the invisible compulsions of conformity to pressures, and yet exercise his spiritual freedom, transcend the circumstantial adversities and preserve his mental health? The need to discover the way stirs and concerns many people representing various fields.³,⁴

Some of the proposed preventive measures are the following:

1. Transcendence of technocracy by inventing creative strategies for shaping, deflecting, accelerating or decelerating change selectively; in other words, by regulating and balancing changes.⁵ In this way, crisis can be turned into opportunity and people cannot merely survive but also crest the waves of change, grow and gain a new sense of mastery over the rates of transience, novelty, and diversity in their milieu.

¹Fromm, The Sane Society, p. 173.
²Frankl, Man's Search for Meaning, p. 106.
³Allport, Personality and Social Encounter, p. 156.
⁵Toffler, Future Shock, p. 373.
2. Helping people to gain a cognitive control over the richness, quality, choice, and flexibility of the action alternatives available to them and encouraging them to make choices. In this way man's identity—which today looks so poor, so swallowed up, so fragmented—can become stronger and integrated to match the rich world in which he lives.

3. Assisting people to recognize a variety of possible achievements, to experience and perceive conflict and irreconcilable value differences, to practice active adjustment, and to form a correct perception of one's self and of reality.

4. Caring for the spiritual dimension of man as well, and guiding him to become aware that life is a problem of heroics which becomes indispensably a reflection about what life ought to be in its ideal perspective.

5. Moral and spiritual renewal of the health professions so that they can contribute, cooperatively with theology and philosophy, to the building of a new civilization in which the Spirit of Christ will be the inner source of personal, family, social, and individual conduct; in which the gathering together of freedom, truth, and love will foster realization

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1 Becker, *The Revolution in Psychiatry*, p. 221.


3 Ron Willey, "Who Cares?", *Nursing Times*, 68, 42 (October 19, 1972), 1328, 1329.


of free and creative personalities;⁴ and in which the spiritual struggle
against sin, the true consciousness of guilt, and the communion in the
redeeming Divine Grace will be the foundations and the safeguards of
mental health.²

Nurses observe in everyday practice that health professionals,
despite all their intention to be objective in their study of man, cannot
avoid polarizing their inquiries in accordance with their own concepts.
For example, he who believes only in material factors investigates the
chemical factors — heredity, drugs, metabolic imbalance — in a mental
patient, forms a materialistic concept of the causes of the disease, and
orients his preventive plans accordingly. He who believes in psychologi­
cal factors will also look at moral factors and psychological conflicts,
and will form a more comprehensive picture of the pathogenesis of the
patient's disturbance. In this perspective, the scope of preventive efforts
will be broader and more inclusive. Finally, he who speculates on the
spiritual development of the patient as having a bearing on his emotional
and even his physical development, examines the physical, psychological,
and spiritual aspects of the patient. From this vantage point, preven­
tive services will cover the physical, the emotional, and the spiritual
needs of the citizens.

The question is: What philosophical stand will be taken by modern
nurses in their endeavor to contribute to protecting, restoring, and
fostering man's mental health? Will nurses choose the spiritual axis —
however risky and costly that might be — to their lives and their nursing

¹ Berdyayev, Slavery and Freedom, p. 294.
² Κορναράκης, Θ. 'Η Νεορωσία δέ, ''Αληθικήν Πλάνην'': Συμβολή
eν τήν Παιμαντικήν Θεολογίαν. σ.116.
services to man? Or will they prefer to tread the wide and plain road of conventionalism even though it proves to be infertile and pathogenic? Will nurses’ antennae grasp the message of the times and make the heroic decision — and this not once but anew every day — "to choose themselves as autonomous — knowing enough, caring enough, to take responsibility, to open up to possibility, to be"? If yes, then nurses can deliberately appropriate for themselves a holistic approach to man; that is, they will provide for synthesis of the available knowledge about the physical, psychological, sociocultural, and spiritual factors influencing mental health and mental illness; they will also work for the constructive transformation of the negatively acting factors while maintaining faith in the spiritual freedom of man and his innate potential to transcend adversities and retain his unity and wholeness. Nurses who choose such a frame of reference may find deep meaning in their endeavors to prevent mental illness in modern times.

Purpose

To discuss the significance of skillful communication and therapeutic interpersonal relations in mental health — psychiatric nursing within the conceptual perspective of all nursing being an interpersonal process.

Content Outline

Nursing: An Interpersonal Process
Communication: Its Purposes and Modes
Perspectives on Communication
Modes of Communication
  Verbal communication
  Nonverbal communication
  The use of space in interactions
  The body language
Therapeutic Nurse-Patient Dialogue
  Interpersonal Climate
  Listening and Talking
    The nurse is listening
    The nurse is talking
Group Therapeutic Approaches
  Dimensions of Group Goals and Therapeutic Potential
  Establishing a Patient Group
  The Task of the Group Leader
  Developmental Phases of the Group
Chapter 4

NURSING: THE SCIENCE OF THE DIALOGUE

Nursing: An Interpersonal Process

Nursing is an interpersonal process. In all the arenas where nurses work, nursing care is a service to man, a social service, a helping relationship, an interhuman language. Therefore it is always actualized within an interpersonal framework, climate, and milieu, within a laboratory of interpersonal relations.

Nursing intervention, indicated in either physical, emotional, or interpersonal problem situations, is always a dynamic interpersonal process. The nurse-patient relationship is vital and pivotal in the

1 Peplau, Interpersonal Relations in Nursing, p. 16.
3 Anderson, "Philosophy and Its Role in Nursing and Nursing Education," p. 4.
7 M. Leah Gorman and Lenora McLean, "Toward a Definition of Intervention," in Maloney, Interpersonal Relations, p. 61.
realization of any nursing activity in the continuum of care that assists either in preventing, reversing, or arresting the pathologic condition in a patient and, in general, in the fulfillment of the nursing goals.

Through the nurse-patient relationship, the nurse comes to know the patient as a whole person; assesses and ascertains the patient’s health problem and the way it has affected and is affecting his relationship with the world, with himself, and with his fellow man; identifies and validates the patient’s personal resources to cope with his present life situation, and his needs for nursing care in order to move toward greater health and well-being; plans to carry out deliberatively, with and for the patient, the nursing intervention indicated in the particular circumstance; and evaluates and validates with the patient the effect of the intervention.¹,²

Nursing, conceived and actualized as an interpersonal process, not only provides for and enhances assessment and validation of the patient’s problems and needs and the cooperative resolution of them in the immediate situation, but it encompasses broader dimensions and reaches goals of a higher order. The nurse may become "a creator of interpersonal situations in which the patient can carry on problem solving for the purpose of arriving at new knowledge, realizing new insights, and testing the new knowledge and insights in his relationship with the nurse."³

¹Wiedenbach, Clinical Nursing: A Helping Art, p. 36.
Furthermore, nursing care as an interpersonal process affects the health of the patient's personality by allowing and encouraging him to disclose his needs, wants, worries, anxieties, and doubts. The patient's self-disclosure communicates to the nurse the contents of his "phenomenal field" — what he is thinking and feeling and what things in the world and his present situation mean to him. This may be a more sensitive indicator of the health condition of the person than, for example, his pulse rate, blood chemistry, X-ray findings, and so forth, and it can provide a wider basis for the nursing diagnostic and therapeutic endeavors. This is so because, above and beyond the discussed dimensions, self-disclosure is a way to self-discovery.

Another point is that through communication the person's view of self, of others, and of a situation, becomes confirmed, modified, or changed. In nursing, therefore, communication with the patient is a way of bringing about change, growth, and learning. In this perspective, nursing is "a therapeutic educative relationship" and "a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living." If, however, the interpersonal nursing situation has potentially such a multidimensional impact upon the patient in that it contributes

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4 Peplau, Interpersonal Relations in Nursing, p. 16.
to prevention of illness, restoration and promotion of health, and fos- 
ters emotional well-being and growth, it also exerts a significant influ- 
eece upon the nurse. The meeting of two personalities has been compared 
to the contact of two chemical substances: if there is reaction, both 
are transformed. Any interpersonal contact in space and time implies 
transaction between the persons meeting, resulting in change in both 
parties. The nurse-patient relationship is a reciprocal process, a 
mutually significant experience, and thus both nurse and patient grow as 
human beings as a result of the relationship.

The learning and insights that the nurse may gain from relating 
with patients are innumerable. Indeed, she has a unique opportunity to 
learn from the living human books of the patients themselves much more 
than from any textbook of pathology, since each patient experiences and 
expresses his illness in unique personal ways. Furthermore, she learns 
the art and science of the dialogue by becoming involved in it with her 
patients, by doing, and by examining how nursing becomes therapeutic 
through positive and constructive communication. The nurse also learns 
a great deal about herself as she begins to understand her reactions to

1 C. G. Jung, Modern Man in Search of a Soul, transl. by W. S. Dell 
2 Γεώργιος Βασιλείου και Βάσω Βασιλείου, "Εισαγωγή εις 
τό θέμα των Καθημερινών 'Ιατρικών - 'Ασθενών," Είς Γ.Κ.Δατείου 
Νοσολογία (Αθήναι: 1971), σσ.5-6.
3 Travelbee, Intervention in Psychiatric Nursing, p. 80.
4 Shirley Burd and Margaret Marshall (eds.), Some Clinical 
Approaches to Psychiatric Nursing (New York: The Macmillan Company, 1963), 
p. 360.
5 Grace Theresa Gould, "Toward a Philosophy of Personalized Care," 
the patient's behavior and what interpersonal abilities she needs to develop in order to cope effectively with interpersonal relationships. Learning is enhanced by the fact that each interpersonal nursing situation is unique in the opportunities it offers for learning, and therefore the nurse may transfer this learning in solving interpersonal problems in broader and different settings.

Beyond and above the cited learnings and insights which the nurse may gain as a result of her relating with her patients, the spiritual dimension of the relationship might be considered. In the perspective of the Greek Orthodox Faith, interpersonal encounters are considered as providing the arena for actualizing Christian love and brotherhood, for achieving communion with our fellow men, for realizing self-transcendence and thus spiritual self-confirmation. The patient is "the neighbor" who in turn is conjectured as "the foundation" from the point of view that he opens opportunities for the practice of love and compassion as a way of becoming divine (ιδέα θεώσεως ). Also, interpersonal

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3 Romans 12:9-14.
6 "Ἀποθέγματα Πατέρων Μινατ. Πατρ. Ρετ. 65, 217. "Ὁ θεμέλιον ὁ πλησίον ἔστιν... εἰς αὐτὸν γὰρ κρέμανται πᾶσαι αἱ ἐντολαὶ τοῦ Χριστοῦ."
7 Σπυρίδων Σ.Μπιλαλης, Αρχιμανδρίτης. Οἱ Μάρτυρες τῆς Ορθοδοξίας. Τόμος Α'. Η Ἐκκλησία τοῦ Χριστοῦ ("Λόγια τῆς Ἐκκλησίας Ορθοδόξου Τύπου, 1973), σ. 297.
Communion through Christian love is seen as introducing the person into communion with God. Thus, nursing as an interpersonal process provides daily opportunities for the practice of Christian love and has the potential to develop in dialogue of personalities, in a meeting and communion of persons on a spiritual plane, yielding spiritual enrichment for both the nurse and the patient.

The foregoing illustrations are examples showing only that nursing as an interpersonal process encompasses infinite therapeutic, educative, and maturing powers still unexplored, which remain to be discovered, utilized, and liberated by nurses who practice nursing as a way of life. The nurse who chooses to commit herself to personalized care for her patients never risks being dragged down by routines and technicalities, or by the dehumanizing automation of our times. On the contrary, she will always find nursing a thrilling and challenging experience, stretching and developing her potentialities in the direction of growth and meaningful service to man up to the last day of her active nursing career. The question is: Will the nurse choose to engage in nursing as an interpersonal process?

Communication: Its Purposes and Modes

Perspectives on Communication

Communication is very broad in scope. People communicate on many levels, for many purposes, with many people, in many ways.

Communication is universally seen as the essential social process by which man achieves his individual humanity. Personalities appear by

1 Αββα Δωροθέου. Διδασκαλία ΣΤ' Β. Μικρο. Πατρικ. Εκδ. 1696 / "...Σπουδάσατε ενωθείναι ἀλλήλους ὥσον γάρ ἐνοῦται τίς τῷ πλησίον τοσοῦτον ἐνοῦται τῷ Θεῷ."

2 Barlund, Interpersonal Communication, p. 6.
relating to other persons. Only by meeting a "thou" does man realize that he is an "I." No natural object in the universe can do this to him. The formation, definition, and evaluation of the self emerge from the successive personal encounters of the individual with others.

Interpersonal encounters are considered as necessary for psychic life as light and air are indispensable for physical life. It is in interpersonal situations that man comes to know and differentiate himself from the others, to identify the boundaries of his personal demands by meeting the rights of others, and to learn self-discipline. Further, it is in interpersonal circumstances that discretion, justice, genuineness, love of beauty, and breadth of mind and spirit are cultivated. Without communication, man can neither realize his own potentialities nor develop and channel properly those talents of which he is aware.

Social systems are produced, maintained, and reformed through communication. It is commonly held that almost all changes in behavior, beliefs, attitudes, and values are mediated by interpersonal communications of one kind or another. To mention only the mass media, the advertising techniques, the various political propaganda, and the literature and art products, one can easily see how instrumental or influential communication may become for better or worse, on the personal, social,

4 Σπετσιέρης. Η Φυσική Ζωή του Ἀνθρώπου, σ.356.
national, and international levels. No form of education can be achieved without some kind of communication, the latter broadly conceived.

Since relatedness influences man's values, his ways of responding, his sense of identity, and his perception of his surroundings -- in other words, his whole being -- it constitutes a vital factor to be considered in any discussion of health. And it is really considered as such, as we have seen in the sections of mental health and mental illness.

Assorted neurotics, psychotics, and psychosomatic patients are described as presenting selective atrophy or overspecialization -- in other words, inadequacy and inappropriateness -- in various aspects of the process of communication. As a consequence, communication is used in various therapeutic modalities, and it constitutes particularly the basis and the matrix of psychotherapy.

All nursing is an interpersonal process. Therefore it is imperative for the nurse to develop communicative sensitivity and skills in order to improve her therapeutic nursing potential. To increase the nurse's understanding of the communication process, the discussion will turn to the various modes of communication.

Modes of Communication

Verbal communication. Language is not just one function among many. Language occupies a central place in the human world. Its most

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Important and principal task is objectivation and systematization. With the first understanding of the symbolism of speech, a real revolution takes place in the life of the child. He passes from a more subjective state to an objective state, from a merely emotional attitude to a theoretical attitude. Language opens a new perspective, and widens and enriches man's concrete experience. It makes possible the formation of concepts, the ascent to higher levels of abstraction, and thus the mastery of both an objective and theoretical view of the world. Without language there is no objective order of reality.

Speech and thought are interrelated. It is with language that thoughts may become organized and new thoughts evolved. Language opens up new orientations and new possibilities for learnings and for action.

The social function of language is of paramount importance. Only by language can cooperation among people be achieved and the youth become knowledgeable of an adult's duties, opportunities, and responsibilities. Furthermore, language not only describes things, but also, the more significantly, perhaps, it arouses human emotions and prompts people to

certain actions. Through language people are taught how to speak and act in their actual social and political world. Examples may be drawn from the great political struggles, the dialectic method of Socrates, and the "rhetoric" developed and used by the Sophists in the Athenian life of the fifth century. It was of vital importance to use language in the right way and continue to improve and sharpen it. Otherwise nobody could hope to play a leading role without diligently mastering the instrument of language.

The foregoing position holds true in everyday life. Through language we can act upon people; we can edify or create people as well as persuade them; we can appraise them of facts or flatter them; we can hurt and disparage and delude them; we can even push them into mental illness or pull them out of it. Words may serve as the best therapeutic agents.¹

Another point needs to be stressed, and this is the notion of meanings conveyed and elicited by messages exchanged between people. Meanings are in people.² The same message may assume different significance according to its location in time, in context, and in situation. Furthermore, the ascription of internal or external motivation produces differences in the evaluation of messages.³ Messages carry both expressive meanings reflecting inner states and instrumental meanings commenting on

¹ Γρηγορίου Θεολόγου Migne Patr. Gr. 37, 954 A. "Λέγω αριστος ιστι φαρμακεύς κακών."


external events. People also do not merely record what they hear, but they relate spoken content and people to each other. That is why it happens that different messages may evoke identical responses, and one single message may elicit a variety of reactions, and that every interpersonal relation is a blend of misunderstanding, non-understanding, and mutual understanding.  

The foregoing information helps us to understand how frequently stress may be generated in interpersonal encounters, through the words and cues exchanged. For example, messages permitting the perception of criticism, rejection, superiority, anger, or indifference may give rise to anxiety, and anxiety, once present, definitely affects meanings. On the other hand, interpersonal antagonisms may be resolved or dissipated through communication. The value of verbal interaction is that it may correct erroneous perceptions of others' feelings and behavior and thereby have a positive interpersonal affect.  

So far, this discussion has focused on verbal communication as a means to master an objective and theoretical view of the world as well as reality; an agent promoting thought, learning, and acting; a facilitator of social interaction and cohesiveness; an instrument to transmit messages and meanings with the potential to enhance understanding, health, unity, or to cause anxiety and to create interpersonal distances. It is important to consider language in relation to nursing.  

The nurse uses words in many ways in her relations with patients. By the use of language she can care and cure; transmit health-related or

other needed information; interpret nursing or medical intervention; keep the patient reality-oriented or help him rediscover reality by providing consensual validation and other reality-testing grounds; loosen delusions and hallucinations and pull patients out of withdrawal. Furthermore, by the use of language, the nurse can become the advocate of her patients, their health consultant; she can transmit hope and faith to the desperate, alleviate fears and reduce anxiety; she can provide support, reassurance, and consolation; she can relieve pain—conceived as having physical, mental, social, and spiritual dimensions.

It is evident that a thorough knowledge of basic concepts and principles, from philosophy, psychology, sociology, psychiatry, general medicine, and, indeed, from nursing, is imperative for the nurse in order for her to be able to use language as a communicative tool in caring for her patients. However, there is almost unanimous agreement among the authorities of the mentioned disciplines that the personality of the therapist makes the difference in using verbal communication therapeutically or not.1,2,3,4

In nursing, great emphasis is given to the personal qualities of the nurse which affect the therapeutic potential of her verbal communications with her patients. Her spiritual sensitivity,5 her inner

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5 Manfreda, Psychiatric Nursing, p. 206.
cultivation, the application of the Golden Rule, and an "educated heart" enriched with love, empathy, and real caring for the welfare and well-being of the patient, are highlighted as important to therapeutic nursing. And then the following verses may become true for the nurse: "Out of the abundance of the heart the mouth speaketh," and "She openeth her mouth with wisdom."

**Nonverbal communication.** The spoken language is not the only means of communication. In addition to what we say with our verbal language, we continuously communicate our real feelings in our silent language, the language of behavior. The whole man speaks. The important point is that nonverbal communications either validate or deny what has been spoken in words. This may be because people do not realize that they communicate through other channels not subjected to control and perhaps to distortion. Thus, nonverbal behavior is the language of sensitivity which exposes the truth in all human relationships.

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5. Matthew 12:34.
Culture is a form of communication. The Greek historical monuments, for instance, speak eloquently and say thrilling things about ancient Greece, its civilization, character, and spirit.\(^1\)

Time and space also talk. They may talk more clearly than words. They can shout the truth where words lie. Language usually is employed to discuss facts, opinions, and problems, while nonverbal signs are employed to express emotions and interpersonal attitudes.\(^2\)

Nonverbal ways of communication — such as body motion or kinesic behavior, paralanguage (namely, voice qualities and proxemics — meaning the use of personal space and the perception of it) — increasingly receive the attention of investigators.\(^3\)

The nurse needs to gain insight into the nonverbal components of communication in order to be able to understand her patients and herself more deeply and fully in the various interpersonal nursing situations. Such insight will further enable her to consciously use nonverbal communication to increase and amplify the therapeutic potential of her nursing.

The use of space in interactions. Every individual, with guidance from his forebears, develops a sense of personal space, the distance at which he prefers to interact with others. Spatial changes, the flow and shift of distance between people as they interact with each other, give

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\(^3\)Starkey Duncan, Jr., "Nonverbal Communication," *Psychological Bulletin*, 72, 2 (August 1969), 118.
a tone to a communication, accent it, and at times even override the spoken word.

The specific distance chosen during interpersonal encounters may reflect the degree of acquaintance of the interactants, their motivations and feelings, the roles that they assume, and their expectations from the interaction. Thus, significant differences in spatial styles may result in attributing different meanings and motives to the same message.

Furthermore, the physical space — the geographical location of a hospital, the architecture, the height and width of the windows, the placement of desks, lockers, screens, and so on — certainly conveys nonverbal messages to the patients which influence the conduct of their interpersonal communication.

A number of subsequent implications may be conjectured for nursing. Since personal space has no visible boundaries, the nurse has to discern in each particular situation what the patient's personal space is conveying. Sometimes a certain arrangement and re-arrangement of the furniture, as well as a relative improvement of the physical setting, can enhance the communicative potential of the patients. For example, it will certainly make a difference whether there is a fixed placement of the chairs along the walls in a living room or the grouping of the chairs around small tables, or even the conveyed flexibility and expectation that everyone may place his chair wherever he wishes, in a given situation.

Special attention is necessary when patient and nurse do not belong to the same culture. Interaction distances to specific situations differ


in their meanings, and are perceived differently in various cultures. The nurse who cares for a patient of another nationality than her own should try to learn what the prevailing norms are in interaction distances in the patient's culture, and then try to understand the messages conveyed by the patient's use of personal space.

If the interaction distance as a model of nonverbal communication were understood and taken into consideration by nurses, it might amplify and augment the caring and therapeutic dimensions of nursing as an interpersonal process.

The body language. The human body is a versatile instrument capable of expressing the whole gamut of ideas and feelings. Persons are engaged in physical conversation even when they are verbally silent. They continue communicating through body idiom.\(^1\) Kinesic behavior, encompassing communicative postural, gestural, facial patterns, qualifies, maintains, changes, and directs interpersonal communication.

Gestures and facial expressions tend to have a more mandatory function than words.\(^2\) They may depict a concept or punctuate the stream of speech; they may illustrate and augment the spoken content as well as reveal the emotional state of an interactant even when he tries to conceal it; they may indicate attitudes and provide continuous feedback on whether one understands, is surprised at, or agrees with what is being said; they

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may inform about the complex interrelationships that exist between non-verbal behavior and content or noncontent aspects of speech.\textsuperscript{1,2,3,4}

Perhaps in no other situation are nonverbal cues as critical — or interpreters as sensitive to them — as in the therapeutic setting. Body language has become a matter of inquiry into the curative process. Expressive body cues are found reliable indicators of emotional states and changes during clinical interviews.\textsuperscript{5,6}

Since gestures, posture, facial expressions, and body motion and appearance in general express meanings, feelings, and attitudes, it is monumentally important for the nurse to be able to recognize, acknowledge, and accurately interpret them during her encounters with patients.

Indeed, in all interpersonal nursing situations, and particularly in psychiatric settings, a comprehensive nursing assessment of the patient's condition, needs, and pleas for help depends heavily on recognizing the nonverbal cues communicated by him.\textsuperscript{7} The initial


\textsuperscript{2}Argyle, \textit{Social Interaction}, pp. 102-103.


\textsuperscript{5}Barnlund, \textit{Interpersonal Communication}, p. 534.


\textsuperscript{7}Wiedenbach, \textit{Clinical Nursing: A Helping Art}, p. 28.
observations of the patient's gestures, facial expressions, and general appearance tell us much about him. We can to some extent perceive the thoughts and estimate the feelings that he has about himself. We can judge whether he is oriented or confused, sad, underactive or hyperactive, in contact with us or not. We can determine whether or not he is regressed or withdrawn or anxious.¹,² Not only gestures and body motions are nonverbal clues worthy of notice, but also the absence of a verbal response may be explored as a form of nonverbal behavior.³ Such observations may help to evaluate the verbally uncommunicative patient.

Recognizing a nonverbal communication is the first step. How it is interpreted will make the difference in understanding or misunderstanding what the patient is really conveying. For example, the elaborate and compulsive hand-washing, the repetitive walking up and down the hall, the autistic withdrawal during a one-to-one or group interaction — all these certainly communicate messages which need to be explored. Also, the blank facial expression while discussing traumatic experiences, the catatonic posture, the making of gestures and grimaces as if hearing and responding to inner voices, the tense and awkward face, and posture with jerky and poorly controlled gestural movements constitute a symbolic — however eloquent — language revealing a great deal about the emotional inner experiences of the patient and about his ways of handling specific interpersonal situations, yet to be clarified and understood.

¹Peplau, Interpersonal Relations in Nursing, p. 305.
²Burgess and Lazare, Psychiatric Nursing in the Hospital and the Community, p. 89.
³Orlando, The Dynamic Nurse-Patient Relationship, p. 42.
⁴Chapman and Almeida, The Interpersonal Basis of Psychiatric Nursing, pp. 82-87.
Nonverbal communication expresses a variety of emotions or needs which depend on many factors, such as who communicates with whom, when, and in what context. Thus, the nurse must consider nonverbal cues in relation to these contextual factors. She must guard against making inaccurate generalizations or stereotypes based on her own past experiences with various people, and moreover, she must avoid automatic actions and reactions.

Of course, the nurse can make inferences about the patient's experience from what he conveys verbally and nonverbally, from what she knows about him, and from what she knows about her own and other people's reactions to similar situations. However, she can use simple acknowledgment, stating how she sees the patient's appearance and actions, and seek clarification and validation by extending and exploring the communication.

Another important point is that the nurse also communicates her feelings nonverbally; i.e., by the way she looks, by the tone of her voice, by the way she touches the patient's body, by the way she wears her uniform. Understanding the implications of her nonverbal communication is important for the nurse, particularly when she is caring for mental patients. These patients are extremely sensitive to the nonverbal signs of others, even though they may interpret them incorrectly. The nurse who always look

4Manfreda, Psychiatric Nursing, p. 265.
hurried, who answers questions abruptly, who slams doors noisily, is likely to be characterized as an angry or impatient person or even indifferent, cold, and uncaring, almost unreachable.

It is evident that the nurse who conveys nonverbally negative feelings — derogative and humiliative — cannot work therapeutically with the patient even though she may master intellectually the best techniques and theories of therapeutic communication. On the other hand, the nurse can use nonverbal communication to convey acceptance, sincere interest, and sympathetic understanding, warmth, tenderness, and compassion.1,2,3,4

A significant way of nonverbal communication for the nurse, worthy of study for its communicative value, is physical care, encompassing the act of touch — that vital means of establishing communication and of communicating emotions and ideas.5 Physical caring activities are vehicles for deepening the nurse-patient relationship. The nurse may notice that when she is giving physical care, the patient tends to discuss his real concerns.6 Indeed, physical care, very succinctly and yet

3Travelbee, Interpersonal Aspects of Nursing, p. 142.
In eloquent silence, tells the patient about the nurse's feelings and attitudes as well as about her philosophical outlook on man, suffering, and human life. In this perspective, it would seem inadvisable to remove from the nurse any more of the physical care, as this may deprive her of an opportunity of easy contact with patients.

As a conclusion, it must be stressed that the nurse's understanding of the patient's and her own nonverbal behavior may enhance the therapeutic outcome of their relationship. Most significantly, the nurse should take care to examine, recognize, and validate her nonverbal communication and how it affects the patient. This practice is likely to challenge her to become involved in the continuous task of refining and ennobling her own emotions and attitudes so that her nonverbal actions reinforce and confirm her verbal communication, so that she will really and sincerely mean what she says always to the greatest therapeutic benefit of the patient.

Interpersonal Climate

The interpersonal climate of the therapeutic nurse-patient dialogue consists of a synthesis of kind and genuine feelings and attitudes conveyed by all channels of communication on the part of the nurse. It is not different from the climate considered as therapeutic by most therapists and it does not depend on what particular school of thought or technique is followed at the actual therapeutic session.


2 Barnlund, Interpersonal Communication, p. 620.
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**Therapeutic Nurse-Patient Dialogue**

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²Barnlund, Interpersonal Communication, p. 620.
The presence of a climate of warmth, love, understanding, and respect constitutes a precondition for self-expression in the therapeutic relationship. Respect is considered as an acute sensitivity to the patient's weakness and strengths, to the influential inner and outer forces which developed his more unfortunate attitudes, and to an affirmation of the patient's capacity to grow. Furthermore, respect encompasses commitment to the responsibility to work and learn about another person, as well as willingness and ability to respond to another person.

Respect, then, may serve as a basis for building compassion and empathy. It seems that empathy is the deciding characteristic which determines the success or failure of the psychotherapeutic endeavor. It means caring about another person, caring fostered by understanding. Empathy is considered as the keynote of good nursing practice regardless of setting. Nursing ought to communicate empathy to be relevant.

Another characteristic of the interpersonal climate of the therapeutic nurse-patient dialogue, related to those already mentioned, is acceptance. Acceptance of the patient means a warm regard for him as a person of unconditional worth no matter what his condition, his behavior,

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or his feelings, and no matter how negative or positive his attitudes of the moment are.¹ Acceptance creates a comfortable, trusting, and secure interpersonal climate in which the patient is made to feel free to express, validate, explore, and evaluate ideas, feelings, experiences, and communication patterns. He does not have to be afraid of being judged or disapproved of. Such a non-evaluative atmosphere contributes in reducing and even dissipating fears, anxiety, and defensiveness, and in restoring the patient's faith in himself and his cooperation for the solution of his problem.²,³

The therapeutic significance of the acceptance of the patient as he is, in the actual stage of his illness, as a starting point for planning nursing intervention, is extensively stressed in nursing literature.⁴,⁵,⁶,⁷ At this point it must be pointed out that acceptance as a therapeutic attitude is not to be confused with indiscriminate laissez-faire. It is "an extremely goal-directed attitude whereby the long-term task is clearly defined and contradictory behavior is utilized for purposes of correction."⁸ It is an active process, a series of positive

¹Rogers, On Becoming a Person, p. 34.
²Poletti, Aspects Psychiatriques des Soins Infirmiers, p. 53.
³Peplau, Interpersonal Relations in Nursing, pp. 186, 187, 206, 207.
⁴Dorothy Gregg, "The Therapeutic Roles of the Nurse," Perspectives in Psychiatric Care, 1, 1 (January-February 1963), 20.
⁶Altschul, Psychiatric Nursing, p. 297.
⁷Mereness, Essentials of Psychiatric Nursing, p. 61.
behaviors aiming to convey to the patient that he is respected as a person of intrinsic worth, dignity, and with the right of freedom to experiment, to make his choices and to correct errors.

To recapitulate, the interpersonal climate in which a therapeutic nurse-patient dialogue can develop should be a composite of conditional love, respect, empathic understanding and acceptance, conveyed by the nurse to the patient through all channels and modes of communication. The expectation is that this climate will encourage self-expression, deeper awareness, more complete perception of self and others, more effective interpersonal functioning, and personal growth.

**Listening and Talking**

In the dialogue, listening and talking are interwoven and constitute a unified whole, like the warp and woof of a piece of cloth. For educative purposes, for deepening insight into both aspects, they will be considered separately.

The nurse is listening. In the perspective of the therapeutic nurse-patient dialogue, listening is more than hearing. It is not monitoring the spoken word with the ears in the mechanical, automatic sense. Neither is it remaining quiet, passive, and detached while the other person is speaking. What is it, then?

Listening is involvement in purposeful action;\(^1\) it is a deliberate use of silence with a genuine interest and eagerness to share with a person when the latter deeply needs to talk to someone.

\(^1\)Travelbee, *Intervention in Psychiatric Nursing*, p. 93.
Listening is love. It takes courage and it requires self-transcendence, the abandoning of personal prejudices, preconceived judgments, and other mental activities unrelated to the speaker. It requires concentrating totally and sensitively on the ideas, meanings, and experiences of the other person.

Listening is a special form of giving, because it takes energy. The nurse stays alert in several areas: she works with her ears, her eyes, her whole being. She engages in "active holistic listening" with all of herself: her senses, her attitudes, beliefs, thoughts, and intuitions, and with her heart as well.

Listening of such a caliber has a specific healing and therapeutic value for two reasons. First, because it conveys attention, respect, and reassurance. It transmits the nurse's "expectant readiness" to listen to the patient's concerns and problems in an attempt to understand him truly and deeply. Indeed, listening with "a concerned face indicating a concerned heart" may convey acceptance, empathy, and caring which, as we have seen, are strong therapeutic agents.

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1. Tillich, Love, Power, and Justice, p. 84.
Second, effective listening encourages verbalization, which appears to be therapeutic in many ways. Verbalizing tensions is one way of ventilating them; putting in words one's state of mind constitutes a kind of insight, and naming an attitude helps to objectify and reorganize it cognitively. From this vantage point, listening as a therapeutic attitude is characterized "cathartic listening." It is widely admitted that the good listener is the best physician for a person who is ill in thought and in feeling.

Sensitive listening of the presented quality ought to be the order of the day in all nurse-patient dialogues, regardless of the particular nursing arena in which they take place. Particularly, listening may be used as the nursing intervention by choice in the nurse-patient dialogues in psychiatric settings.

While listening, the nurse is engaged in accomplishing the following tasks:

1. She listens to the patient's words and gathers pertinent information about his feelings, problems, and needs. She listens and observes the patient's nonverbal symbolic expressions with her fullest concentration and comprehension of what the patient communicates.

2. She listens between the words and behind the patient's contrived screen of verbalizations in search of meanings and themes that are conveyed. It has been said that "he who listens with a third ear hears also what is expressed almost noiselessly, what is said pianissimo."

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2. Ruesch, Therapeutic Communication, p. 128.
It is really like listening to music "for the themes and variations, for the nuances of meaning that are conveyed indirectly through sound or hint."  

3. She listens without criticism, prejudice, or condemnation. She tries to see and experience the patient's problem in the way he does, while she deliberately examines her own reactions to the actual situation.

4. She listens sensitively and with heightened alertness to the patient's silences, too. Talkativeness is sometimes silence when it avoids and takes away from crucial themes. What is spoken may often not be the most important thing. Thus the nurse is alert in identifying what speech conceals and what silence reveals. Furthermore, she is attentive in noting when the patient's speech breaks down or his words become irrelevant, and why. Is it fear, anxiety, or something else which blocked the patient's talking?

5. She listens to the healing forces within the patient in order to mobilize and use them in helping the patient toward growth.

6. She condenses, abstracts, and decodes what is being said and in what context. She discriminates between main ideas and details, and she weighs the verbal evidence used by the patient to support the points that he makes. She summarizes and evaluates within herself the important issues at hand. Then she tries to visualize the situation as a whole.

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1 Hildegarad E. Peplau, "Talking with Patients," American Journal of Nursing, 60, 7 (July 1960), 965.


Listening has been discussed as a purposeful nursing action aimed at communicating to the patient acceptance, reassurance, and caring on the part of the nurse, and encouraging him to talk out his problems and become involved in their solution cooperatively with the nurse. Through listening, the nurse comes to know the patient and can plan a relevant nursing intervention. Thus, listening is therapeutic within the perspective of all nursing conceived as an interpersonal process.

The nurse is talking. Talking with the patient is direct nursing care and, as such, it is responsible, deliberate, goal-directed use of words.

The focus is the patient — his present experience of illness, his needs, problems, interpersonal difficulties, and interest in learning. Therefore, what is discussed must be relevant and appropriate for the benefit of the patient.

The overall goal of the therapeutic nurse-patient dialogue is the development with the patient of a clear and adequate conception of his experience with illness and to assist him in gaining increased clarity about himself and his relations with others, in improving his interpersonal competence, and in becoming more able to cope with the problems of life adequately and comfortably. However, specific objectives are

1 Fagin, "Psychotherapeutic Nursing," p. 301.
2 Peplau, Interpersonal Relations in Nursing, p. 297.
3 Travellbee, Intervention in Psychiatric Nursing, pp. 60-65.
formulated with every particular patient, and even for every nurse-patient interaction, according to the identified existing and emerging needs and problems. For example, one objective may be just listening to the patient regain contact with reality, obtaining and giving information, or helping him to improve his communication skills.

In general, the nurse talks little. She encourages the patient to take the lead in the dialogue and to express himself freely, with few verbal contributions.

In the dialogue, the nurse maintains feedback circuits; that is, she relays back to the patient what she has heard him saying in order to help him to clarify, extend, or possibly to alter his original idea. Feedback enhances correction of action through incorporation of the information about its produced effects.¹ The patient learns to observe the effect of his communications and actions upon others and is helped to include these observations in his future encounters.

Simple acknowledgment on the part of the nurse of what she hears and sees the patient saying and doing is one instance of feedback which acts as an incentive for further clarification. At times the nurse restates what has just been said, putting it in the form of a productive question to elicit a fuller description of the patient’s experience as he perceives it. For instance, when the patient says: "I went home over the weekend," and the nurse responds questioningly, "You went home?" the patient may continue to describe whom he found there, what he did, and what the experience meant to him.

¹Ruesch, Therapeutic Communication, p. 159.
This is the so-called reflective technique, which may be applied when the nurse helps the patient to elaborate on his thoughts and describe personal perceptions of his experiences. Also, it gives the patient a feeling of prestige and importance because it conveys to him the positive regard, permissiveness, warm interest, and empathic understanding of the listener. His desire to communicate and his satisfaction from communication become strengthened. He becomes more critical of his expressions and makes more effort to clarify them.

The nurse may further assist the patient in clarifying expressed feelings by reflecting on the meaning of what she sees or hears. She crystallizes in a few words or sentences her understanding of the feelings expressed by the remarks of the patient, sharing with him in a wondering way her thoughts and feelings about her perception of his verbal and nonverbal behavior. She may say: "You sound as if you are angry," or "You are making a face as though you feel uncomfortable. Is this how you feel? I wonder why?"

Thus, the patient is encouraged to reveal what he is experiencing, thinking, or attempting to communicate in the situation and to identify cause and effect in his experiences. Focusing on expressed feelings and attempting to clarify them with the patient has considerable therapeutic value. This is so because clarifying expressed feelings helps to reduce anxiety, conveys understanding, and stimulates further self-exploration, which leads to self-understanding and learning.

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1 Peplau, Interpersonal Relations in Nursing, p. 294.
2 Saralund, Interpersonal Communication, p. 640.
3 Travelbee, Intervention in Psychiatric Nursing, p. 87.
Some patients have great difficulty in steering a conversation to the subject of their concern. They touch superficially and inadequately on many different subjects in a short span of time. As a result, no meaningful and constructive discussion of any can be realized. This may happen either because they are intellectually confused and emotionally tense to the point that they do not know in what direction to move, or because they want to avoid real self-expression.

The nurse uses some directness to produce reorientation in such a patient, and she suggests focusing on and elaborating one topic for a period of time. As soon as the nurse makes the suggestion, the patient can agree with or oppose it. In either case, he is stimulated to clarify an issue and he eventually learns how to cope with contradictions and confusion within himself by formulating a tentative plan of action.\(^1\)

The foregoing effort of the nurse implies that, once the patient focuses on one subject, she will not change it by introducing some other topic unless she notices that the subject arouses such anxiety in the patient that he becomes blocked and incapable of any constructive and useful communicative performance.\(^2\) In the nurse-patient dialogue, the nurse always attempts to avoid arousing anxiety, and acts to restrain its development. In this perspective she deliberately changes the topic of conversation and provides continuous reassurance to the patient to help him recover from the experience of anxiety. Flexibility is advisable in working with mental patients, so that the nurse can operate on the immediate cues from the patient and not be frustrated because the

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\(^1\)Ruesch, *Therapeutic Communication*, pp. 132-133.

initial objective was not met. Today is more important than yesterday or tomorrow.

The patient may ask about the nurse's personal life and affairs, for several reasons. He may want to avoid focusing on himself; he may try to test the nurse's capacity and preference for concentrating on his needs; or he may even attempt to meet her needs so that he can expect her help in return. The nurse does not have to answer personal questions. She can say: "This time is for you," or "You can use this time to talk about your experiences." She also may ask the patient what he needs this information for. Usually a simple question by the nurse, "Tell me, how did you spend your time last evening?" is enough to refocus the conversation. This nursing approach conveys sincere concern about the patient and elevates his self-esteem, because he is made to feel important enough to deserve using the nurse's time for himself.

During the patient's talking, the nurse pays special attention to and, preferably, reflects on interactional components of the subject. For example, she may express interest in knowing what was the patient's participation in a given group meeting and ask no question about how the hall was furnished or what food was offered at the meeting. Her purpose is to help the patient see himself as an active participant in life's situations, influencing and being influenced by the behavior of others, and to improve and gain a deeper understanding of his interpersonal patterns.

So far, it has been pinpointed that the nurse's talking with the patient is a responsible, purposeful action focusing on the patient with

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the aim of fostering in him healing, learning, and growth in interpersonal competence. The nurse pursues this goal by encouraging the patient to speak freely, by keeping feedback circuits, by assisting the patient to focus, to clarify his thinking and feelings, by incorporating the effects of their expression on the nurse, and by offering continual reassurance so that the patient's desire to communicate is strengthened and transferred to other life situations.

In concluding, it must be said that learning how to talk with the patient in a therapeutic nurse-patient dialogue is a very difficult thing. The guidelines highlighted here constitute only a broad orientation. They do not give standardized directions nor include rules and sets of words to be used in working with patients. Each nurse-patient dialogue is an original creation. "There has never been one exactly like it before and there will never be another one that is exactly the same." When the nurse is talking with a patient there are almost infinite possibilities of what might be said and of the emotional atmosphere which might exist. The variability and unpredictability of the interpersonal nurse-patient encounter make each nurse responsible for choosing and deciding what she must say or do in any given situation.

Nevertheless, the nurse should not fear that she is hurting the patient's self-esteem or causing him harm if, when speaking and as fitting the situation, she elects to say: "Whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever

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2. D. Cormack, "Clinical Teaching in a Psychiatric Hospital, I," Nursing Times, 60, 40 (October 5, 1972), 1261-1262.
things are pure, whatsoever things are lovely, whatsoever things are of good report. . . .

Group Therapeutic Approaches

Dimensions of Group Goals and Therapeutic Potential

Modern psychiatry tends more and more to utilize group psychotherapy, mainly because psychiatric symptomatology is increasingly conceived as having both its origins and its actual expression in disturbed multi-transactional processes among intrapsychic, interpersonal, intergroup, and social variables. Also, it has been found through clinical practice that mental functioning can be improved through the psychological effects of several persons upon another.

Group therapy is primarily a social and psychologic process, in which a number of persons get together at an appointed time and place for a definite period to influence beneficially their mental health and functioning by psychologic means. Group therapy undertakes the simultaneous treatment of many individuals in interaction within the group, and it has unlimited therapeutic possibilities in the treatment plan for

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1Philippians 4:8.


a wide variety of persons which makes it an economical way to reach a greater number of patients by fewer professional persons.

There are many different types of group therapy, labeled either according to any one of the group's properties, to the operational principles applied or to the theoretical framework in which the group is conducted. Representative examples are: family therapy, group psycho-drama therapy, existential therapy, and so on. In this section, group therapy will be discussed broadly as a nursing intervention with psychiatric patients, which may be adapted to other nursing settings as well.

Like the nurse-patient dialogue, the group nursing approach aims to benefit the patient. The central therapeutic goal is interpersonal learning. This encompasses many dimensions such as sharing information, instillation of hope, universality, altruism, imitative behavior, improvement of communication skills, forming meaningful interpersonal relations, group cohesiveness, and catharsis.¹

The curative factors that operate in group therapy primarily are mediated not by the nurse-leader but by the other members — the patients themselves — who provide the acceptance and support, the hope, the experience of universality, that is, the realization that one's problems are not unique,² the opportunities for altruistic behavior, and the interpersonal feedback, testing, and learning. Thus, the group is the therapeutic tool,³ the agent of optimum change.

³Mary T. Ramshorn, "The Group as a Therapeutic Tool," editorial comment, Perspectives in Psychiatric Care, 8 3 (1970), 104.
The psychotherapy group, after the initial phase of orientation, hopefully enters the working phase; that is, it "evolves into a social microcosm" in which increased interaction takes place among members. The group members, through consensual validation and self-observation, gain increased awareness of their interpersonal behavior: their assets, their weaknesses, and their maladaptive behavior which invites undesirable responses from others. The therapy group with its encouragement of accurate feedback may stimulate interest for correction, yet maintain a supportive and respectful attitude toward the person.

It is not the intellectual content of the interaction which helps the patient to gain awareness of objectionable aspects of his behavior, but it is the amount of affect associated with the interaction. Whatever it appears to be on the surface, the group situation "is charged with emotions which exert a powerful, and frequently unobserved, influence on the individual" and effect learning. As a result of this awareness, the patient may try new modes of behavior and expression. As the others find his behavior likable and express approval and acceptance of the patient, his social anxiety diminishes, his self-esteem strengthens, and he is likely to carry the behavior learned in the group into his environment outside the group.

As adaptive behavior becomes rewarding personally to the patient, he may continue interpersonal learning in a more or less autonomous way; that is, not needing direct dependence on the group therapy cues in order

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to understand his malfunctioning. This is a sign that professional therapy is no longer necessary and that it is time to undergo the termination phase of the group therapy experience.

The foregoing illustration was an example of optimum, interpersonal learning that may potentially result from the group therapy experience, not only for one or two individuals, but for most of the group members.

Establishing a Patient Group

In planning to initiate a patient group, decisions must be made regarding the following aspects:

1. Setting the goals of the group. Possible goals are: learning to cooperate, self-expression in socially acceptable ways, exercise in problem-solving, accomplishing a particular task such as formulating rules for hygienic ward living, and so forth.

2. The size and composition of the group. A group of ten to fifteen members may be optimal so that each individual may participate fully and the nurse is able to observe the emotional relations and reactions of all members. It is obvious that the selection criteria for membership depends upon the designed goals of the groups. There may be a nursing decision to establish a group of nonverbal psychotic patients with the purpose of assisting them to feel more comfortable in being with other people and engaging in cooperative activity, so that eventually they can speak in the group setting. Then the unifying factor

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determining the selection will be that all patients are nonverbal. Furthermore, social and recreational groups, with the ultimate purpose of enhancing interpersonal relatedness, will require analogous membership criteria.

In general, the group does not have to be homogeneous in terms of age and diagnosis if the goal is interpersonal learning. It has been found that the balancing of persons with diverse problems facilitates the development of therapeutic interchanges. It is advisable to exclude persons who would not benefit from the shared experience or who might exert a disruptive influence on others.

Other aspects which must be taken into consideration are the structure of meetings, the physical arrangements, and the preparation of patients for the group experience.

An effective plan for group experiences must be flexible enough to allow for change and spontaneity, to incorporate suggestions offered by the participants, to be practical and to provide for variety as well as rewarding experiences.

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1 Ruth W. Bell, "Activity as a Tool in Group Therapy," Perspectives in Psychiatric Care, 8, 2 (1970), 85.
3 Spotnitz, "Comparison of Different Types of Group Psychotherapy," p. 5.
4 Kalkman and Davis, New Dimensions in Mental Health-Psychiatric Nursing, pp. 588-592, 594.
5 Brown and Fowler, Psychodynamic Nursing, pp. 323-324.
The Task of the Group Leader

In the initial meeting of the group, the nurse-leader orients the members as to the purposes and goals of group therapy, offers general information, and answers questions. By this cognitive orientation, she aims at alleviating the patients' anxiety regarding role expectations and difficulties they might encounter.\(^1\)

The leader's task is to help the group develop into a cohesive unit with an atmosphere maximally conducive to the operation of the already mentioned curative factors. The leader is the group's primary unifying force. The cohesiveness is conceived as connectedness, mutual bond between the members;\(^2\) as a concern of each member for every other member in the group\(^3\) which facilitates the therapeutic mutual influence.

The leader functions as a catalytic agent, a resource of support, of information and of consensual validation. She does not govern but guides the conversation and facilitates interaction within the group. She consistently keeps a democratic and mostly non-directive attitude, allowing for friendliness, motivation, originality, and group-mindedness to emerge. She conveys acceptance and permissiveness and encourages participation, verbally and nonverbally, by acknowledging, rephrasing, respecting contributions, asking questions which do not threaten anyone.

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\(^1\) Roberta Cohen, "Cognitive Orientation for Patients in Group Psychotherapy," Perspectives in Psychiatric Care, 7, 2 (1969), 78.


but stimulate constructive movement of the discussion, as well as by accepting conflicts or disagreements in the group if expressed in socially acceptable ways.¹

Furthermore, the leader is sensitive to nonverbal communication going on within the group, to members who tend to withdraw from or to dominate the discussion. She keeps group members from hurting each other and intervenes deliberately only when other group members cannot handle the situation.² Although the leader guards against becoming preoccupied with one member's needs and neglecting the needs of the group, she pin-points behavioral problems of individual patients and works with them individually, between group sessions.

The nurse-leader, having in mind that task accomplishment fosters group maintenance, which is the continuity of satisfying interpersonal relations,³ provides for variety of group activities. Among other things, she may offer the group an operational goal to achieve, such as collectively drawing an image on the blackboard. This technique may open an impersonal communication line allowing for the channelling of tensions as well as complementing and enhancing interpersonal interactions.⁴

¹Mary G. Swanson, "A Check List for Group Leaders," Perspectives in Psychiatric Care, 7, 3 (1969), 123.
²Bell, "Activity as a Tool in Group Therapy," p. 91.
⁴Φ.Καζαμίας, "Αθηνά Κοκκουράκου και Γ.Βασιλέας. "Η Συναλλακτική Διά Συλλογικού Ειδώλου Ψυχοθεραπεία Όμαλος (Transactional Group Image Therapy) ΞΠ Προκεχωρημένης 'Ηλικίας Ασθενών." Νευρο-Ψυχιατρικά Χρονικά, 8, 1, Μάρτιος 1969, σσ.34-35
Developmental Phases of the Group

Numerous systematic observations have been conducted regarding processes and behaviors occurring in groups, and the yielded knowledge is subsumed under the term "group dynamics." This section will comment only on the development of relatedness in the group.

The group undergoes an initial phase called the orientation phase, in which members are reserved and guarded. A normal social routine is taking place. Discussions are typical and neutral. Furthermore, a dependency on the leader may be noticed for an assurance of belonging and inclusion in the group.

Eventually the group enters the working phases in which members risk talking about their personal problems. Power struggles and competition may rise among the members as they move toward individuation and satisfaction of personal needs, such as attraction of attention, domination, proving one's worth, and so forth. Hopefully, with the therapeutic though indirect intervention of the leader, the group progresses toward development of mutuality and affection. "Primary are concerns with equality and giving as distinguished from taking only."¹ The members reach the point of "reacting freely and openly to and with each other,"² of engaging collectively in problem-solving, and of looking critically at their modes of behavior and expression in interpersonal situations.

When the group members show progress in understanding their difficulties in relating to people and become involved in developing new, more

¹Fried, "Basic Concepts in Group Psychotherapy," p. 56.
effective ways of relatedness somehow autonomously from the supportive and motivating environment of the group therapy, they have entered the termination phase and the group therapy experience may end.
PERSONALIZED NURSING CARE OF THE MENTAL PATIENT

Purpose

To explore and illustrate the dimensions of the nursing care of the mental patient as a unique person with a personal expression of his illness. The nursing care will be discussed as an open, dynamic nursing process, based on a continuous nurse-patient interaction and committed to help the mental patient achieve his potential for self-direction and toward health. Furthermore, the importance of the therapeutic environment in the actualization of personalized nursing care will be emphasized.

Content Outline

Nursing Assessment of the Patient's Level of Health

Basic Guidelines

Areas of Information

Who is the patient?

What is the presenting problem?

Psychosocial development

Psychological functioning (contact with reality; emotional reactions; perception, judgment, insight; interpersonal relations; thought processes, and content)

General appearance and behavior

Medical health condition

Resources of strength in the patient and his family

Identification of the patient's problem

Planning personalized nursing care

Actualization of the personalized nursing care plan within a therapeutic environment

Evaluation of the effectiveness of nursing care
Chapter 5

PERSONALIZED NURSING CARE OF THE MENTAL PATIENT

Nursing Assessment of the Patient's Level of Health

Basic Guidelines

Personalized nursing care is the core and the essence of the whole interpersonal nursing process. Assessment of the patient is the starting-point of this process. It provides the basic information for planning the nursing care of the individual patient. It constitutes the content of the first nurse-patient meeting, but it will continue to be part of all subsequent nurse-patient encounters, throughout the period of the patient's care, as his condition will be changing and his care will need revision and adaptation.

The psychiatric nursing assessment represents the nurse's endeavor to meet, to know, to understand, and, subsequently, to care for the whole patient as a bio-psycho-social and spiritually unique being who perceives, thinks, feels, acts, and interacts within his physical and human environment. The psychiatric patient, similarly to every other person, has his personal, unique history. He presents current psychosomatic and social needs. He has his own memories, aspirations, and fears for the future. He has his familial and social ties. It follows, then, that the nurse who looks exclusively at the patient's psychiatric symptoms may pinpoint

1 Στεφανής, Μαθήματα Ψυχιατρικής Με Στοιχεία Ψυχολογίας Τεύχος Α', Έκδοσε Μέρος Εκδ. Β'.
them with a great deal of accuracy, but she will miss knowing the person
who suffers from them and pleads for help. And it is questionable whether
she will be able to intervene therapeutically even with the best and most
comprehensive theoretical preparation.

It is true that the showing area of malfunctioning is likely to be
the psychological. However, the causes, the precipitating factors, the
multiple variables transacting at the time of the onset of the illness,
and the consequences to the patient and to his environment, may touch on
other than the psychological parts of the patient, and need also to be
investigated in order for appropriate remediation to be designed. For
example, an epileptic psychosis may be a symptomatic manifestation of a
brain tumor or a brain wound, namely, a biological disturbance which, if
not detected early and treated, may have serious evolution. A patient
may be depressed because of real guilt feelings. Thus, the spiritual
dimension needs also to be stressed. A four-year-old child was considered
and treated as an autistic for almost two years, and only after he was
identified as being deaf was there a change in his medical treatment.

The basic nursing skills required for assessing the patient's health
needs and problems as well as his assets and strengths are: observa-
tional and interpersonal skills. Observation is an active, complex proc-
есс. It is a selective consideration of what is perceived through all
one's senses. It is an independent function of the nurse, the development
of which requires comprehensive knowledge of theoretical concepts from the
natural and social sciences related to the functioning of man as well as
knowledge of pathology. The nurse must know what she is looking for,

1 Παπαδημιου Σωτηρος. Τομες Παιδαφάρ., Τομες Α.Τεχνική,
Παιδατική. Τομες Α.Τεχνική, σ.616.
When to expect it, and what nursing steps to take when she finds it.

Skill in observation is not merely looking into pertinent areas and seeing things, but in relating observations, one to the other, and to what the patient is saying; in noticing the presence or the absence of certain conditions, and in discriminating critical factors from the normal and natural, thus detecting incipient problems.¹,²,³,⁴

Interpersonal skills complement and validate nursing observations. Listening, in particular, combined with open-end questions which encourage the patient to describe his distress, is the best way to get to know the patient as a unique person.

It must be stressed that, although assessment of the patient is the subject of discussion of the initial nurse-patient interviews, the ongoing interviewing process is a dynamic and unique interchange between the nurse and the patient, thus geared to decreasing the patient's anxiety and establishing rapport with him. This is the orientation phase during which the nurse and patient, strangers to each other, meet together in order to get acquainted and, hopefully, to proceed to work together for

⁶Διον.Λιάρος. Ψυχιατρική. (3η "Εκδοσις" Αθήναι,1974), σ.140.
the benefit of the patient. Therefore, the initial contacts have a deci-
sive influence on the development of the nurse-patient dialogue. Indeed,
this is the time for the therapeutic nurse-patient alliance to be founded.
The nurse uses the opportunity to convey interest, concern, and support
so that the patient does not feel he is an information source for exploi-
tation or a plate under the microscope for study, to the learning benefit
of others.

Another point needs to be made: the patient's initial assessment
may have been made either by the psychiatrist before or on admission, by
the public health nurse, or by the outpatient clinic nurse. Thus, infor-
mation about the diagnosis as well as the current problems of the patient
are available for the ward nurse to become oriented. In such a case, the
nurse uses the available information to orient herself and does not duplic-
ate data that are gathered by others.¹ She focuses her nursing assessment
on current needs and problems of the patient. Her data may complement,
cross-validate, or clarify the already identified strengths and weaknesses
of the patient.

The following section will outline the essential areas of inform-
ation which are of concern in the total assessment of the mental patient
and serve as a guide in planning his nursing care.

Areas of Information

Who is the patient? Important information is the identification
of the patient: name, sex, marital status, education, occupation, reli-
tion, and cultural origin. Not infrequently people from other countries,

¹Little and Carnevali, Nursing Care Planning, p. 29.
as visiting tourists, happen to seek health care in Greece because of emerging problems, therefore their religious and cultural backgrounds should be identified.

What is the presenting problem? Both subjective and objective information are useful in understanding the patient's difficulties. Important questions to be asked may be: When did the disturbing problem begin? What event or condition precipitated its occurrence or recurrence at this time? How does the problem influence the person's life and functioning as well as his environment?

It is advisable that the patient be seen privately as well as in the presence of his family, which may validate, complement, clarify, or deny information given by the patient. Furthermore, the patient-family interaction may provide clues as to how the patient's problem has affected or been precipitated by family life conditions.

However, the nurse must keep in mind that what the patient reports may not be what really happened. It is likely that he magnifies, minimizes, or modifies in many ways the condition he describes because of disturbed perception, defense mechanisms in operation, or lack of knowledge as to what is the important aspect to describe. Also, fear of the consequences of what he will reveal of himself or of the others' behavior toward him may influence what he says and what he avoids saying.

Similarly, family members or colleagues, whose information is necessary to cross-validate, test, and confirm what the patient reports,

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1 Παπαδημητρίου, Σύγχρονα Ψυχιατρικά. Τόμος Α Ψυχιατρικά, σσ.618-619.
2 Buss, Psychopathology, p. 15.
may not be able to clarify objectively the patient's condition because of excessive tolerance of the patient's psychopathology, of purposeful reservations, of personal and incorrect interpretations of events, or because the person who gives the information may also be mentally ill.

The foregoing points suggest that the nurse should continue her investigation and not rely exclusively on the verbal report of the patient and his family regarding the presenting problem.

**Psychosocial development.** The nurse becomes interested in knowing how the patient has grown up and whether he has had any psychotraumatic experiences during early childhood. What was the family atmosphere and constellation as well as his relation to his family while living within it, may shed some light on the current problem. What were the characteristics of his school life and academic performance, as well as his relations with other persons during the school period and following it within his in-group and out-group, constitute important areas to be investigated. The experience of serious illness, major surgery, any mutilation by accident or scheduled operation, hospitalization, or any separation from home, significant loss of loved ones, repeated failures, and the like, provide information about stresses and crises in the patient's life prior to the incidence of the present problem.

The foregoing information -- far from being comprehensive and encompassing all life areas -- provides representative material from the patient's personal history which may guide in identifying specific problem areas and probably the beginning of the current difficulty.

**Psychological functioning.** The present psychological functioning of the patient is of paramount importance for planning his care. It includes:
1. **Contact with reality.** This refers to the person's correct perception and evaluation of a situation, to his ability to adjust to daily experiences and relationships, and to his ability to differentiate between self and environment. Also, orientation to time, place, and person is indicative of the sense of reality. Disturbances in this area may be delusions, hallucinations, confusion about one's identity, and so forth.

2. **Emotional reactions.** These include the patient's mood, presence or absence of anxiety, agitation, withdrawal, depression, euphoria, etc. It is important to notice whether the patient's emotional reactions are appropriate to the things he is saying; for example, whether the patient is laughing while talking about sad things, and vice versa.

3. **Perception, judgment, insight.** These functions may be evaluated concurrently with other aspects of the patient's functioning. For example, when the patient is encouraged to talk about his present difficulties, the nurse may estimate his perception of his illness, whether he has any insight of being psychiatrically disturbed or he claims that he is not sick but his family thinks he is, or he is hallucinating. Also, his judgment is apparent in the reasons he gives for his disturbance or for his admission. These functions often are impaired in mental patients and more seriously in the schizophrenics.

4. **Interpersonal relations.** Evaluation of the patient's current relationships with his family and other close friends or relatives focuses on what is prevailing in his relating to others, i.e., affection, closeness, dependence, hostility, distance, or withdrawal. Also, it must be

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1Kalkman and Davis, *New Dimensions in Mental Health-Psychiatric Nursing*, p. 553.
explored how the patient perceives himself in comparison to others:
similar, superior, inferior, or unfit, and on what basis he rationalizes
his perception. Disturbance in interpersonal relations usually is the
major outer manifestation of mental illness.

5. Thought processes and content. The patient's ways of discuss­
ing topics may reveal whether his thinking is logical or rambling from
one idea to another without any coherent linkage. For example, the
depressed patient may be slow and hesitant in thinking while the manic
flits quickly from one topic to another and the schizophrenic's thinking
sometimes sounds, in his words, so disorganized and nonsensical that it
is characterized as "word salad." The patient may have delusions; i.e.,
he may feel that people persecute him, or he may have suicidal thoughts
and give clues in his talking.

General appearance and behavior. It has been discussed earlier
that attitudes, feelings, and thoughts are reflected in posture, gesture,
facial expression, vocal tone, mannerisms, and generally in the appear­
ance and behavior of the person. It is important to observe whether the
patient is neatly or carelessly dressed and groomed; whether he is rest­
less or immobile; whether he makes gestures and actions unsuitable to
what he is saying; whether he seems to be hearing hallucinating voices;
whether his facial expression reveals fear, anxiety, depression, or blank­
ness; whether his conversation is rapid or slow, timid or apologetic, or
incoherent. The body language of the mental patient says much more than

1Chapman and Almeida, The Interpersonal Basis of Psychiatric
Nursing, p. 62.

2Ρασιδάκης, Επιστήμη Ψυχιατρικής, p. 46.
his verbal description about his condition. That is why the nonverbal aspect of communication is important in the assessment of the mental patient.

Medical health condition. The evaluation of the physical condition of the mental patient in terms of medical symptomatology constitutes an integral part of his total assessment. It is helpful to look for any dysfunction in the following systems: sensory, circulatory, respiratory, gastrointestinal, genitourinary, and neuromuscular systems. This information is needed for tracing the tentative causes and precipitating or complicating factors of the patient's mental illness, including its psychosomatic manifestations, for planning the physical aspects of his total nursing care, and for watching for possible side effects of the psychotropic medications. For example, in a study conducted in the medical ward of the Dromokasikon Mental Hospital in Athens, under the medical director Leukaditis, it has been found that certain psychotropic drugs, such as largactil, influence unfavorably, namely, reactivate a pulmonary tuberculosis. On the other hand, the medical care of the TB mental patient becomes problematic because of the cooperation difficulties of the patient. Hence, the significant role of the nurse in early assessment of medical problems and respective planning of the care of that patient.

If the nurse is the first health professional who meets the mental patient, as in the case of the public health nurse, she should initiate

1 Burgess and Lazare, *Psychiatric Nursing in the Hospital and the Community*, p. 137.
his general medical examination. If such an examination has preceded the nurse-patient first contact, the nurse should become aware of the results of the laboratory tests and clinical check-up. Also, her data may pinpoint the need for specific medical checking.

Resources of strength in patient and his family. The symptoms of mental illness are considered by a number of authorities in the field as expressing not only the pathology but also the mental patient's tendency toward mental health, that is, toward adjustive success in his relationships with other people. This is based on the belief that there is a tendency toward health in every human being, including the mentally or physically ill. This tendency is likened to the tendency toward the intake of food and liquids in the hungry and thirsty. In the mental patient, this tendency toward reorganization and maintenance of the personality may become deeply buried under multiple layers of encrusted psychological defenses, or it may be hidden behind elaborate façades denying its existence. However, it exists in every person and may be released and expressed under proper conditions. This intrinsic potential is the greatest and most reliable strength in the mental patient upon which nursing care depends.

The nurse, while assessing the various aspects of the patient, notices other strengths as well. For example, if the psychosocial development of the patient took place within a stable family and did not have any serious psychotraumatic experiences, significant losses or failures in the achievement of any developmental tasks, then the personality of

1 Fromm-Reichmann, "Remarks on the Philosophy of Mental Disorder," p. 166.

2 Rogers, On Becoming a Person, p. 35.
the patient may resist the disorganization that mental illness often precipitates.

Furthermore, if the patient has insight into his own condition and understands that he is emotionally disturbed, if he is expressive and communicates his distress, and if he is motivated for his treatment, these are significant strengths which must be identified and utilized in his nursing care.

Another point which needs to be emphasized is that mental illness does not destroy the whole personality altogether and at once, but it affects greater or smaller parts of it. Certain areas remain relatively healthy, though fragmented and dispersed, like islets in the midst of the wild waves of the tempest of mental illness. These areas refer to some deeper elements of the personality which strongly resist the deteriorative inroads of the illness, but do not become easily disclosed to the periscope of observation, and especially not to the disinterested and detached observer. It takes loving, caring understanding and compassion to listen to the dramatic notes of the patient's heart and discover those strengths. They are: a genuine sensitivity to the right, the just, and the moral; a sense of trust and of responsibility; a sincere gratitude for the offered love and support. Mental patients are extremely sensitive to injustices done to them. They hate to be deceived and treated with inconsistency. They sense very quickly the real love and concern of others, and only then do they trust and cooperate in their own care. Very often mental patients are capable of taking responsibility; they have a special sense of altruism in helping their fellow patients, in watching over them, and in trying to

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1 Παπαδημητρίου, Σάγγανη, Φυσικά. Τόμος Ι, Γενικά Φυσικά, σ. 147.
keep them out of trouble; but only when they are convinced that they are treated as important and worthy persons. Moreover, their gratitude toward those who really care about them may be deep and lasting.\textsuperscript{1}

The foregoing illustrations support the notion that the greatness of the human heart in terms of the emotions may often be met and sensed within the wards of the mental hospital.\textsuperscript{2}

Another strength which may possibly be found in the mental patient is an artistic talent, because this presents the greatest endurance and resistance in comparison with other aspects of the personality, during the mental illness. In other words, the artistic talent is almost the last to be affected by the onset and the process of mental illness. This explains why the artist, though schizophrenic, can still produce healthy art. Furthermore, during the period of reorganization of the personality, artistic talent is the first to recover. This explains why the schizophrenic artist, still under the impact of his illness and before it recedes, can create frontier and completely healthy art.\textsuperscript{3} This constitutes a significant strength for the mental patient because it can serve as an expressive tool to communicate his distress and his need for help; it can give diagnostic clues as to the evolution or the recession of his illness; it can provide an arena for mastery and achievement to elevate therapeutically the patient's self-esteem; and it can become a means for earning his livelihood.

\textsuperscript{1} Παπαδημητρίου, Σύγχρονη Ψυχιατρική, Τόμος Α', Γενική Ψυχιατρική, σσ.149-151.


\textsuperscript{3} Παπαδημητρίου, Σύγχρονη Ψυχιατρική, Τόμος Β', Ειδική Ψυχιατρική: Μοσολογια-Θεραπευτική, σ.1698.
A classical example of the foregoing is the case of the Greek artist Yianouli Halepa (1851-1938) who, while schizophrenic, sculptured in marble, around 1880, the famous statue of the "Sleeping Woman" (Η Κοιμώμενη του Χαλέπα) established in the first cemetery of Athens.¹

Strengths should be assessed not only in the patient but also in the family and close environment. The Greek family potentially has certain significant strengths which may be utilized in the therapeutic care of the patient. These strengths are: the strong emotional ties among its members, the expressiveness which prevails in familial life, the fact that everyone's failure or success, illness or recovery, constitutes a familial common affair and all members rally in pursuing common goals; and, above all, the support provided by the in-group to the family when it fails in achieving its goals to its interest. These strengths do not negate the possibility of psychopathology running within the family, nor that there are not cases in which families abandon their patient within the mental hospital. In the first case, the in-group people may easily become mobilized and substitute the family in the care of the patient. The second case may happen when the family lacks knowledge about the nature of mental illness and has an excessive fear of the social stigma. These can be reversed and usually are when the nurse or the doctor take time to talk with the family members and explain to them that it is a matter of a health problem which can be alleviated with their cooperation. A characteristic example is the case of a mother who, furious with her daughter's behavior, brought her to the mental hospital for the purpose of disciplining her. When the doctor explained to the mother that her

¹ Παπα Δημητρίου, Χάγιναν Ψυχιατρικά, Τόμος Β', Ελληνικά Ψυχιατρικά Μορφολογία - Επιλογική, σ. 1681.
daughter was sick, she answered: "If I knew she was sick I wouldn't bring her here; I would care for her at home."

If the nurse shows genuine concern about the patient and the family, then she is considered as an in-group member and the family is ready to cooperate and do their best for the therapy of their patient.

Identification of the Patient's Problem

The nurse looks at the information collected and tries to validate it with the patient, if at all possible, especially that referring to her own observations, in order to secure its relative accuracy. She then proceeds to interpret the data at hand, making inferences or clinical judgments about their possible meaning and the relevancy of these meanings for nursing care. In other words, the nurse tries to identify what inabilities, inadequacies, stressful experiences, and inappropriate ways the patient presents in expressing and meeting his needs and in effective personal and interpersonal living within the context of health.¹

The extent to which the nurse may become able to develop valid inferences with regard to the patient's needs and problems is determined greatly by her theoretical preparation and her ability to apply theoretical concepts in making interpretations in nursing situations.² For example, she needs to know what the behavioral indicators of anxiety are and how they may be identified and discriminated from observable indicators of other feeling states. Further, she needs to reflect her

¹Bower, The Process of Planning Nursing Care, p. 12.
²King, Toward a Theory for Nursing, p. 16.
observations, descriptively stated, upon the theoretical base she possesses and be able to make a sound inference as well as to explain it in terms of whether or not the patient's behavior appears tentatively as an expression of anxiety.

After having arrived at tentative conclusions, the nurse tries to verify them with the patient by talking with him and by further observing him. An additional way of validation of the nurse's interpretations is to ask one of her nursing colleagues to observe the patient's behavior and then discuss each one's inferences related to and explained on the basis of theoretical concepts. The validated interpretations have a greater possibility to be correct than the non-validated.¹

Securing relevant information and interpreting it, validating both with the patient, other professionals, and factual data (i.e., laboratory tests, medical records), as well as relating them to theory, compose the assessment of the patient which in turn constitutes the basis for planning, actualizing, and evaluating his nursing care.

Planning Personalized Nursing Care

Designing nursing action implies decision-making as to the setting of nursing goals and choosing the ways and methods of their actualization, on the basis of the assessment of the patient.²

The variables which determine decision-making in the patient's care are:

¹Travelbee, Intervention in Psychiatric Nursing, p. 37.
1. The whole person of the patient and his personal expression of his illness.

2. The specific information obtained by and about the patient's needs, problems, and resources.

3. The education, skills, experience, imagination, and creativity, as well as commitment of the nurse to the patient's care.

4. The nurse's ability to secure appropriate and accurate data, to apply theory to observation, interpretation, and decision-making, and to utilize available resources in the patient's care.

5. The particular setting where the patient is to be cared for, i.e., home, hospital, outpatient clinic, or other.

Actualization of the Personalized Nursing Care Plan
within a Therapeutic Environment

The nursing care plan (see Figure 3) may be actualized in any setting: home, outpatient center, or hospital, with analogous modifications and adjustments. It is patient-centered, therefore the patient's cooperation is invited, welcomed, and supported, to whatever degree it is possible. This is, hopefully, the working phase in the nurse-patient relationship, during which the patient, having already developed realistic expectations from the nurse, feels free to talk out his problems and seek help in learning more effective ways of coping with everyday living. The patient's assets, such as insight in his health condition, contact with reality, communicative ability, motivation for therapy, artistic talents, and other positive resources whenever present, are utilized and fostered in his care.
Nursing Assessment of the Patient

Information base

Information obtained through communication, observation, and reviewing patient's records; validation of information

(Sadness)
(Crying)
(Feelings of worthlessness and hopelessness)
(Weight loss)
(Walking of interest in activities and interactions)
(Thoughts of suicide)

Identification of patient's problem

Tentative interpretation of validated information on the basis of theoretical concepts; validation of conclusions with a nursing colleague

(Depressive behavior)

Planning Nursing Care

Setting nursing goals

(Prevent suicide)
(Convey acceptance, caring, respect, and readiness to listen)
(Secure adequate nutrition)
(Encourage socialization and activity)
(Provide opportunities for learning)
(Problem-solving)
(Strengthen family communications)

Designing nursing actions

Establish a therapeutic dialogue with patient, in the context of which pursue the following:

Allot time to remain with patient;
Bear patient's sadness and crying and convey genuineness and reassurance;
Elevate patient's feelings of personal worth while helping him with self-care (if needed) and prevent him from committing suicide;
Intervene to prevent suicide according to guidelines suggested in a later section;
Encourage eating by providing company and allowing for personal eating patterns and preferences;
Plan patient's activities with him, if at all possible, related to daily living (i.e., meeting individual needs of hygiene);
Create a therapeutic milieu promoting positive living experiences and positive health changes;
Instruct patient's family in how to deal with depressed behavior, and foster patient-family communications; utilize patient's and family's resources in his care;
Continue to observe certain parameters related to depression (i.e., suicidal risk, psychosomatic manifestations, sleeping problems, weight loss).

Figure 3

Example of Nursing Care Plan
A point worth emphasizing is that the nurse carries out the nursing care of the patient through nursing and multidisciplinary team approaches, within and in accordance with the dimensions of the patient's medical treatment plan. Furthermore, the nurse encompasses the patient's family in the whole process of nursing care from the very beginning of the initial assessment. This nursing method not only amplifies the psychotherapeutic impact of nursing care upon the patient, but it also constitutes family nursing and, in extension, community nursing, through which education of the public in mental health matters, decrease of the social stigma attached to mental illness, and the prevention of mental illness, may be pursued. Also, this approach paves the way back home for the patient as soon as he enters the phase of rehabilitation and opens new perspectives for future possibilities to care for the mentally ill within their family and in-group circles.

The consideration of the patient's family and in-group people constitutes one important parameter of the therapeutic environment or therapeutic milieu as a therapeutic nursing method in caring for the psychiatric patient. In case of hospitalization, the therapeutic milieu takes into account all persons in the setting who have contact with the patient, namely, patients and staff in the given ward. The therapeutic milieu is a dynamic living environment which provides a place where the patient can express his feelings and wishes, and is helped toward realistic behavior alternatives. As a result, the patient may gain new insights about himself, as well as experiencing feelings of trust, security, support, comfort, and protection in accordance with his specific needs. It is obvious that not only the individual but also the patient group needs are taken
In the Greek cultural context, the nurse's unique contribution in establishing a therapeutic milieu consists in creating, sustaining, and fostering an in-group atmosphere in the ward. She can achieve it, mostly by conveying her personal genuine concern for every patient and his family and by supporting explicitly and implicitly any — however subtle — manifestation of concern on the part of one patient for another. Indeed, the therapeutic in-group milieu may amplify the therapeutic potential of nursing care, and this not only in a psychiatric but also in any nursing setting.

Evaluation of the Effectiveness of Nursing Care

Evaluation of the quality and effectiveness of nursing care is a part of the nurse's therapeutic function. It is an on-going process throughout the period of nursing care and it focuses on the achievement of the particular goals of the care.

The extent to which the nurse is able to achieve these goals by skillful, conscientious, and effective performance of all nursing tasks is the criterion used to evaluate the nursing care given. Of course, the answers to whether nursing decisions and actions are effective or ineffective may be found in the primary source of data, the patient. Thus, the progress of the patient in learning to cope more effectively

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with his illness and with life situations, or lack of them, any change, however subtle, in the patient's health status and in his ability to respond positively to his therapy, are looked at in evaluating nursing care.

The overall purpose of the evaluation of nursing care is that of initiating changes based on new information and on the degree of achievement of patient care goals. Changes in the nursing care plan may emerge not only from changes identified in the patient's condition or responses but also from changes in the perceptions or knowledge of the nurse.\(^1\)

The illustrated interpersonal nursing process is actualized through the development of a therapeutic nurse-patient dialogue which terminates when the patient has reached the state of recovery in which he can function effectively enough without the support of the relationship.

The patient should be informed early enough about the reasons for termination of the relationship. Furthermore, he should be allowed and invited to express his thoughts and feelings regarding termination. Sometimes at the prospect of discharge, the patient is afraid of going home and feels incompetent to face the life situation with its subsequent difficulties. In this case, the nurse assists the patient to make realistic plans to deal with the anticipated problem.\(^2\) If the patient was cared for by the public health nurse at his home, he also needs clear explanations as to why his relationship with the nurse is to be discontinued, and he must be supported in finding ways to cope effectively with problems he fears.

\(^1\) Little and Carnevali, *Nursing Care Planning*, pp. 161, 165.

\(^2\) Travelbee, *Intervention in Psychiatric Nursing*, pp. 163, 166.
All kinds of therapeutic nurse-patient dialogues are bound by certain limits; these limits are determined by the achievement of specific nursing goals and by situational factors. This notion, once understood by the nurse, helps in preparing herself emotionally as well as her patient for the termination of the relationship.

In summary, personalized nursing care consists of the nursing assessment of the patient, planning his care, actualization of the nursing care plan within a therapeutic environment, and evaluation of the effectiveness of the nursing care provided. The whole constitutes a dynamic interpersonal nursing process open to revision, modification, and adjustment according to the patient's changing condition. The therapeutic nurse-patient dialogue which lies at the core of the nursing process proceeds from the phases of orientation and cooperation to the phase of termination as determined mainly by the achievement of its specific nursing goals.
[Outline of Chapter 6]

THE PSYCHOSOMATIC APPROACH

Purpose

To illustrate the reciprocal reactions of body and mind within man in health and in sickness, in order to promote understanding of all illness as a psychosomatic disharmony. Selective concepts for interpretation of this approach, discussed in this chapter, are psychological stress, anxiety, and crisis, encountered in a variety of nursing settings. This chapter begins with a contemplation of the mystery of suffering, one part of which is illness.

Content Outline

The Mystery of Pain and Suffering

Man as a Psychosomatic Unity

Every Illness is a Psychosomatic Disharmony and a Crisis

Psychological Stress

Sources of stress

Reactions to stress—individual differences

Implications for nursing

Anxiety

The nature of anxiety

Causative factors of anxiety

Effects of anxiety on the person

Nursing intervention with the anxious patient
Chapter 6

THE PSYCHOSOMATIC APPROACH

The Mystery of Pain and Suffering

Confronted with pain and suffering, man raises questions about their meaning: What is the purpose of pain? Why suffering? Who is responsible for it? The why of suffering joins the why of existence.\(^1\),\(^2\) Hence the meaning of life itself stands in question.

Modern man has reached the moon and has conquered admirable scientific heights with his intellect. Yet, he cannot reason why there is suffering and he cannot approach it by the problem-solving method. This is so because suffering cannot be understood by logic and by human knowledge. It must be speculated in a wider perspective. Suffering is not a problem to be solved; it is, rather, a mystery calling for contemplation. Problems have solutions, mysteries do not.

Ancient Greeks considered suffering as a mode of punishment used by gods when angry with man. This conception is found nowhere in the New Testament. On the contrary, the prevailing teaching is that "God is love."\(^3\) In the context of Christian faith, pain and suffering are pedagogic means

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\(^3\) 1 John 4:8.

\(^4\) Hebrews 12:6.
through which God teaches, educates, and disciplines, "that we may share His holiness."

They become experiences fostering spiritual growth and fulfillment according to the saying, "tribulation brings about perseverance; and perseverance, proven character; and proven character, hope; and hope does not disappoint; because the love of God has been poured out within our hearts. ..."  

Christianity does not deny or suppress suffering and does not preach that suffering is easy to bear, but it reveals its meaning and inspirits man to endure and transcend it with God's grace. Not all men adopt the Christian faith and there are many adventurers who wander in anguish, looking for the meaning of pain and suffering in various directions. It is true, however, that very often the suffering soul approaches God, and for many people, the declaration of the Psalmist becomes theirs: "In the day of my trouble I sought the Lord."  

For the person who still ignores the deepest meaning of suffering, suffering remains a negative aspect of life with all bad and afflicting consequences. Through Christian faith, though, suffering potentially can be transformed into a positive experience and become an opportunity for spiritual reorientation, psychic enrichment, and reformation of the whole person.

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1 Hebrews 12:10.  
2 Romans 5:3-5.  
3 Επιστολή Καίσαρι μ. Μινέας Πατριάρχη, 53 C. "Κάμνουσα ψυχή Ιγγυς εστί Θεού..."  
4 Psalm 77:2.  
In the spiritual perspective, suffering is likened to a plow which digs up the earth hardened by easy and careless living; a pedagogical means which cultivates and beautifies the soul; a chisel which works out artistically the marble of the soul to make of it a masterpiece; a spade by which God, like a miner, searches for gold in man's inner depths; a pair of scissors which cuts through the cloth of egoism and selfishness enveloping man; a tenderizer rendering the soul sensitive and lenient, sympathetic, and responsive to the suffering of others.¹

Suffering may become a laboratory of love, a means toward strength, depth, and clarity of wisdom.² It provides an opportunity for heroism;³,⁴,⁵ it molds heroes of patience and self-transcendence. Indeed, in the white heat of suffering life gains shape and form, and its true meaning may be discovered.

There are innumerable forms of human suffering, one of which is illness. The nurse in her clinical practice deals every day with the suffering patient and is involved in his care. "Therefore, these aspects -- suffering and its transcendence -- for the nurse do not remain in a sphere of a remote philosophical investigation; they constitute aspects of everyday life which demand confrontation."⁶

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¹ Tihamor Teth, Ο Χριστός και τά Σύγχρονα Προβλήματα, (Αθήναι: 1959), σσ. 178-179, 185.
² Sister Marie Simone Roach, "Toward a Value Oriented Curriculum with Implications for Nursing Education," p. 87.
⁶ Lanara, op. cit., p. 120.
Illness as a salient painful human experience causing disharmony in the whole person and precipitating crucial questioning of its meaning will be discussed in a separate section within this chapter.

**Man as a Psychosomatic Unity**

Man has been created as a psychosomatic unity and as such has become the object of speculation by many disciplines.

For Aristotle, man is primarily an indivisible ("a-tomon, μονον") being, a living unity. Psyche and body are not even two different elements combined or united with each other but merely two aspects of the same reality.¹

In the perspective of the Christian Orthodox anthropology, man is conceived as a psychosomatic complete and not partial unity.² Neither the psyche itself nor the body alone can be called anthropos, but the unified whole of both.³ The body is the vessel and the residence of the soul;⁴

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² Ιωάννου Δαμάσκηνου. "Εκδοσίς 'Ακριβής τῆς Ορθοδόξου Πίστεως." Εκκλησία, 94, Κεφ. 11, 1983, Άλ. Ι: "Η δὲ ψυχὴ συνδέεται τῷ σώματι ὅλῃ ὅλω καὶ οὐ μέρος μέρει."
³ Γρηγορίου Παλαμᾶ, Διάλογος περὶ Ψυχῆς καὶ Σώματος. Εκκλησία, 150, 1361, C: "ὅτι ἐν ψυχῇ μόνη, μήτε σῶμα μόνον λέγεσθαι ἄνθρωπον, ἀλλὰ τὰ συναμφότερα, ἐν δὲ καὶ κατ᾽ εἰκόνα πεποιηκέναι Θεὸς λέγεται."
⁴ II Corinthians 4:7.
⁵ II Corinthians, 5:1. Σε μία Προσκοπία Παζαίου. Εκκλησία, 87, 1997, Άλ. Ι: "Ἡ σάρξ σινήτριαν ἐστὶ ψυχῆς."
it bears the image of God¹ and thus it becomes a member of Christ² and
the temple of the Holy Ghost.³ The body is the "coach" of the soul in
life;⁴ it is the instrument of praising and worshipping God.⁵ All parts
of man, namely, body and soul, as a whole can share sanctification: "And
the very God of peace sanctify you wholly; and I pray God your whole
spirit and soul and body be preserved blameless unto the coming of our
Lord Jesus Christ."⁶

There is a reciprocal influence and interdependence between psyche
and soma established by the Creator; psychic strength penetrates and
animates even the most remote and invisible bits of soma; the soma
sympathizes psychic states and the psyche suffers pains originating in
the body.⁷

The contemplation of man as a psychosomatic unity constitutes more
and more an eclectic approach used by the health professions. It begins

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¹ Κλημέντια, "Ομιλία ΙΑ' 4. ΟΕΠΕΓ 1, 148: "Εἰκών Θεοῦ ὁ ἄνθρωπος...Εἰκών θεοῦ τὸ ἀνθρώπου βαστάζει σῶμα."
² I Corinthians 6:15.
³ I Corinthian, 6: 19. See also: Κλημέντος 'Αλεξ. Παραγγέλματα. ΟΕΠΕΓ 8, 335: "Ο Χριστὸς "Δικρινείς καὶ
σώματα τῶν αὐτῶν θεραπόντων ὑπερβαλλόντως περιέπει καθάπερ ἱερὰ καὶ ναοὺς αὐτῶν."
⁴ I Thessalonians 5:23.
⁵ See also: Δημητρίου Β.Τοάμη. Η Πρωτοχοτά του Βασιλέου (Θεσσαλονίκη: Κέντρον Βυζαντινών 'Ερευνών, 1970). σ.139.
⁶ I Corinthians 6:20 and Romans 12:1.
⁷ I Thessalonians 5:23.
with Hippocrates, whose conception of man as psychosomatic unity has been formulated by Plato.¹

In Ancient Aesclepeia of Greece, all therapies applied in the care of the sick may be characterized as psychosomatic because they aimed at the concurrent restoration of psychic and physical health. Massage, baths, and drugs were always combined with recreational activities, listening to music, therapeutic dialogues, and suggestions for pursuing inner serenity.

Modern medicine manifests an increasing interest in the subject. Emphasis is put on man as a personal unity in which there is an absolute interdependence between psyche and soma.² Emotions are used as the best example to indicate the merging of man's somatic and psychic substance in a whole and as a unity.³,⁴,⁵,⁶

Emotions precipitate physiological changes and are expressed by physiological processes: sorrow by weeping, amusement by laughter, shame by blushing, and fear by palpitation of the heart.⁷ Usually the prevailing mood of the person (joy, anger, fear, despair) can be recognized from his facial expression.

¹ Plato, Charmides, 156 b c d e, The Collected Dialogues of Plato, pp. 102-103.
³ Μαρίνος ΓερουΚδνος. 'Η Ιατρική &τι& Πνευματικές Ετεχεροπήσεως. (Αθήναι:Έκδοσε Ι ε Δαμασκός 1956). σ.56.
⁴ Σπετσιέρης. 'Η Φυσική Ζωή του Άνθρωπου. σ.59.
⁶ Gillis, Human Behavior in Illness, p. 111.
This is the magnificent and the tragic in human nature, simultaneously: the modifications of his body resound in the modes of his activity either psychological, intellectual, or moral. In the same way, psychological dispositions resound on the state of his organs, on the beat of his heart, on the quality of assimilation of chemical cellular exchanges.  

Yet, it is not a matter of mere psychic influence upon the body as an independent agent, but it is a matter of one holistic psychosomatic expression in everything regarding life. The person is and responds as a unity, as a being in his whole composition of body and mind, of matter and spirit, of physiology and psychology.

In the health professions we encounter this excellent unity called anthropos. He is a psychosomatic living entity which cannot be understood only by the laws of physics and chemistry. He exists as a person with social ties, problems, and conflicts overriding the physical dimension, and as such demands a holistic confrontation.

Every Illness is a Psychosomatic Disharmony and a Crisis

Illness is not merely a functional disturbance or anatomical damage of an organ, but it is a disturbance of the functional interrelationships

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1 Biot, Au Service de la Personne Humaine, p. 51.

2 Γερουλάνος. "Η Ιατρική να δια Πνευματικής Επισκοπής.


4 Δαή. "Η Επίδρασις τοῦ Φυσικοῦ Παράγοντος εἰς τὸν 'Οργανισμὸν." σ.152.
among the various parts of the human being, a disharmony in the rhythm of all functions precipitated by the defective function of one organ per se. In any such disharmony, the psyche not only participates but precedes in setting the stage for the onset of illness. It is said that the psyche suffers long before the soma manifests morbid symptoms.¹

Low spirits, bad disposition, fear, pain, insomnia are often the predominant symptoms of an impending physical illness; the objective somatic manifestations may appear later.

Furthermore, unfavorable psychological states such as anxiety, inner conflicts between a sense of duty and the path followed, feelings of guilt for ethical transgressions or unfair practices and attitudes toward others, feelings of greediness, malice, hate, hostility, and the like, may lower the physiological resistance of the person and render him vulnerable to morbid agents and to illness.²,³

Besides the decrease of bodily defenses of a person affected by psychological factors, the latter very often constitute the salient determinant among the various causative factors in the development of a functional and even an organic disease.⁴,⁵,⁶ This is supported by the

¹ Γερουλάνος. 'Η Ιατρική ἀπὸ Πνευματικάς Επισκοπήσεως. σ.21.
² Δ.Ε.Χαροκόπους. "Πρὸς Νέους Ὄριζοντας." Εἰς: 'Η Ἀψώστρα καὶ Ἡ Φυσή Νο. 1 σ.111.
³ Γερουλάνος. 'Η Ιατρικὴ ἀπὸ Πνευματικάς Επισκοπήσεως. σ.25.
⁴ Alexander, Psychosomatic Medicine, p. 146.
⁵ Νείλου Λόγος πρὸς Εὔδογιον Ὀμογόνον μίας Πετρ. Τόμος 73, Κεφ. τ'1104,Α: "Λύπη, ψυχῆς νόσος καὶ σαρκῶς τυγχάνει." Τόμος 79, Κεφ. τ'1104,Α: "Λύπη, ψυχής νόσος καὶ σαρκώς τυγχάνει."
⁶ οὐδένου Χρυσοστόμου, Τὰ Εὐρυσκόμενα Πάντα. Ἐκπομπή πρὸς Ὀλυμπίαδα, μίας Πετρ. στρ. Τόμος 2, Ἐκπομπή Δ'87 ά χρ.: "Ποιεῖ μὲν γὰρ νόσον καὶ σαρκῶς ὀστᾶν ὑπὲρ καὶ φίλας πεπονηκότοι ἢ καὶ ἐξαιτωθεὶς, καὶ ἐν ἁμελείᾳ διακατέργει πολλή... ἔννοιον, ὅτι οὗ μικρὸ ἐνεπέθεν προσύνη γίνεται τοῦ δεινοῦ."
repeated observations that among persons exposed to the same morbid conditions, those who become ill usually have a personal history of psychotraumatic experiences and present conflicts along with psychic upset.¹

Moreover, unstable emotional states, prevailing depressive feelings, fears, doubts, and hopelessness, influence unfavorably the course, duration, and termination of the physical illness. Sometimes the responses to pain, tissue damage, or to the symbols of tissue damage, namely, to threats, are more destructive than are the effects of the damaging agent.² On the other hand, psychic vigor and strong will, inner harmony, and a climate of faith, hope, and love — these intangible, impalpable, and invisible forces — not only strengthen the biological resistance of the organism but also affect favorably the course and the outcome of illness.³,⁴,⁵ Hippocrates was teaching that "in every disease it is a good sign when the patient's intellect is sound . . . but the contrary is bad."⁶

In the foregoing context, a person's psychological development and functioning has a direct relation to his health and disease. His thoughts and emotions as well as his relations with other men may precipitate

¹Δαϊνος. *'Η Επιδράσεις τοῦ Ψυχικοῦ Παράγοντος είς τὸν Ὀργανισμόν." σ.145.

²Wolff, "Disease and the Patterns of Behavior," p. 55.

³Γερουλάνος. *‘Η Ιατρινή από Πνευματική Επισκοπή τοῦ Οργανισμού." σ.61.

⁴Menninger et al., The Vital Balance, pp. 393, 397.

⁵Tournier, The Healing of Persons, p. 11.

changes in his health, determine the cause, the time and setting of
disease onset, and the course, duration, and outcome of the illness.\textsuperscript{1,2,3}

It is important to speculate on the changes that physical illness
may precipitate in the psyche of the person.

All illness, regardless of the diagnosis it entails, constitutes
a threat to man in a number of different areas and in different ways. At
the first attack of illness, the initial reaction of the person usually
is fear: fear of the present and the future; fear of the unknown and the
unpredictable; fear of the deprivations and renunciations it probably will
require; fear of the revision of values and goals; fear of serious suffer­
ing, of incapacitating disability, of termination of the life experience.

Illness makes the person stop what he is doing, makes him withdraw
from his usual activities, and narrows his focus on himself. He has time
to think and to contemplate, to review and examine his life, to determine
what ought to take priority, where he aspires to go, and what life is all
about.\textsuperscript{4} The most crucial experience of the patient is that he is face to
face with his enemy, death, all the time, day and night, night and day,
internally wrestling with him, having long, imaginary conversations with

\begin{enumerate}
\item Engel, Psychological Development in Health and Disease, p. 240.
\item \textquote{\textit{Αχιλλέας Θ.Σαμοθράκης. }"Αδαμάντιος Κοραής 1748-1833."} "Ελληνική Ιατρική. 7, 7, Ιούλιος 1933, σ.698 ήπιοσμη.Επιμελής
Κοραής: "ιδο διηκοντα διά των σωμάτων πνεύματι και τά φυσικά
συνισονται τε και διοικείονται και τά νοσήματα πάντα τούτου
κρικοκαθόντος γίνεσθαι."}
\item National League for Nursing, Psychiatric Nursing Concepts and
Basic Nursing Education, p. 125.
\end{enumerate}
Every illness is like a pawn advanced by death; it raises the question of ultimate meaning and it makes of it the theme of a drama and a tragedy played out in secret, in the person's inner life.

Illness is a painful crisis. Each crisis involves a loss followed by pain, the intensity of which is determined by the meaning invested in the situation. Illness involves and implies, actually or symbolically, many losses: loss of freedom of decision and action because of specific limitations imposed by illness and the modes of treatment; loss of body parts in case of amputation or mutilating surgery; changes in and loss of roles; separation from loved persons in case of hospitalization or other type of confinement, and so on. Even though all this depends to a great extent on the seriousness of illness, the amount of suffering it produces, its duration, and its prognosis, nevertheless, the responses of the patient are determined by his personal and unique perception of his illness, and "could be understood only to the extent that one had

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2 Tournier, The Adventure of Living, p. 103.
4 Elizabeth M. Maloney, "The Subjective and Objective Definition of Crisis," Perspectives in Psychiatric Care, 9, 6 (1971), 267.
5 Δ.Ε.Χαροκόπος. "Νοσοκομειακή Περίθαλψη και Άνθρωπος Β'". Ακτίνες, Μάιος 1957, σ.214.
6 Field, Patients Are People, p. 58.
knowledge of what the illness meant to him at this point in time, both in real and symbolic terms.\(^1\)

It must be pointed out that illness of one member in the family may precipitate serious problems, such as changes in roles, placement of children outside the home, and even a family crisis.

Illness as a life-threatening experience demands interpretation and becomes the touchstone of ultimate concern. What has been discussed previously in the section about suffering is relevant also to illness considered as a form of suffering. It will only be remembered that illness is really a bad thing, characteristic consequence of man's fall.\(^2\) However, for the faithful it means a profitable discipline and an opportunity to contemplate, under the prism of eternity, God's concern about man's spiritual interest.\(^3,4\)

Illness potentially may yield all positive outcomes that suffering may yield, as discussed. Especially it may become an impressive lesson in philosophy for the patient as well as for the attending family and friends; an opportunity for testing the patient's faith and confidence in God and showing him as an example of perseverance calling for imitation;

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\(^2\) Μιχαήλ Σπ. Καρδαμάκης, Πρωτοπρεσβύτερος. 'Η Διαλεκτική μετάβαση Λαθείνσας και Διακήρυξ τη Μαυλεστώ Θεολογία. Διατριβή ἐπὶ Διδακτορία. (Θεσσαλονίκη 1968). σ.16.

\(^3\) Γρηγορίου Θεολόγου, Ἐπιστολή 31, Μίνης Πατρ.Γρ. 37, 68 Β; ἡ νόσος παιδαγωγία πρὸς τὰ συμφέρον.

\(^4\) Θεολόγου Σπουδίτου, Ἐπιστολή ΜΕ' Διαλεκτικής Πατρ.Γρ. 99, 1785, 1789 ι.: ἡ τὸ τῆς νόσου μοι λόρον εὖ, τέκνον, δέχον. Ἐπισκόπη γάρ ἐστὶ θείας φροντίδος.
an arena where family and friends may practice and prove their love, charity, and sacrifice in caring for the suffering patient. And not infrequently illness may resolve serious family problems and conflicts, repair marital disruptions, or prevent an impending family breakdown.

In such critical moments, when the mystery of pain and suffering, through illness, is unfolding in the patient's inner depths, and when internal stirring of forgotten and faded ultimate values and concerns takes place and may lead to a spiritual recreation, the nurse's personal presence at the patient's bedside is a unique privilege and a great responsibility.

It is a privilege because, attending and witnessing such mysteries and their outcomes expressed in the patient's behavior and life, even if this is his last life experience, is a moving, joyful, and satisfying experience, and it is the strongest validation of the deeper meaning of illness in man's life. On the other hand, it is a tremendous responsibility for the nurse, in terms of significance, to serve as a catalyst, supporting, reassuring, and accompanying — sometimes only in empathic silence — the suffering patient in his existential agony. It is not at all granted that the patient will surely discover the meaning of his illness, and this will be a positive revelation in his life and a source of inner strength to draw upon in later life crises. Illness may tax and deplete the patient's resources; it may bring about hopelessness, helplessness, drifting into despair, and withdrawal from life. Illness is a life test in which failure is as likely to occur as success. It is believed that the quality of the nurse-patient dialogue as a therapeutic nursing intervention can make the difference.
The nursing implications deriving from the consideration of all illness as a psychosomatic disharmony will be exemplified in the following section dealing with the concept of stress.

Psychological Stress

Psychological stress is: a state of the whole organism under extenuating circumstances; the internal or resisting force brought into action partially by external influences or loads; a condition interfering with goal-directed activity but not blocking it. It encompasses all processes, originating in the environment or within the person, which impose a demand upon the person requiring primarily psychological confrontation. Psychological stress is also considered as those conditions which interfere with behavioral homeostasis and cause some degree of behavior disorganization.

Anxiety, on the other hand, is a response to psychological stress; it is an unpleasant effect, an intrapsychic distress, which in turn demands handling on the part of the person in order to be dissipated. Stress

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2H. Wolff, Stress and Disease (Springfield, Ill.: Charles Thomas, Publisher, 1953), p. v.


4Engel, Psychological Development in Health and Disease, p. 264.


6S.M.H. Zaidi, "Reactions to Stress as a Function of the Level of Intelligence," Genetic Psychology Monographs, 62 (1960), 1-104.

7Engel, op. cit., p. 267.
differs from anxiety by exhibiting low susceptibility to embarrassment, being dissociated with internal conflicts and suspension, and being more specific to a limited situation, and probably more momentary. Nevertheless, there is an observed overlap of anxiety and stress, and this occurs in the physiological area, and in the person's awareness of pressure and tension. The concept of anxiety will be discussed in the next section.

Sources of stress. Sources of stress are those events in a person's life situation that threaten his sense of biological, psychological, or social integrity, produce some degree of disequilibrium, and the possibility of a crisis. Loss or threat of loss of objects (i.e., loss of a loved person, ideals, job, body parts, function, social roles, etc.), injury or threat of injury (i.e., the infliction of pain, mutilation, etc.), and frustration of needs (biological, psychological, or social) constitute potential sources of stress.

In the foregoing context, physical illness, especially when it is chronic and degenerative, can be a completely stressful condition in that it threatens or causes loss of physical integrity and hence becomes a psychological trauma. Furthermore, a major surgical operation constitutes


3 Engel, Psychological Development in Health and Disease, p. 265.

a stress situation, likened to other kinds of catastrophes in that the person is confronted with a tripartite imminent danger: the probability of suffering acute pain, of experiencing body mutilation, and of dying.  

Another stressful situation may be perceptual isolation such as deprivation of social and sensory stimuli, which sometimes is imposed upon hospitalized patients requiring isolation measures; if appropriate nursing intervention does not prevent it. The contrary also constitutes a highly stressful situation; that is, sensory overload, which is the case of treatment and monitoring regimens in intensive care units along with confinement to bed rest and dependence on hospital personnel and equipment in order to maintain vital life functions.  

It is worth noting that stress may originate in one's interpersonal encounters. A person's relationships with his family, colleagues, and social acquaintances may entail several elements acting as stress factors. 

To recapitulate, one could say that stressful conditions may result from environmental, interpersonal, and intrapersonal pressures.

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Reactions to stress—individual differences. With the exception of extreme and sudden life-threatening situations, it is observed that no stimulus is a stressor to all individuals exposed to it. Great individual differences in response to stress have been recognized. Whether or not a particular situation or process constitutes a psychological stress for a particular individual cannot be determined from the nature of the external event alone, but it requires knowledge of the response as well.¹ In general, the induction of stress depends on the mediation of some appraising, perceiving, or interpreting mechanism working within the individual.

Different individuals respond to the same conditions in different ways. Some fall immediately into a stress state, others exhibit increased alertness and improved performance, and still others are not influenced at all by the stress-producing environmental circumstances. Also, the emotional expression, namely, the consequent emotional behavior in response to stress, varies from person to person. Some persons are cautious and unexpressive in the face of psychological stress, others are impetuous and express their feelings easily; some tend to be aggressive, others dependent; some attack the challenge, others withdraw from it.²

It has been observed that the effects of increasing amounts of stress on an individual's behavior is curvilinear.³ To a certain point, increasing the level of stress improves behavior; the person finds it challenging. Beyond that point increased stress produces disorganization and disruption of behavior.

¹Engel, Psychological Development in Health and Disease, p. 264.
Some of the factors, which are likely to influence the person's ability to tolerate and master stress include: his past experiences and his present character structure and their relation to the demands of the present stressful situation; his capacity to master strong and disturbing psychological tensions; the extent to which he knows all aspects of the situation, that is, he is aware of the nature and source of threat; his resources in terms of skills and other means of handling it effectively and the strength of his motivation to do so.¹

What seems to decrease the person's psychological integrative capacity for overcoming a stressful condition and may precipitate a breakdown are: poor physical health or lowered biological resistance of a person by insomnia, exhaustion, pain, malnutrition, infection, sepsis, and intoxication. Usual reactions to stress are: anger and aggression, direct or indirect, or fear and depression.² Still other reactions may be: impaired ability to concentrate and to learn, varying degrees of anxiety, compensatory fantasies, regressive behavior, illusions and hallucinations.³ Various combinations of these reactions may also be manifested in facing the stress of physical illness.

The issue is: what kind of help does a person need to increase his resistance to stress, to maintain an eagerness to conquer life at any cost of experiencing stress and not merely to stand it, to develop a personal

philosophy which will guide him to transcend stress and not only remain unaffected by it but also to gain a deeper feeling and understanding of life? Relevant highlights are included in the next section.

Implications for nursing. The foregoing illustration of the concept of psychological stress leads to crucial implications for nursing. Nursing helps people in stress and stressful crisis. Nursing as a loving art and as a science constitutes an intervention in people's critical circumstances, when health is damaged or endangered and life is thus threatened.

Psychological stress -- either denied or witnessed -- is almost the internal climate and the behavioral denominator of the sick. Illness, whether physical or mental, of short duration or chronic, disabling apparently or symbolically, produces many stress-inducing threats to the person. It threatens, as we have already seen, psychological and physical integrity, family and social life, academic and professional status. And the effect of illness on lowering the resistance and on increasing sensitivity to stress must also be taken into consideration.

The nurse needs to know that there is a wide range of individual differences in terms of tolerance of stress and of reactions to stress. Psychological reactions many times are not obvious in behavioral expressions; they may be disguised in psychosomatic symptoms. Decreased flow of talking and of interpersonal interaction can be a sign of experiencing stress as truly as it can be in over-talking and exhibiting over-optimistic views and carelessness. What determines a person's perception of a situation as stressful and his psychological reactions to it, depends on his personality, on his philosophical orientation, on his constitutional predispositions, on his social and cultural background, on his previous
experiences, intelligence level, knowledge, learned behaviors, and training.\(^1\) The implication derived from this understanding is that the nurse cannot expect two patients to be alike, nor can she observe for a predetermined cliché of stress-expressing behaviors, but she must watch with an open mind for any change in the usual behavior of each of her patients, whom she tries to know personally.

In nursing, it is very important to know that severe psychological upset may cause greater sensitivity to pain and delay the patient's recovery from a somatic disease. As a consequence, high-quality nursing cannot be achieved unless the nurse assumes her psychotherapeutic role inherent in her profession, and becomes involved in helping patients undergoing the crisis of illness. Self-expression often acts as a sort of safety valve to ward off internal tensions and anxieties. Listening with understanding and genuine concern to the patient along with non-judgmental acceptance of him, as has been stressed previously, encourages self-expression and allows the patient to be comfortably himself.

Psychological preparation of the patient for an impending stressful situation, such as radical surgery, is another thing which must always be considered on the basis of the individual patient. Providing relevant information to the patient before his exposure to the stress stimuli, the nurse helps him to develop concepts and anticipations concerning the limited duration of pain, the protective features of the environment, and the compensatory gains to be derived as recompense for undergoing suffering. This gives the patient a sense of knowledge about and control over the stress situation.

The nurse, through creating a supporting and reassuring environment so as to minimize stressfulness and maximize stress resistance, is more likely to protect the patient from repressing anxiety, from disorganization, and from the sensitization effect of stress. Also, she can help the patient in maintaining good reality-testing and in making realistic plans for the future, within the frame of his limitations.

Crisis intervention is a particularly meaningful mode of nursing intervention for the nurse who has constant and intimate contact with individuals in stressful situations, threatening them in many ways. She is in a strategic position to recognize early the psychological impending crisis of stress in the patient. Thus, she can take advantage of the heightened openness to environmental influence produced by the crisis disequilibrium which measures to the same degree as vulnerability can be produced. Then, she can transmit an expectation that the patient can or will be able to cope with, adjust to, and effectively approach this stressful health problem. In the meantime, the nurse can contribute to the realistic perception of the event by the patient, to the mobilization of his inner strength and energy to cope constructively with stress, so that equilibrium can be regained and valuable learning can take place.

Helping a patient to face directly the experience of stress and do something toward overcoming it brings another important benefit. It prevents him from regressing — reaction to stress verified by research experiments, already mentioned — which, when identified, guides the nurse to diagnose stress or warns her that the coping with stress mechanisms of the patient have failed and she must re-evaluate the nursing intervention plan for this individual patient.

Teaching health measures or therapeutic exercises is a component of professional nursing. The nurse needs to profit from the findings of experimental psychology which point out that psychological stress interferes with learning. Thus, a patient can really learn when he is relatively free from stress. The nurse must first identify the level of stress in her patient, try to lower it if it is high, and then proceed to teach him.

When the patient enters the convalescent stage and a rehabilitation program is set for him in order to regain lost skills or learn new ones to cope successfully again with life, he usually experiences a great deal of stress. Many times the rehabilitation program begins at such a point of the patient's incapacity and disability that hope is not easy to be built up, motivation is difficult to be generated, and life cannot be seen as a challenge. And now to live again is painful and costly to a patient with, perhaps, one or more of his limbs paralyzed, or with some other disability. The rehabilitation program resembles a long trip, the terminal of which cannot be determined from the beginning. It is uncertain how much strength and skill can be regained, and yet the patient has to begin exercising, even if there is much evidence that it is not worth while. Attending and understanding this tragedy taking place in the inner depths of her patient, the nurse needs to keep in mind that the quality of a person's performance is negatively influenced by failure-stress experiences; and stress has a curvilinear relation with learning.

Mild degrees of stress appear to be associated with enhanced performance, but high degree of stress hinders successful performance and

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learning. A patient can move through his rehabilitation program successfully, he can learn how to do successful exercises for a paralyzed limb only if his motivation and morale are kept high; if failure is to be prevented, it must be by progressively estimating his ability and accordingly assigning more complex exercises; successful exercising must be praised; and reassurance must be provided throughout the entire rehabilitation process.

When a patient must be isolated because of communicable disease, an intensive care program, or when disease itself, such as blindness or deafness, isolates the patient from perceptual and sensory stimuli, the nurse must keep in mind that perceptual and sensory deprivation, as well as social isolation, is a stress-inducing situation and may be detrimental to the patient by producing unhappiness, disorientation, and mental symptoms. Therefore, the provision of adequate stimuli must be included in the isolation measures because it is as important as are food and oxygen to maintain life.

Nursing is an interpersonal process. Thus, the nurse's style of relating to patients has a significant influence on the patient's personality. If the nurse can transmit an empathic understanding and an unconditional positive attitude to the patient during his psychological crisis of stress, we may believe that the current, positively-faced, stressful experience will serve as an amplifier of the patient's personality traits, and the value of his transcendence of stress in the present situation will be a transfer of learning for constructive coping with stress in the future.

In this perspective, with the knowledge and understanding of the effects of stress upon human personality and of the psychological reactions to stressful conditions, one of which is illness, the nurse, regardless of
her particular field of work, can become a positive contributor to safeguarding and promoting the mental health of the members of contemporary society.

**Anxiety**

The nature of anxiety. The concept of anxiety has been variously defined and illustrated. Because of its relation to man's health and his interpersonal functioning, the nurse needs to have a thorough understanding of what anxiety is, how it is evoked, what are its effects upon the person, and what the implications are for nursing intervention.

Anxiety is a diffuse apprehension, differing from fear in its vagueness and lack of objectivity; it is associated with feelings of uncertainty, helplessness, and is a threat to the core of the personality.¹

Anxiety is an unstable and variable combination of interacting fundamental emotions (fear, shame, guilt) evoked by situations interpreted as personally threatening.² It is an emotion based on the appraisal of threat, an appraisal which encompasses symbolic, anticipatory, and other uncertain elements.³ "Anxiety is a signal of danger to self-respect, to one's standing in the eyes of the significant persons present even if they are only ideal figures from childhood..." ⁴

Anxiety is an unpleasant and painful emotional experience of inner distress, a way of response to stressful, traumatic, threatening conditions, connoting an inability to cope. Anxiety looms large in the development as well as in the manifestation of mental disorders.

Causative factors of anxiety. Anxiety, though variously defined and illustrated, is almost always connected with the notion of threat — objective or subjective, realistic, symbolic, or imagined — to the person's sense of well-being. Threats may fall into the following major categories:

1. Threats to the organismic integrity, the maintenance of which is sought by adaptive operations described as dynamic homeostasis, vital balance, and the general adaptation syndrome. Although organic, these threats may induce fear of being hurt by physical pain and fear of a bad diagnosis.

1 X. Ισραηλίκου, Ν. Κοκαντζής και Α. Ρούτσον. "Συμπεράσματα έκ της Ψυχοδυναμικής Αξιολογήσεως Αγχών Νευρώσεων." Ελληνική Ιατρική. Α/36, 6, Ιουνίου 1967, σ. 641.

2 Λιάρος. Ψυχιατρική. σ. 174.


2. Threats to the personality include any lowering of self-esteem, feelings of guilt, inner and interpersonal conflicts, risk of failure, threat to values which the individual considers essential to his existence, i.e., loss of freedom, loss of psychological and spiritual meaning, death.

Effects of anxiety on the person. Anxiety precipitates certain somatic, psychological, and behavioral processes:

1. Somatic changes. As a signal of danger, anxiety is accompanied by a number of interrelated somatic processes which represent activities preparatory to emergency action. These are: massive endocrine reaction activating the autonomous nervous system; increases in heart rate, systolic blood pressure and cardiac output; in respiration rate, muscle tension, palmar conductance, activity of the central nervous system and in the blood-sugar level. Accompanying these changes are decreases in the peripheral resistance, diastolic blood pressure, hand temperature,

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1 Sullivan, The Psychiatric Interview, p. 102.
3 K. Κωνσταντινίδης, "Περί Φόβου, 'Αγωνίας και 'Αγχους," Ρ'Συνέοριον Ελλήνων Νευρολόγων - Φονιάτρων, σ.39.
6 May, The Meaning of Anxiety, p. 191.
and salivary output.1,2,3,4

The foregoing highlighted physiological adaptive processes expressing the person's experience of anxiety constitute a vivid proof of the nature of man as a psychosomatic unity.

2. Psychological and behavioral effects. In the anxiety state the sufferer undergoes a dreadful and foreboding experience of an impending catastrophe; an experience mainly considered as that of lowering self-esteem accompanied by feelings of acute, diffuse discomfort involving interpersonal situations.5

Anxiety may be experienced in four progressive phases: inertia, apprehension, free anxiety, and panic.6 Respectively, the effects on the person become more and more debilitating, disruptive, and destructive. At any point of the above mentioned phases, appropriate confrontation may contribute to alleviation, reduction, dissipation, or constructive use of anxiety. The effects of anxiety will be discussed here in a general way without being classified under the named phases.

To allay or avoid anxiety, certain psychological activities are called for. These activities required for the reduction or relief of anxiety are called "security operations" because they are "addressed to

3Φιλιππόπουλος, Ανυπνίκι Φυσικτρική, σσ.177-178.
4Ρασιάκος, Σεαίνεια Φυσικτρική, σ.93.
maintaining a feeling of safety in the esteem reflected to one from the other person concerned.\(^1\)

Security operations work by a demarcation of awareness and limitation of activity, which complicates the interpersonal situation, restricts sensitivity to experience, develops resistance to change, and thus curtails the freedom of the person toward continuing growth and effective living. In other words, the essential element in the endeavor to avoid anxiety is some sacrifice of possibility for self-development and for interrelation with other persons.\(^2\)

Security operations usually are named after the mode of communication employed. They include selective inattention and psychosomatic phenomena.\(^3\) Selective inattention means that the person overlooks what aroused his anxiety and shifts to other non-threatening, impersonal topics or to safer activities, encompassing usually the element of regression. This instrumentality complicates the interpersonal situation, excludes new learning, and stunts the person's capacity to adapt to new situations.

Physical symptoms and psychosomatic forms of illness constitute another psychological operation for coping with the anxiety-creating situation.\(^4\) The psychological conflict is converted into a somatic problem with which there is a greater probability of coping. The tension of anxiety is alleviated, but at the price of limiting experience and censoring growth. The problem is not resolved.

\(^1\) Sullivan, The Interpersonal Theory of Psychiatry, p. 373.
\(^2\) May, The Meaning of Anxiety, p. 226.
\(^3\) Pearce and Newton, The Conditions of Human Growth, p. 400.
The avoidance of anxiety is sought by many kinds of behavior which may appear relatively normal in moderate use, but become "neurotic" in compulsive form. For example, frantic activity of any sort, like compulsive work, repetitive hand-washing, and so forth, may serve to channel the tension caused by anxiety, but without resolving the underlying conflict. The assumption that the conflict remains may be validated by the fact that rigidity of thinking and behavior insist and tend to take the form of compulsive neurosis.

Anxiety is considered as the psychic common denominator of all disease as well as of all behavior disturbances. It is the prime causative factor in neurotic patterns. Indeed, anxiety impoverishes the person. It inhibits in greater or lesser degree the productive activities of the individual on several fronts; it disrupts consciousness; it restricts thinking and feeling capacities; it handicaps and complicates the learning process; and it curtails the capacity to choose among alternatives, to take risks in pursuing new paths, to creatively plan and act.

In situations of extreme anxiety, where the person cannot cope with the threat by operations such as those mentioned above, and where his capacity to evaluate stimuli realistically or to distinguish between subject and object is impaired, he is forced to renounce a large area of activity and of reality and yield to psychosis.

1Fischer, Theories of Anxiety, p. 71.
3Pearce and Newton, The Conditions of Human Growth, p. 34.
It is possible, however, and not infrequently achieved, for the person to confront the anxiety-creating situation directly, admit his fears and tensions and move — despite the anxiety — toward higher levels of self-organization, well-being, and growth. It is important to speculate on the nurse's role in facilitating the constructive use of anxiety and in preventing negative confrontation.

Nursing intervention with the anxious patient. Knowing the nature of anxiety, how it is likely to develop and experienced, and what its effects are on the person's health and behavior, the nurse can assess its presence in her patient. Of course, each person experiences and expresses anxiety in unique individual ways and only by knowing him as a person is assessment and understanding of his experience and communication of anxiety possible.

Anxiety indicates the existence of a problem most frequently arising in the context of interpersonal relations — actual, referential, or imagined — including the nurse-patient relationship, which needs to be solved. As a consequence, the nursing intervention in this case consists selectively in the use of interpersonal skills geared to help relieve or reduce anxiety to manageable levels, and neutralize or cope with its damaging effects. Of course, there are sedative drugs and tranquilizers which can decrease technically the person's anxiety. Nevertheless, by heavily medicating the anxious person, one can only reduce the problem to a dormant state while suspending its pathological resolution.

The more serious consequence is that the patient resolves nothing, learns nothing, and gains nothing.¹

One major difficulty the nurse may encounter in intervening with the anxious person is that a peculiar distance, an impasse, is felt in the endeavor to share the patient's situation and develop a sense of "we" in such a situation.² This is so because the situation of the anxious patient, that with which he is distressingly concerned, is invisible to the nurse. As a consequence, the anxious patient and the nurse do not share a here and now, a common domain of concern, and they cannot be fully present to each other. All that is given to the nurse is the patient's behavioral manifestations, i.e., his uncomfortable facial expressions, the shaking and sweating of his hands, the hesitating and rigid quality of his movements, the urgency of his speech, and so on. Unless a nurse-patient dialogue develops which assists the patient to reveal his situation to the nurse, he remains a distant being involved in an invisible world.

The nurse, by developing a meaningful dialogue with the anxious patient, helps him particularly along the following dimensions:

1. She encourages recognition of the experience of anxiety and acceptance of it as a challenge to clarify the underlying problem.

2. She fosters expansion of awareness by helping the patient to see the relation between his feelings and his anxiety-relieving or avoiding behavior, and concentrate more upon the circumstances which — in the past and currently — produce anxious behavior in him and upon his patterns

²Fischer, Theories of Anxiety, p. 134.
of relieving anxiety. It should be emphasized, however, that intellectual insight alone cannot establish good rapport, but it must be accompanied by an emotional experience as well, to enable the nurse to make the cognitive appraisal therapeutic.

3. The nurse creates a therapeutic interpersonal climate by which she prevents or catalyzes stressful environmental factors; she sees that no serious demands are imposed upon the anxious patient, since his perception, adjustment, and communicative skills are handicapped; she makes certain that the patient gets adequate rest and sleep; she plans the progressive introduction of the patient to group activities and contacts with others constructive enough to counteract painful interpersonal experiences in his past; and if the underlying conflict is identified as real guilt feelings, the nurse facilitates ventilation of and liberation from guilt through confession, by conveying her availability and readiness to make the appropriate arrangements if the Greek patient expresses an interest in this direction.

4. The nurse deliberately avoids inducing anxiety in the patient, either by her behavior or while talking with him, and she always seeks to facilitate alleviation, reduction, and constructive handling of anxiety whenever it is aroused in the patient, by means already discussed.

5. When caring for an anxious patient who has already developed any sort of psychosomatic illness (i.e., peptic ulcer, colitis, asthma, or skin disturbances, etc.), communicating his anxiety symbolically, though unconsciously, the nurse acts according to the following principles:

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1Peplau, "Interpersonal Techniques," pp. 53-56.
a. The somatic symptoms, i.e., pain, vomiting, or other, are real and distressing, sometimes endangering the patient's life. The patient will continue to experience them as long as he needs them in order to handle — though imperfectly — his anxiety and as long as the underlying problem is not resolved.

b. Concern and action to alleviate the physical symptoms of the patient are effective ways to establish rapport with him and engage him in helping to handle his anxiety constructively.

c. Acceptance and respect of the patient as well as conveying a non-judgmental attitude toward this particular form of his maladjustment — the psychosomatic illness — elevates the patient's self-esteem and motivates him to venture self-examination and confrontation of his problem.

The above mentioned nursing intervention provides the patient with adequate support and reassurance in admitting and clarifying his anxiety, and hence expand his awareness and achieve mental health. Further, this approach helps the patient to respond to the experienced threats to his existence affirmatively and move through his anxiety, despite his apprehensions, toward positive goals.

In conclusion, it must be pointed out that the achievement of positive handling of anxiety is likely to be actualized only when the person can be convinced that the values to be attained in moving ahead are greater than those to be attained by escape.¹ The nursing experience accumulated over the years confirms that negative affective states such as fear and anxiety, especially in patients whose life is at stake,

¹May, The Meaning of Anxiety, p. 229.
can be transcended by more powerful constructive efforts and that the ultimate effect for the faithful encompasses love of God and confidence in His loving care and providence. In such a case, the affirmation of the Psalmist is repeated: "The Lord is my light and my salvation; whom shall I fear? The Lord is the strength of my life; of whom shall I be afraid?" \(^1\)

\(^1\)Psalm 27:1.
Purpose

To study behavior as a personal expression in health and in disease, with special emphasis on the range of pathological behaviors in mental illness and on the nursing care of mental patients with particular behavior problems. This chapter will also include a discussion of selective behavior problems exhibited by physically ill elderly patients.

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Chapter 7

BEHAVIOR: PERSONAL EXPRESSION IN HEALTH AND DISEASE

Behavioral Theories

Behavior is an expression of the whole person. It encompasses not only those activities and processes that can be observed objectively, but also internal processes such as thinking, emotional reactions, and the like. Behavior is never a single-variable phenomenon, nor a single two-variable interaction. Usually it includes the simultaneous occurrence of multiple behavioral units with multiple attributes. Moreover, it is determined by a complex of factors such as biological, psychological, sociological, and anthropological. No behavioral unit can be understood apart from its encompassing units and its arrangement in time, and, most importantly, without knowing the whole person who expresses it. There are several theories which propose different frames of reference for the study and understanding of behavior.

Behaviorism emphasizes stimulus-response relationships and learning in accounting for the development of behavior and its present manifestations. This approach requires that "all concepts and propositions be anchored precisely to measurable properties in the empirical world."


2Ruch, Psychology and Life, p. 11.

3Millon, Theories of Psychopathology, p. 323.
other words, emphasis is placed on the use of objectively observable behavior or reactions which can be inferred from directly observed external cues. Further, all environmental influences upon behavior likewise are to be defined objectively. This theory, with its emphasis on observable responses rather than internal promptings, can be considered too mechanistic and hardly regarding the individual uniqueness of man and his self-initiating characteristics.

The organismic theory takes the position that "principles of organization, interaction, homeostasis, heterostasis, steady-state maintenance, adaptation, modification, and regulation may be applied to the psychology functions or aspects of the human being in the human situation." In this frame, all behavior represents the endeavor of an organism to maintain the vital balance, that is, constant internal and external environment by promptly correcting all upsetting eventualities. Of course, the adjustment suggested by this theory is a continuing, never-completed process which involves a complex relationship between the individual's needs, the opportunities presented by his environment and his personal competence in using the resources available to him. Nevertheless, this conceptualization of man's behavior does not sound sufficient as a basis for explaining future-oriented, complexly organized behavior, which seems to precipitate rather than reduce high levels of tension. A question might be raised here: Aren't there values far more important than the avoidance of discomfort, pain, illness, and occasionally even individual survival, which are pursued by man knowing the price they will cost him?

The consciousness or unconsciousness of the motivation of behavior has also been studied. The theory of unconscious motivation "illustrates

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1Menninger, The Vital Balance, p. 128.
the main point that suppressed motives find indirect, symbolic, or disguised expression."\(^1\) Thus, the resulting behavior is considered as a mechanism of defense used by individuals to reduce their anxiety.\(^2\)

On the other hand, the cognitive theory of motivation studies behavior on the basis of preferential choice or of decision-making.\(^3\) From the standpoint of the behaving individual, behavior is not random. Every action stems from causes that can be discovered and is goal-directive whether or not the goal is consciously recognized.\(^4\)

It cannot be denied that the degree of consciousness of the motivation of behavior is only one dimension which has to be looked upon, especially in the realm of psychopathology. However, man's behavior can be understood only by reference to his psychological make-up as a whole and to his personal ways of expression and reaction.

Behavior is speculated by the "field theory" as a function of the field at the time it occurs. According to this view, "the effect of the past on behavior can only be an indirect one; the past psychological field is one of the 'origins' of the present field and this in turn affects behavior."\(^5\) It is pointed out that there are many potential attitudes but none can appear and function except in a certain situation.\(^6\) The environment potentially influences behavior. It

\(^1\) Hilgard and Atkinson, *Introduction to Psychology*, p. 151.
\(^3\) Hilgard and Atkinson, *op. cit.*, p. 155.
involves a number of active processes which selectively spur, guide, and limit behavior. The physical environment is also considered as significantly influencing psychological states and social behavior. Hence the ecological approach to the study of behavior, which examines the spatial properties of human behavior.

Yet situations have no universal significance and may elicit different responses, not only from different people but even from the same individual at different times, depending on the personalized interpretation of the experience and on the presence or absence of other environmental conditions. At this point the role of the culture in guiding the formation of such meanings and environments must be emphasized.

According to the theory of personology, man's functioning shows:

(1) the determining influence of internal, self-initiating characteristics more than of external forces, (2) both momentary and long-term organization, (3) complexity in the sense of change and the possession of many distinguishable elements, (4) the rationality of conscious intent, choice, and planning in greater magnitude than the irrationality of unconscious, irresistible impulses, (5) a large degree of species and individual uniqueness, and (6) the future orientation of continuing purpose and a tendency toward psychological growth.

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3Wolff, 'Disease and the Patterns of Behavior,' p. 57.


In the perspective of the foregoing theory, any approach that attempts to explain present adult behavior on the basis of rigidifying effects of early habits and instincts or by consideration of the external characteristics of the stimulus situation, or even through the principle of homeostasis, is inadequate and lacks a deep holistic conception of man.

Ancient Greeks first emphasized the factor of heredity as a determinant of behavior. This approach is reflected in Greek epics and tragedies. Plato offers metaphysical support to this belief by stating that God created some people with gold, others with silver, and still others with iron. Socrates makes a change by stressing the influence of education. Aristotle accepts three factors as formative of a person and his behavior: the nature, the habit, and the logos.

Contemporary Greeks consider behavior as the synthetic expression of the whole personality; that is, they accept its individuality. Of course, certain forms of behavior, habits, and rules of living, along with general beliefs, values, and goals, are transmitted to man by history, tradition, and cultural morale. However, the person decides actively and chooses to adopt those ways which correspond to his own being, his inner emotional state, and his potentialities. Behavior is motivated by

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2 Plato, Protagoras, 355a, b; also, Timaeus, 86e, The Collected Dialogues of Plato, pp. 346, 1206.
4 Αρ.Α.Ασπιώτης, Η Ψυχική Θεωρία του Ἰππόκρατου. Μελέται του Ιατρικού Ινστιτούτου Ιατρικής Ψυχολογίας και Ψυχικής Υγείας (Αθήναι: 1959), σσ.57-58.
multiple factors such as physical, chemical, psychological, social, and cultural. It expresses the needs, intentions, wishes, moods, interests, habits, goals, pursuits, values, and the traits of the personality.\(^1\)

The contributions of the various theories which consider the constitutional, adaptational, educational, and early-experiences-element as formative factors of man's behavior, are discussed critically by Greek authorities in the field along with an emphasis on the ontological make-up of man which includes elements which do not exist in the realm of matter and nature. Emphasis is placed on the role of consciousness, of the will and of the individual growth potentialities which provide for self-regulation, free choice, and responsible action. The will of the person is considered not as the "daughter" of pain but as the "daughter" of the valuing conscience which is able to conceive and adopt values beyond the level of needs and usefulness and to pursue them as primary goals.\(^2\)

Indeed, man is endowed with such inner potentialities that he is able to transcend the survival needs, to strive not so much to preserve life as to make it worth living, to live and even to die for the sake of his ideals and values. Thus, he may not follow any laws of adaptation. Man has the inner power to overcome the most strenuous external pressures, to maintain social autonomy, to resist any behavioral conditioning from outside, and to lead a life expressive of self-actualization and cognitive understanding, if he chooses to do so. Even if all environmental stimuli — physical and social — are exactly determined, a person's

\(^1\) Λωκέτσος. 'Ιατρική Φυσιολογία. σ.38.

\(^2\) Σπετσιέρης. 'Η Φυσική Ζωή του Βασίλη Ανδρίκου. σσ.79,80,119.
behavior cannot be predicted. Individuals emerge quite different from the same environment. Very often there appear personalities rising above their time and place and becoming symbols for all ages.

As far as the cause and effect notion is concerned, it must be mentioned that causality exists everywhere in nature and, consequently, in man's nature as well. The only difference is that man, through his will, creates for himself primary causes conducive to actions. Man makes absolute initiations. These causes are his goals which act as motives, and these in turn direct his actions.

In conclusion, it may be said that the various theories certainly have contributed, each at least partially, to the study and understanding of man's behavior. Further, out of these theoretical speculations of behavior, it became possible to design behavior modification techniques, especially useful in cases of psychopathology, when man's behavior becomes disordered. Nevertheless, it must be kept in mind that behavior is a personal expression under various forms, either that of communication and creativeness or that of defense, coping, reaction, and adjustment. In all cases, behavior is chosen and initiated by the person as a whole and thus it is marked with uniqueness and individuality.

If this perspective permeated nursing, there would be no room for routine care. There would be only respect for and acceptance of the individual patient as a unique person and the treating of his actions as meaningful expressions of his personality.
**Nursing Approach to Mental Patients with Behavioral Problems**

**Nursing Care of the Withdrawn Patient**

The process of withdrawal. Withdrawal is a behavior in which the individual retreats from interpersonal relationships, social situations, and anxiety-producing conflicts. Withdrawal may be a "security operation," a defense or adjutive reaction to frustrating situations, for overcoming, avoiding, circumventing, escaping from psychological threat, and protecting self-esteem.

Withdrawal may vary in its modes and degrees of expression. It may be a maintenance of social distance from others or a physical escape from a threatening situation or even a temporary retreat into daydreaming without losing awareness of the uneasy feelings and while keeping contact with the real world. In such a case, when withdrawal is employed in moderation and does not exclude more realistic facing and solving of problems, it may facilitate rallying of inner resources and reintegration of the personality in order to reach a realistic solution. However, actions based upon security operations can never be genuinely satisfying and growth fostering, because they are impelled by extrinsic drives.

Moreover, withdrawal can be a psychotic syndrome, a state of existence removed from the realm of reality, for preserving personal

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security. Patients who utilize patterns of withdrawal from reality as a specific reaction to an extremely severe state of anxiety, perhaps originated in childhood and reactivated later in life by psychological factors, are diagnosed as schizophrenic.¹

Because of severe frustration of the need for tenderness in childhood and the concomitant cumulative failures in building up self-esteem and establishing meaningful, interpersonal relationships,² the patient has developed the conviction that there is no one in the world who can be trusted to value and love him. He easily undergoes reactivation of emotional configurations — from which unpleasant experiences he comes to protect himself by distance, indifference, and apathy.³

The break (schizo-, σχίσις) splits off those psychic processes which constitute the objective external world. The patient does not care any more about the objective world. He breaks his contact with it and detaches his emotional investment from it. The only reality that remains is the subjective symbolic world of fantasy, which is not bound by logic and is free from the conventional symbols of society.⁴ Another way of thinking differently from the objective Aristotelian logic and unique language operations develops as the patient progressively becomes insulated like a prisoner in a castle of his own construction, in his symbolic autistic world.⁵

³Sullivan, Schizophrenia as a Human Process, p. 313.
⁴K.A. Konstantinídis, Ηαθέματα Ψυχιατρικά (Αθήναι 1946), σσ. 174-175.
⁵Γεώργιος Ν. Παπαδημητρίου, Σύγχρονη Ψυχιατρική, Τόμος Β', Εθική Ψυχιατρική: Η απολογία του πρακτικού (Αθήναι: Εκπαιδευτικός Ι.Δ.Κ. Α. Καρατζάνος, 1974), σ. 1573.
Autism refers to the pathological reaction which consists of withdrawal from reality, abolition of the logic, and production of imaginary, and thus illogical, ideas.\(^1\) The more the patient divests himself of common symbols, the more desocialized he becomes and the more he loses the benefits of interchange with society. Further, by desocializing, he becomes lonely and loses a great part of himself.\(^2\) This is really the tragic effect of withdrawal in schizophrenia. However, the fear of interpersonal relations is even stronger than the loneliness experienced. Isn't it a real challenge for nursing to make such fear less powerful than the desire to establish contact with other persons?

**Therapeutic nursing intervention.** The plan of therapeutic nursing intervention in the patient's withdrawal from reality requires that "a priority be set which will enable the nurse to focus on a process and to evaluate intervention and change in it."\(^3\) The judgment will be formulated according to the major problem areas of the withdrawn patient. These are emotional and interpersonal.

The patient has a low self-esteem produced by unfortunate interpersonal encounters. He experiences high levels of anxiety when confronted with social situations, all perceived as threatening. In order to reduce anxiety, he resorts to security operations, mainly to withdrawal from reality, reason, society, and emotions. By withdrawing, he undergoes further impoverishment and disintegration as a person.

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\(^{1}\) Κωνσταντινίδης, Μαθήματα Ψυχιατρικής, σ.175.

\(^{2}\) Arieti, *Interpretation of Schizophrenia*, p. 305.

As a consequence, the priority for nursing intervention is to interrupt the patient's progression into withdrawal and to encourage him to turn toward reality. The intervening nursing behaviors aim at strengthening the patient's self-esteem and helping him to relate increasingly more successfully with others. It is hoped that the resulting satisfaction of the patient's need for security and relatedness — tenderness — ultimately will help him to accept and remain in contact with reality.

Even though there is an extensive literature on schizophrenic withdrawal and its interpretation, each patient is unique and expresses his illness in unique personal ways with specific meanings to him. The nurse approaches him as a person and she is interested in knowing him and in understanding his strengths and weaknesses as he strives, however inadequately, toward adaptive success in his relationships with other people. Although the patient may seem to himself to be a non-person, an uncommitted object among other objects, the nurse perceives him as a person who, however disorganized and despairing, still has a potential to emerge from his withdrawal in the direction of social recovery and still is susceptible to influence by interpersonal factors.

The nurse views the patient as much more than a collection of behaviors to be identified and labeled, or as a subject to be measured against theoretical criteria. She looks upon him as a human being in distress, deserving not charity but dignity, not tolerance but respect. Thus she conveys to him at all times the message, spoken or unspoken, that she

1Fromm-Reichmann, "Remarks on the Philosophy of Mental Disorder," p. 166.

2Sullivan, Schizophrenia as a Human Process, p. 255.
recognizes, respects, understands, and cares about him as a person and that she accepts his actions as meaningful.

The attitudes of the nurse are of primary importance because they set up the interpersonal climate, where nursing intervention takes place. Creating and maintaining a supportive climate, consistently conveying empathic caring and unconditioned concern is a deliberately designed therapeutic nursing action to increase the patient's self-esteem. Further, the nurse's reassuring physical presence and availability support the patient emotionally without pushing him by any means to talk out his personal problems or to respond in specific ways. Nevertheless, the atmosphere provides stimuli to which the patient is exposed, offering opportunities for response. He is left to respond as he wishes. In the meantime, his thinking and emotions are drawn systematically toward reality.

The patient may try to test the authenticity of the nurse's conveyed attitudes, to see whether they are sincere and worthy of his trust. He may express hostility, rebuff her offerings, remain apathetic, or withdraw further. The nurse accepts him without criticism and without ignoring him while, at the same time, ignoring his behavior. She continues to display perseverance and patience in making herself available for as many short periods as the patient needs to become accustomed gradually to this interpersonal contact which he deeply desires but at the same time doubts.

By a pleasant arrangement of the patient's physical environment and by helping him with his physical health and appearance, if such a need is

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1. Gagnon and Lamothe, Soigner c'est Vivre le Défi Quotidien, p. 60.
3. Tremblay, Soins Psychiatriques, p. 53.
identified, the nurse reflects her belief in the patient's worth and
dignity which in turn serves as a lever to raise his self-esteem. Prais­
ing the patient when he really tries, or accomplishes something worthy of
praise, may also foster his self-esteem. Opportunities for commenting
approvingly on the patient's performance may be related to improvements
in his grooming, increased involvement in contacts and activities with
others, and so forth.

The foregoing points are only examples of what the nurse can do
to strengthen the patient's self-esteem and to pave the way for reaching
him emotionally and establishing an effective relationship with him.

In this initial stage of the patient's care, the nurse as a par­
ticipant observer comes to know him as a person and to identify his par­
ticular problems and needs as well as his assets. She observes his
behavior, the state of his affect, his level of thinking, perception, and
language, his relatedness to persons and things, his psychosomatic func­
tioning, his capacity for caring for himself, and his contact with reality.¹

The nurse tries to clarify and validate her observations with her col­
leagues, and particularly with the patient.

Even though the nurse must be knowledgeable of the prevailing
theories which describe and interpret the process of withdrawal, only
through direct contact with the particular patient will she understand
how he, personally, expresses his symptoms, in what interpersonal contexts
they developed, what these mean to him, and what he tries to communicate
by them. Moreover, only by establishing a positive interpersonal rela­
tionship with the patient can she help him move toward better health. It

¹Brown and Fowler, Psychodynamic Nursing, pp. 198-199.
is important, then, to highlight certain points of the relationship of the nurse with the withdrawn patient.

The nurse first establishes contact with the patient by dealing with everyday topics and the necessities of the ward life. The fact is that informal rather than formal talks on non-traumatic and anxiety-free subjects are more successful in moving the withdrawn patient toward an interpersonal experience. After all, exploring reality issues, however simple the means may be, is therapeutic. Emotional problems or painful areas, when touched in conversation, may upset the patient, increase his anxiety, and make him react by recoiling and excluding himself in his autistic world. As a consequence, the nurse watches the patient during the interaction for early signs of a possible increase in his anxiety. Whenever it occurs, she turns to a subject which is non-loaded emotionally. This is aimed at reducing his anxiety.

When the patient presents difficulties in verbal communication, the nurse maintains the relatedness on a nonverbal level by the use of gesture, silence, space, and other means. She may decide to engage the patient in simple activities, using them as a means of communication. For example, the nurse may invite the patient to play with her domino or tavli, to help her in decorating the dining room of the ward, or to do some gardening task in the front yard of the ward. The fact that the nurse spends time with the patient and uses the opportunity to convey her genuine interest -- as well as the stimulation for some objective thinking and decision-making, either in the game under play, in decorating, or in gardening

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1 Manfreda, Psychiatric Nursing, p. 111.
2 Burgess and Lazare, Psychiatric Nursing in the Hospital and the Community, p. 244.
tasks — is of great importance in mobilizing the patient toward contact with people and with reality.

When the patient introduces autistic material in the interaction, such as words and expressions of his subjective construction, the nurse confronts him directly and sincerely by saying that she doesn't understand him at this particular point. If the patient corrects his language, he gets immediate recognition of effective communication by the nurse. If he is unable to clarify his subjective symbols, the nurse reflects his emotional tones (i.e., anger, sadness, or other) back to him, asking for consensual validation from him on the feeling level. The nurse further helps the patient by avoiding abstractions and by keeping her language to a concrete and descriptive level.¹

The patient often talks to the nurse about his delusions and hallucinations. (Delusions are false beliefs maintained against logical and objective contradictory evidence. Hallucinations are false subjective perceptions without external objective stimuli.)² The nurse may indicate that she does not accept their reality.³ However, she does not argue about them and does not attempt to reason them away. In the face of his delusional ghost-persecutors, the patient may become very anxious, overwhelmed by a sense of impending disaster. The nurse maintains a supportive attitude, conveying understanding and reassurance. She remains

² Παπαδημητρίου, Σύγγρωνη Ψυχιατρική. Τόμος Α' Ψυχιατρική. Τόμος Β'. Τόμος Π. Κων. 726, 762.
³ Chapman and Almeida, The Interpersonal Basis of Psychiatric Nursing, p. 120.
on the patient's side and she sustains him in his experience.¹

The nurse may encounter problems in providing safety for the withdrawn patient while under the influence of his delusions and hallucinations. He will probably require protection from injuring both himself and others. It is important not to allow the patient to hurt another person physically, not only for the sake of the victim but also because of the deep guilt feelings the patient would experience after recovering from his bewilderment.² Probably the most significant part of any combination of safety measures is an adequately educated and interested personnel to secure individual attention and a variety of therapeutic activities for all patients.³ Personalizing rather than routinizing the care of the mentally ill as far as precautionary measures are concerned is a real therapeutic nursing intervention.

As the patient begins to feel comfortable and secure in his relationship with the nurse and becomes involved in retraining himself in establishing communication with another person, the nurse gradually broadens the contact to include another patient or another nurse. Later still, the patient is introduced into a group and is encouraged to participate in shared group activities.

Systematic encouraging of secure feelings in interpersonal relations and support in facing reality often help the withdrawn patient to renew efforts at adjustment to real life and to regain his capacity to conduct his life.

²Ibid., p. 319.
In summary, the therapeutic nursing intervention with the withdrawn patient consists of:

1. Creating a positive interpersonal climate, permeated by the hope that there is always within the patient an intrinsic tendency toward more reorganization and health, which may be strengthened by nursing care.

2. Elevating the patient's self-esteem.

3. Checking his tendency to withdraw from social contact.

4. Helping him to learn the interpersonal reality.

5. Fostering in him the conviction that reality is safe and more desirable than the autistic world, even though reality is not "a rose garden," but that it takes continuous struggle and transcendence.

The withdrawn patient offers a constant challenge to the nurse to break through the wall of apparent apathy and establish contact with the person who lives behind it. Although the nurse does not always see spectacular, direct results of her therapeutic intervention, she does not give up striving because she believes that every interaction of tenderness makes the next experience more accessible, fuller, and deeper. The effects are cumulative.

Nursing Care of the Depressed Patient

The process of depression. Depression is the presence of a pathological internal feeling and mood; it is the emotional expression of a


state of helplessness and powerlessness of the person; it is exaggerated sadness coupled with pessimism, and pessimism is the essential element which differentiates depression from ordinary "low" feelings which we all experience from time to time; it is deep-seated psychic pain connected with guilt feelings and extreme unhappiness. 3,4

Depression contributes to many clinical problems, diagnostic as well as therapeutic, daily. This is so because it may be a cause of illness and a consequence of illness. 5 It may be masked, appearing with symptoms suggesting physical illness and often accompanying physical illness. This is likely to happen when the physical illness is serious, incapacitating, and requires mutilating surgery or other difficult adjustments. 6 Some physical illnesses likely to lead to depression are malignancies, certain endocrine disorders, cardiac and lung diseases imposing stressful limitations on the sick person, 7 and many of the severe infections. 8

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1 Hakaz M. Grigorian, "Aging and Depression: The Involutional and Geriatric Patient," in Enelow, Depression in Medical Practice, p. 67.

2 Hugh A. Storrow, "The Diagnosis of Depression: Recognizing the Depressed Patient," in Enelow, Depression in Medical Practice, p. 23.


4 Παπαδημητριου. Σύγχρονη Ψυχιατρική. Τόμος Β'Εθική.


7 Γ.Γ. Γαλανός. "Τό Άγγιος στά Παθολογικά Συνόρα." σσ.196-197.

8 Β. Παρμενίδης, Α. Κατσίκης, Ζ. Δάφνης, Γ. Καρυώτης και Β. Τερεκίδης. "'Αγγίζοντας καταθλιπτική Συνδρομή Συνεπεία Ηλικιακού Νηπιαγορά." Προσφυγα, Αρχείο Νευρολογίας και Ψυχιατρικής. 7, 1-2, 1979, σ. 201.
On the other hand, depression may be masking physical illness such as malignancies, peptic ulcers, and so on, especially when depressive symptoms prevail in the clinical picture. This thought suggests that the diagnosis of depression should not inhibit or exclude the investigation for physical disease. In general, depression may simulate, precede, accompany, or follow physical illness.

Depressive behavior usually is a response or reaction to a psychotraumatic experience, to conditions of loss such as death of or separation from a loved person, loss of an ideal, or loss of status, of various kinds precipitated by physical illness, all of which have an influence on lowering self-esteem.

The depressive response, of course, is highly subjective, depending greatly upon disturbances of early personality development, among other factors. What depresses one person may leave another unaffected. Rising and falling moods, becoming discouraged, dejected, or disillusioned from time to time on the basis of identifiable objective conditions, all fall within the range of normal behavior. Such emotional states usually

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2 John J. Schwab, "Depression in Medical and Surgical Patients," in Enelow, Depression in Medical Practice, p. 117.
4 Φιλίπποπουλος, Ανυγική Φυλασσική, σ. 366.
6 Cameron, Personality Development and Psychopathology, p. 412.
do not reach proportions which prevent the individual from engaging in everyday living, and they end with a spontaneous remission.\textsuperscript{1,2}

However, depression may become "a preoccupation of consciousness, with a very restricted progression of grief provoking ideas"\textsuperscript{3} and turn practically into "a standstill of adjustment."\textsuperscript{4} In other words, depression may present a psychotic syndrome which may accompany any of the recognized mental disorders, i.e., schizophrenia; may be part of the manic-depressive psychosis which is characterized by recurring episodes of psychotic depression or mania (mania is the reverse of psychotic depression; manic patients have an elated mood, are hyperactive and over-talkative); may be diagnosed as a separate category called involutional melancholia.

The symptoms of depression refer mainly to three domains: the affective, the somatic, and the behavioral. The person grows chronically preoccupied with complaints of hopelessness, helplessness, failure, sadness, unworthiness, guilt, internal suffering, and a self-concept of "badness."\textsuperscript{5} He accuses himself of having committed unforgivable sins, of having drawn his family toward disaster, of being responsible for every misfortune that has befallen them, and for every evil in the world. He


\textsuperscript{4}Sullivan, Schizophrenia as a Human Process, p. 115.

pleads for indulgence and forgiveness. He feels that life is mournful, painful, dark, meaningless, and useless. He considers the present, as well as the future, absolutely hopeless, and he is exceedingly pessimistic about ever feeling better. A depressed person characteristically said to his therapist: "There is no road map — large open fields without any direction. It's sort of lonely." Another patient described his depression as "the Universe of Horror." Anxiety-tension symptomatology is always present in depression.

Physical activities in depression are retarded. All thoughts that do not harmonize with the psychic pain are made difficult, so that thinking reaches the point of complete monideism. Retarded thinking is compared to the slow flow of a gluelike substance through a tube, as against the running flow of water. Irresolution may grow to an unbelievable extent; the person cannot make any decision since, for him, everything is useless and futile. Inhibition of the will takes on a great significance.

Speech is quiet, slow, as brief as possible. The patient may become inarticulate, not only to others but to himself. However, the

1 Geowgouàs kal Oýwàs. Stoikèia Psychiatríkic. ς.34.
2 Konstantinàakis. Píchmatà Psychiatríkic. ς.164-165.
5 Geowgouàs. Stoikèia Psychiatríkic. ς.177.
6 Ibid., p. 173.
message about his deep unhappiness comes across very clearly through the body language. Facial expression is painful, desperate, anxious, with mimic rigidity. The look of alertness and the sense of relatedness to the milieu are attenuated mostly because of the reduction and restriction of perception and lack of interest in people. Symbolic communication through gesture and other means is diminished.\(^1\) However, there is a lot of weeping.

The ability to work declines rapidly. Movements become trying, slow and weak. The patient is disinclined to do any work; he is inclined to sit in the same place for long periods of time.\(^2\) If the retardation becomes severe, then the patient resorts to depressive stupor, namely, definite movement inhibition. He is absorbed in his own prevailing feeling of depression that he cannot focus his attention on his environment. He cannot take care of himself. He lies in bed mute and has to be fed.\(^3\) At other times, however, there may be increased motor activity, or agitation with an extreme restlessness, i.e., pacing the floor and the inability to sit still. Nevertheless, his restlessness is unproductive.

The most significant manifestation of severe depression is preoccupation with suicide. Attempted suicide or committing suicide may be the first or the last expression of one's depression.\(^4\) It appears to offer the patient the only solution to his difficult life circumstance.


\(^2\) Maslow and Mittelmann, Principles of Abnormal Psychology, p. 503.


\(^4\) Φιλικόπουλος, Δυσηλική Ψυχιατρική, σ.381.
The depressed person frequently has delusions and hallucinations, the meaning content of which include self-accusation, guilt, disease, and ruin.

Finally, depression presents somatic symptoms such as insomnia, anorexia, and, respectively, loss of weight, constipation, decrease in blood pressure, and cessation of menstruation.¹

In concluding, it must be pointed out that the depressive behavior may be displayed by children -- however, with quite different clinical manifestations from those seen in adults -- adolescents, adults, and elderly people; by medical and surgical patients; and by psychiatric patients. Depression probably causes more human suffering than any other disease. The nurse must always be alert to recognize, in any setting, depression frequently masked by -- or masking and complicating -- other nosological conditions, and to answer sensitively and genuinely the cry for help from the depressed person.

Therapeutic nursing intervention. Every depressed person certainly does not present all symptoms described in the foregoing section. Also, the depth and degree of the symptoms manifested, as well as their causes and meanings, vary extensively from person to person. Each depressed person experiences, expresses, and communicates his suffering, his needs and problems, and his appeal for help in unique personal ways. Thus, the nurse, oriented by her theoretical knowledge of depression, observes the patient's behavior, listens for tones and themes as well as the spoken content, interacts personally with him, and tries to know and understand

¹Maslow and Mittelmann, Principles of Abnormal Psychology, pp. 503-504.
understand him as a whole person. In this way she makes an initial assessment of the patient's needs and plans a therapeutic nursing intervention, always open to change as the patient's condition evidences the need.

Therapeutic nursing intervention in caring for a depressed patient focuses on three major areas: (1) developing a nurse-patient interpersonal relationship; (2) providing physical health care for the patient; and (3) creating a therapeutic milieu.

Developing a nurse-patient interpersonal relationship. The crucial thing in the confrontation of the depressed patient is that he looks indifferent; he stands apart in a dejected and withdrawn fashion; he often cannot make the effort to ask for anything; and he is unable even to respond to other people. As a consequence, the nurse -- without being invited or challenged -- must seek and discover the patient. This very first step may be considered as a therapeutic intervention, mobilized by "therapeutic love" and geared to recognize and give primary consideration to the patient's feelings and needs.

The nurse, by her supportive attitude, transmits to the patient that she is concerned, genuinely interested, available and open to discussions of emotional difficulties. By her caring presence, she conveys to the patient her readiness to listen if the patient chooses to externalize his feelings. Even though he may repeat over and over again self-depreciative and nihilistic ideas, verbalization itself may be therapeutic.

\footnote{Joan Risley, "Nursing Intervention in Depression," Perspectives in Psychiatric Care, 5, 2 (1967), 66.}
The nurse does not deny or disapprove the patient's feelings of worthlessness and guilt, because of their special meaning to him and because such a nursing attitude will make him feel hurt and will increase his loneliness and despair. After all, it is this special meaning, perhaps unrelated to the reality of the loss and regardless of its apparent severity, that triggers the special reaction — depression. She does not dispute the patient's statements, but, whatever she says and does, she communicates the thought that, while she accepts his experiences and his distress, she does not share them. For example, when the patient expresses feelings of worthlessness, the nurse counteracts them by indicating that she considers him worthwhile. She exemplifies his worth by caring for him, by staying with him, by tolerating silences, allowing weeping, and doing for the patient those tasks which he is unable to accomplish for himself. By this deliberately designed intervention, the nurse tries to diminish gradually the patient's feelings of rejection, worthlessness, and guilt.

The nurse empathizes with the patient, she reflects a mood and attitude in harmony with his — not cheerful. An atmosphere of cheerfulness created by the nurse, in contrast to his own depression, may deepen his despair and misery. Without manifesting joy and happiness, she is warm, calm, serious, and understanding. She stresses the good prognosis of the illness and she is patiently and quietly encouraging.

3 Kyes and Hofling, Basic Psychiatric Concepts in Nursing, p. 244.
conveying explicitly as well as implicitly by her behavior that she hopes the patient will get well.\textsuperscript{1}

The therapeutic value of hope and the dangers of hopelessness are often discussed in the field of psychiatry.\textsuperscript{2} Hope can be transmitted from the nurse to the patient through her attitude and her nearness, suggesting that she cares. And hope can become a healer.\textsuperscript{3,4} The Greek nurse bases her hopeful attitude on her Orthodox Christian Faith, which provides for the Sacrament of Confession. Through confession and by means of Divine Grace, man is granted forgiveness for his sins, freedom from his feelings of guilt, and strength for resolving his inner conflicts. The nurse reminds the Greek patient of this spiritual way of relief from his guilt and hopelessness, of experiencing an inner catharsis, and of liberating his psychic energy, to be invested in full, responsible, and self-actualizing living. Of course, the patient is left free to decide personally to ask for spiritual help. It must be pointed out that spiritual intervention may be of help in those cases where real guilt and deep conflicts with one's own conscience have precipitated the syndrome of depression.

The foregoing approach may be used by Greek nurses caring for Greek patients because they share the same Faith. When the Greek nurse cares


\textsuperscript{2}Sullivan, The Psychiatric Interview, p. 16.


for a person of different religious orientation, she may encourage him to speculate alternative solutions of his problem in the context of his personal philosophical system.

In most cases, the depressed patient is communicative to a greater or lesser degree, kept out of bed, and ambulant. However, there are patients who fall into the state of depressive stupor, completely unable to communicate and to respond. In such cases, the nurse should be able to give emotional warmth and personal care even though she does not receive any response. The stuporous patient is not unconscious. He is just too sick, enveloped in his melancholia, to utter a word or move hand or foot. He may stay in bed. He cannot answer, but he can still hear what the nurse says to him (and what she says about him, in his presence, to others) and he may sense her emotional attitude. The patient actually is desperately lonely, and craves any assistance which will make him feel less lost and hopeless.

The nurse takes care that, by virtue of being in bed, the patient is not isolated either from nursing contact or from other patients. This constitutes a danger, especially in a psychiatric ward where most of the patients are ambulant. The nurse talks to this patient in simple language. She greets him when she goes to nurse him in bed. She tells him what she is going to do. She also uses her eyes, hands, and smile to tell the patient of her sympathy and continuing concern, and her hope that this condition will be transient. By giving him her time and attention, she lets the patient know that she has chosen to be with him rather than with any other patient.

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The physical nursing care of the patient in depressive stupor is not different from the care of any physically ill patient who is unable to take care of himself. That is why the interpersonal approach to this kind of patient has been stressed. However, specific aspects of physical health care of the depressed patient will be outlined in the next section.

Providing physical health care for the patient. Since the depressed patient is retarded in his thinking, feeling, and acting, he tends to neglect himself and takes little interest in his food, cleanliness, and physical appearance. He avoids exercise and, as a result of inactivity, he may develop constipation, edema in the extremities, and susceptibility to infections. Furthermore, anorexia, losing weight, insomnia, and general deterioration of the physical condition tend to match the severity of the patient's depression. His physical symptoms speak of his emotional state.

Insomnia has to be faced seriously. Dealing with the sleep problem alone may take a whole group of nursing processes in the perspective of the patient's therapeutic nursing care. Taking a history of the particular patient's sleeping patterns to be used as a guide for nursing planning, giving him an opportunity to talk about his worries and troubles before going to bed, arranging the physical environment to one conducive to sleep (control of lights, noises, distractions) are only representative examples of what the nurse can do to help the patient sleep.

Attention to the patient's appearance, concern about his physical health and physical ministrations, may become the way to success — when

1Norris, "The Unique Nursing Content of a Selected Therapeutic Routine in Psychiatric Nursing," p. 122.
other approaches have failed — in establishing interpersonal contact with the patient.

Eating may be a real problem. The depressed patient lacks appetite and often expresses delusions of being unworthy of food or too poor to be able to afford it. His refusal to eat may also be an attempt at suicide by starvation. The nurse explores the patient's personal reasons for not eating his meals and plans to intervene accordingly. Finding out what the patient likes and dislikes in terms of food; preparing and serving his meals attractively; providing enough time so that he will not feel compelled to finish within a time limit; letting him know that there is a firm and irrevocable decision for the protection of his health and his life because of his dignity and worthiness; keeping him company during his meals, thus reflecting unconditioned love, acceptance, and understanding. These are only examples of what the nurse can invent to help her patient.

If the patient is suicidal, protection of his life becomes a primary goal in the overall therapeutic nursing intervention. The nurse's role in prevention of suicide will be discussed in a separate section.

Creating a therapeutic milieu. Therapeutic milieu refers to the total environment but with special emphasis on the interpersonal environment. The depressed patient characteristically stays away from involvement with people and is unwilling to engage in group interaction and activities. This behavior stems from the psychomotor retardation, the loss of confidence, the lack of interest, and the self-depreciation, all being symptoms of his illness.

Care should be taken to avoid forcing him too early into the stream of activities or social contacts. He will feel miserable for his
inability to respond. However, as soon as he shows signs of interest, he should be encouraged into a few activities. For example, he may be invited for a short walk with the nurse in the garden of the ward or to visit the occupational therapy department to choose materials to work with, such as embroidery staff, knitting set, wood carving, book binding, and so on.

The patient should be encouraged not to make unnecessary and unreasonable demands on himself, since his energy and attention are enlisted by his inner suffering. And yet, he should be engaged in some activities, however meaningless they seem to him at the moment, because this mobilization will help him ultimately to get out of his depression.

The nurse introduces the patient to a few fellow patients who can sympathize with him and enhance his self-esteem. It may be very reassuring to the depressed patient to discuss with another patient the latter's recent similar experience of depression and his ongoing experience of recovery from it.

The nurse avoids leaving the patient alone at the beginning of his introduction to the group. By her accepting and caring presence, she counters the patient's feeling of unworthiness and helplessness, watches that he participates in simple, easy, and quickly-realized tasks, useful for the others, and gives recognition for his success. The patient may be gradually introduced to a more active group so that he will be challenged — though indirectly — to express talents and creative abilities.


2Gagnon and Lamothe, Soigner c'est Vivre le Défi Quotidien, pp. 65-66.
Hopefully, in the deliberately created therapeutic milieu, the patient will be made to feel loved, accepted, and understood, his self-esteem will be elevated, his depression will decrease, and he will eventually reach the stage of restored health.

The foregoing discussion focused on the therapeutic nursing intervention, which may help the depressed patient move toward better health. Differentiation of the various types and degrees of depression has not been made here. The suggested nursing approach, focusing on the nurse-patient relationship, the physical health care of the patient, and the creation of a therapeutic milieu, may be adapted according to the particular patient, to the particular way he expresses his depression, and to the particular circumstances under which the depressed patient will be nursed — home, community, general or mental hospital. Also, the psychiatric therapies available to relieve depression (i.e., psychotherapy by a psychiatrist, antidepressant medications, and electric convulsive therapy) have not been discussed here. It must be implied, however, that the nurse keeps fully informed of the medical therapies indicated for the particular patient, collaborates whenever her contribution is needed, adapts her nursing intervention accordingly, and follows up for evaluation of the positive influence and/or probable side effects of the applied therapies.

Nursing Care of the Suicidal Patient

Theoretical speculations on the nature of suicidal behavior. Suicide refers to all cases of death which result directly or indirectly from an act of will of the victim himself, which he knows will produce
this result.\textsuperscript{1,2,3} Suicidal behavior does not constitute a unitary disorder but spans quite a broad spectrum of nosologic categories, and it may even be exhibited under normal health. It touches both sick and healthy people, unlettered and educated, rich and poor.\textsuperscript{4,5}

The increase in the suicide rate in our age\textsuperscript{6} on the one hand, and the growing interest in understanding and alleviating all forms of self-destructive behavior on the other, has precipitated an upsurge of suicide-prevention activities in many western countries in the last years. In the United States in the last decade, a great number of suicide prevention centers have been established, the American Association of Suicidology was founded, and a journal devoted to this topic, the Bulletin of Suicidology, was initiated. As a result of all the scientific and clinical activities in the field of suicide prevention, important refinements of concept and insight into the subject have been available through related literature. Hence, selective views will be presented here.

The threat of suicide is considered in almost all severe depressions and particularly in the manic-depressive depression, to the point

\textsuperscript{1}Emile Durkheim, Suicide: A Study in Sociology, transl. by John A. Spaulding and George Simpson, edited by George Simpson (Glencoe, Ill.: The Free Press, 1951), p. 44.


\textsuperscript{3}Jack D. Douglas, "The Absurd in Suicide," in Shneidman, On the Nature of Suicide, p. 117.


that depression is seen as a way-station toward death. Of course, suicide risk is not limited only to depression; it occurs in other behavior disturbances as well, such as schizophrenics, and in many neurotics. In view of the total number of suicides, the percentage of suici
ding patients with mental illness is small.

The precipitants of suicide vary extensively. The most frequently discussed include psychosocial isolation and a confusion of norms or a destruction of all the traditional social bonds leading to "anomie," the materialistic interpretation of life as an enterprise which can fail and is thus not worth living; hopelessness, despair, and desperation which make of suicide a disease of hope; suffering deprivation in one's social relationships at an early age and sensitivity to later losses such as loss of position and downward vertical mobility, loss of a person, through separation, divorce, or death, and other losses; and experiencing one's very being as acutely "in question."

1 Durkheim, Suicide: A Study in Sociology, p. 63.
5 Durkheim, op. cit., pp. 208-209.
6 Fromm, The Sane Society, p. 137.
7 Farber, op. cit., pp. 12, 16.
9 W. Breed, "Occupational Mobility and Suicide Among White Males," American Sociological Review, 28 (1963), 179-188.
10 Bakan, "Suicide and Immortality," p. 126.
Besides the mentioned precipitating causes of suicide, there are still others reported, such as drug abuse, alcoholism, the dread of a painful and hopeless existence, as in chronic illness and old age, disordered interpersonal relationships, and feelings of guilt.  

On the surface, it seems that persons commit suicide when there appears to be no available path that will lead to a tolerable existence. However, it must be kept in mind that the external desperate situation alone usually does not lead to suicide. Suicide is an individual act, a highly personal tragedy.

The symbolic language of suicide. Suicidal behavior is often viewed conceptually as a communicative effort encompassing messages of suffering and anguish and pleas for response. Most suicides are characterized as "dyadic"; that is, primarily transactional, social, and relational in nature. In this perspective, the self-destructive

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6 Edwin S. Shneidman, "Prologue: Fifty-eight Years," in Shneidman, ibid., p. 15
behavior being part of a dialogue, may be contemplated either as initiated communication or as a response to others' communications. A person may destroy himself in response to an invitation or the experience of an invitation originating from others that he stop living. Such an invitation may be abandonment, indifference, derogation, psychic trauma caused by significant others.

There are cases when suicide expresses not a message addressed to others nor a response to a message, but a debate, a disputation, a dialogue within the personality. It simply expresses the special inner state of the person. Notes left by suicidal persons bear this out. They include either private views of personal existential struggles and inner unresolved philosophic disputations or express feelings of guilt, inadequacy, worthlessness, and indications of strong anxiety and tension. When addressed to other persons in the environment, suicidal notes may include accusations, expressions of hostility, blame, and explicit or implicit demands for changes in behavior and feelings on the part of others.2,3

Usually there are prodromal communications or clues to suicide. These may be classified as verbal, behavioral, situational, and syndromatic.6 The verbal communications may be direct, indirect, or coded.

The behavioral communications may be direct, such as an actual suicide attempt, or indirect, such as making a will and giving away prized possessions. The situational communications refer to circumstances where a patient has been told or believes that he has cancer, when he is scheduled for mutilative surgery such as an amputation, or other events such as family discord or financial bankruptcy. Finally, the syndromatic communications may be syndromes of emotional overreaction, i.e., depression, defiance, and so forth.

A question arises at this point: Why do a substantial number of suicidal persons communicate their intent before they die? Perhaps they are ambivalent about dying, and the communication is a plea for help; they may want to prepare their relatives to reduce the shock of hearing about the suicidal death; or they may have no desire to die but wish to threaten their relatives and friends.

As a conclusion, it may be said that, however symbolic the suicidal language might be, the point is that most suicides cast some shadows before them and this makes suicide prevention possible. The nurse, in whatever area she works, deals with people in problematic or miserable situations in which the risk of suicide usually is very high. Thus she is in a strategic position to listen and to answer promptly "the cry for help." The question is: Are her antennae refined and sensitive enough to grasp the cues?

Suicide in the perspective of the Greek Orthodox Faith. Suicide is a type of murder and, as such, is considered a sin against God's will. This belief is based on the Bible which speaks on the subject. Jesus
Christ said: "Do not kill"¹ and "Thou shalt do no murder."²

The prompter who suggests suicide or extends to man an invitation to suicide is considered to be the devil. Satan tempted even Jesus to suicide when he took Him up into the Holy City, made Him stand on a pinnacle of the temple, and told him to cast Himself down. If He had obeyed Satan, it would have been suicide. But He did not, and by His example He taught that the Devil may and should be driven away by obeying God’s words.³

Saint Paul the Apostle explains his position against suicide in his epistles. He writes to the Romans: "For none of us liveth to himself, and no man dieth to himself."⁴ He further reminds the Corinthians: "What? Know ye not that your body is the temple of the Holy Ghost which is in you, which ye have of God, and ye are not your own?"⁵ and "If any man defile the temple of God, him shall God destroy; for the temple of God is holy, which temple ye are."⁶

The Bible warns man that he will suffer tribulations in his life,⁷ but at the same time it reassures him that he will not be deserted,⁸ and it guides him on how to overcome all adversities.⁹

¹Mark 10:19.
²Matthew, 19:18.
³Matthew 4:6,7.
⁴Romans 14:7.
⁵I Corinthians 6:19.
⁶I Corinthians 3:17.
⁷John 16:33.
⁸Matthew 28:20.
Moreover, the Bible provides a leading story in suicide prevention. Paul and Silas were imprisoned in Philippi of Macedonia and the jailer was charged to keep them safely. At midnight, while they were praying and singing praises to God, suddenly there was a great earthquake, all the doors of the prison were opened, and everyone’s bonds were loosed.

And the keeper of the prison, awakening out of his sleep and seeing the prison doors open, he drew out his sword, and would have killed himself, supposing that the prisoners had fled.

But Paul cried with a loud voice, saying, "Do thyself no harm; for we are all here."

Then he called for a light, and sprang in, and came trembling, and fell down before Paul and Silas,

And brought them out, and said, "Sirs, what must I do to be saved?"

And they said, "Believe on the Lord Jesus Christ, and thou shalt be saved, and thy house."

And they spoke unto him the word of the Lord, and to all that were in his house.

The foregoing passage makes suicide prevention a duty for every Christian, not just for the health professionals; and it provides guidelines for this accomplishment, as follows:


2. Talk with, and reassure the person by helping him to see also the positive aspects of the critical situation. "We are all here," Paul said (Acts 16:28).

3. Listen sensitively to the theme of the cry for help. "What must I do to be saved?" (Acts 16:30)

4. Teach the suicidal person how to choose alternatives of action in his life in the perspective of the Christian Faith. "And they said, 

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1 Acts 16:27-32
Believe on the Lord Jesus Christ, and thou shalt be saved, and thy house. And they spake unto him the word of the Lord . . ." (Acts 16:31-32). (It must be pointed out that Paul and Silas did not give very specific and clear-cut advice. They only brought to the jailer knowledge and awareness of a broad, optimistic, and faithful outlook on life. The jailer himself remained free and responsible to make his own choices for action and reaction.)

5. Care for the suicidal person's family which, once helped and enlightened, may become a supportive and therapeutic environment for the individual member and may join forces for a constructive confrontation of critical situations in the future. Paul and Silas spoke to the keeper of the prison the word of the Lord, "and to all that were in his house" (Acts 16:32).

Two more guidelines may be derived from the passage presented above. The one is to follow up to see whether the suicidal person has recovered and is able to continue a meaningful life. Paul and Silas made a home visit to the keeper of the prison and saw how he had become involved, as he greeted them, "and rejoiced believing in God with all his house" (Acts 16:34). The other guideline is the education of the public at large. Paul and Silas succeeded in this by having their deed recorded in the Bible so that all succeeding generations may learn on matters of suicide prevention.

The Fathers of the Church have also emphasized that suicide is a sin and cannot be condoned. Saint Jean Chrysostome considers suicide a crime worse than murder. He refers to Judas who betrayed Jesus Christ

1 Ιωάννου Χρυσοστόμου Μηνιν Πατρ.Ερ. 61, 618-619.
or the love of money and then, tormented by feelings of guilt and despair, hanged himself.\(^1,2\) The same Father suggests confidence in God's providence as a way to transcend adversities and tribulations and not lose hope.\(^3\) Great Basil stresses the point that God's will and not man's mind sets life's deadlines according to man's spiritual interest.\(^4\)

There are specific Ecclesiastic "Canons" (κανόνες) which prohibit funeral services in the church as well as memorial services for the person who has committed suicide, unless it can be proven that he was mentally ill.\(^5,6\)

More references about the Christian Orthodox position with reference to suicide may be found in Hatzopoulos' doctoral dissertation: Τέ Πρόβλημα τῆς Αὐτοχειρίας (The Problem of Suicide)\(^7\) and in Kapsi's book: Εὐμερετικά Θεολογικά Μελετήματα (Commingled Theological Studies).\(^8\)

The value and the meaning, the rationale, and the spirit for becoming involved in and committed to suicide prevention are found in the Bible:

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1. Ιωάννου Χρυσοστόμου, *"Ομιλία εἰς τὸν Ματθαίου 85η*, Κεφ.20ν, Miγν. Πατρ.Π. 58,760.
2. Άπειροι, 759. "Οδέ γὰρ ἦσσε τὸ συνειδός μας τίζον αὐτὸν."
3. Ιωάννου Χρυσοστόμου, Περὶ Εἰμαρμένης, Miγν. Πατρ.Π. 50, 749.
5. Τιμόθεος Άλεξανδρείας, "Κανών ΙΔ" Εἰς Νικοδήμου Αγιορείτου. Στάλιον. ("Αθήναι: 1970), σ.673.
6. Κων/νος Ράλλης, Καθηγητής τοῦ Ἐκχειρισματικοῦ Δικαίου ἐν τῷ Ἕβρεικῳ Πανεπιστήμῳ, "Αὐτοχειρία" Εἰς Ἐκχειρισματικὸν Δελτίον Ἐκπαιδευτικὸν. Τόμος Β', Λέξεις: "Αὐτοχειρία".
1. Suicide is a sin.

2. No opportunity for repentance exists after death: "And inasmuch as it is appointed for men to die once, and after this comes judgment." As a consequence, the person who commits suicide will be confronted with God's judgment and will endanger his salvation.

3. Jesus Christ is "not willing that any should perish, but that all should come to repentance."  

4. Christian love is the force that urges the faithful to watch over each other for suicide prevention: "Bear ye one another's burdens, and so fulfill the law of Christ." "Look not every man on his own things, but every man also on the things of others." "For the love of Christ constraineth us."

The foregoing beliefs are held by all Greeks sharing the same Faith, and constitute the theme of their discussions in any case of attempted suicide. Greeks tend to become involved in suicide prevention whenever they sense or identify a danger. Suicide prevention in Greece is not uniquely assigned to health professionals unless the potential or the actual attempt is diagnosed in their field of work or it has been brought to their attention by any means. The Church, the family, and the school are equally considered and held morally responsible for educating people on how to deal with critical life circumstances and for giving adequate support -- preventing suicide -- to the suffering person.

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1 Hebrews 9:27.
2 II Peter 3:9.
3 Galatians 6:2.
4 Philippians 2:4.
5 II Corinthians 5:14.
Suicide has not, thus far, been an obvious problem in Greece, in comparison with other countries. The reasons may be:

1. The religious beliefs already mentioned.

2. The religious practices, such as prayer, the divine liturgy, the sacraments of Confession and Holy Communion, which unite the faithful with God, the caring and helping Father, and provide for liberation from guilt and for renewal of the spiritual life orientation.

3. The one common religion through the whole country so that, besides providing human support, people can remind each other of the already known spiritual resources for renewing strength, hope, and faith.

4. The family ties are still strong enough, as well as the ingroup interdependencies and real concern for each other, so that early detection and provision of help may be realized.

5. The expressive and striving Greek character which helps to channel feelings and to try alternative ways of dealing with problems and adversities.

Nevertheless, suicide and particularly attempts do take place, and are increasing as a problem in Greece. Thus, Greek nurses need to acquire all the available knowledge on the subject in order to be able to design and implement preventive as well as therapeutic plans. The aim is, on the one hand, to reduce the suicide rate and, on the other, to inhibit its increase particularly with the materialistic technological advances of the times.

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1 "Εμ.Καλαϊτζάκης,Ιερεύς, "Τό Πρόβλημα τῆς Αὐτοκτονίας στή Χώρα μας."
Συνέντευξις γιά τό Κέντρο Αντιμετώπισης και Προλήψεως Αὐτοκτονιών (Κ.Α.Π.Λ.) στό 'Εθνικόν "Ιπποταμιαίον Καθ. Ιατρείον" στο Κέντρο "Αντιμετώπισης και Προλήψεως Αὐτοκτονιών" (Κ.Α.Π.Λ.), Εκπ. Πληροφορική Χρονικά τῆς Νέων, 19 Νοέμβριος 1974, έδρα Αθήνα.
Suicide prevention—nursing dimensions. Suicide prevention is a dimension of Christian love, a nursing duty, an honorable activity for any society which values, or ought to value, the life of every person.

The nurse's central goal is to reach the suicidal person, who feels helpless, hopeless, and deserted, and to answer the cry for help. Her concern does not focus only on the inhibition of the suicidal act for the extension of life's length, but encompasses also the broadening of life's scope, if possible. She endeavors to assist the person who attempted suicide to widen his perceptual view of his problems and of the availability of choices in his life, to find hope again, to augment and confirm his values and purposes, to recreate himself, to become reinspired.

The most clearly established goals, however, and the best designed plans, cannot ensure prevention of suicide without the personal involvement and commitment of the nurse. Coupled with knowledge from the specialty of suicidology and the other disciplines enlightening the subject, suicide prevention must begin with human sensitivity and alertness. Indeed, sensitivity along with understanding, respecting, and caring, is of paramount importance in suicide prevention because the nurse will act primarily as a person and not merely as a repertoire of principles and predesigned plans.

The following guidelines offer suggestions as to how therapeutic nursing interventions may be planned, keeping in mind that they may have

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to be modified, adapted, and personalized in each particular situation and with each particular suicidal person. Since suicide attempts do not occur only in mental hospitals, but also, and more often, in general hospitals and in the community at large, the suggested guidelines do not fit any particular situation. They are general enough to be used in various settings, wherever the nurse is engaged in suicide prevention.

1. **Assumptions basic to suicide prevention.** Individuals who contemplate suicide still wish very much to be rescued. Suicide prevention depends on the active and forthright behavior of the potential rescuer. Most suicidal persons are conscious of their intention. There are cases where the person is unconsciously inclined toward suicide, but he may nonetheless give indirect clues to his intention.

Practically, all suicidal behaviors stem from a sense of isolation and from feelings of some intolerable emotion on the part of the victim, as he personally sees it. Suicidal action is a decision resulting from a complicated internal debate of many voices, some for life and some for death. In almost all cases, there are prodromal clues.¹

2. **Primary prevention.** Primary prevention with reference to suicide involves the identification of persons with potentially high suicide risk, the development of helping relationships with them, and the planning of methods for the most effective intervention.²

The nurse, working either in a mental hospital or a general hospital, or in community health services of various kinds, is in direct, daily contact with high suicidal risk people. She nurses the mental

¹Shneidman, "Preventing Suicide," pp. 111-112.
patients — hospitalized or discharged — the terminally ill, the unwed mother, the isolated elderly, the widowed or divorced, and many others. She encounters every day persons who experience stressful situations arousing anxiety and leading to depression, and thus to contemplation of suicide. The distress may be connected with their illness — for example, chronic or incurable disease, loss of or severe damage to body parts, imminent death. However, there may be other overwhelming personal problems not directly connected with illness which can induce feelings of hopelessness and lead to suicide.

Beyond the obvious critical life incidents which lead to the identification of the potentially high suicide risk, the nurse must always have in mind that whether or not an individual attempts suicide depends not upon the objectively assessed stressful situation, but upon what the critical event or the catastrophe means to the person. Furthermore, the breaking point varies with each individual, depending on multiple factors operating in the situation. Therefore, the nurse must always be on the alert to seek out the potentially suicidal person, to pick up the communicative clues, and to act on time as an effective helping resource 1 to prevent suicide.

Nursing intervention: psychological first-aid. During the initial stage, time is of the essence. The primary concern is to save the patient's life. An instant later may be too late. The following

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principles may guide the nurse's intervention:

1. Do take seriously every suicidal threat, comment, or act.

2. Don't dismiss a suicidal threat or underestimate its importance.

3. Don't assume that time heals all wounds and everything will get better by itself.¹

4. Be ready to act with dispatch. The aspect of time is important.

5. Be available to listen.

6. Do not judge.²

7. Assure the patient of your interest.

8. Assure him that he is worth saving and his life will be protected.

9. Do not maintain the customary confidentiality between nurse and patient in order to allow yourself the freedom to contact persons who might be helpful to the nursing effort.

10. Provide intensive nursing care and insure its continuity.

Steps in working with suicidal persons. Once the initial phase, which was an emergency situation, has passed, there is still reason for concern, and a therapeutic nursing intervention must be designed to support the patient and invite him to try life again by renewing the sense of meaning, direction, and purpose of his existence.

¹Frederick and Lague, Dealing with the Crisis of Suicide, p. 16.
²Marilyn K. Bodie, "Suicide," Perspectives in Psychiatric Care, 6, 2 (1968), 79.
The following steps may be applied in a nursing intervention with suicidal persons:

1. Establishing a relationship, maintaining contact, and obtaining information.
2. Identification and clarification of the focal problem.
3. Evaluation of the suicidal potential.
4. Assessment of the patient's strengths and resources.
5. Design of a therapeutic nursing plan and mobilization of the patient's and others' resources.

As far as the physical safety measures are concerned, general and mental hospitals usually have definite policies about establishing safe conditions in the physical environment. An example of such safety measures is the policy that patients are asked to swallow their oral medications at the moment of their delivery to them. Still another measure is not to allow weapons to be kept in the closets of the patient's room.

Some hospitals require continuous supervision of the suicidal patient, especially in the initial phase when he struggles with ambivalence as to whether to try to take his life or not. This measure, however, may prove very ineffective if it is applied in a police-like, distant, or clerical manner.

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1Farberow, Heiling, and Litman, Techniques in Crisis Intervention, pp. 3-4.


4Sam M. Heilig, "Training in Suicide Prevention," Bulletin of Suicidology, 6 (Spring 1970), 42.
way, because it may make the patient feel that he is unreliable and untrustworthy, and this hurts his self-esteem. To prevent this latter undesirable effect, observation and protection of the suicidal patient should be provided through companionship, through distracting him and engaging him in constructive activities and contacts, and through intensive nursing care, responding to him as a whole person with a wide gamut of needs, not only the needs for extension of his life. Then the patient may be convinced that life is worth living and his will to live may be reawakened.

Consequently, the most effective and reliable prophylactic measure against suicide is an alert and imaginative nurse who, through developing a positive nurse-patient relationship, becomes aware of the patient's potentialities and of the possible methods of suicide open to the patient, and keeps acutely sensitive to how the patient really feels.²,³,⁴

The need for the involvement of the significant others in the treatment of the suicidal patient is stressed by almost all the authorities in the field. The significant others are almost invariably a part of the total suicide syndrome, and they must be involved as resource persons in the overall treatment plan.²,⁶ Their attitudes may mean the difference between life or death for the suicidal person. If they accept and

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¹ Moreness, Essentials of Psychiatric Nursing, p. 126.
² Manfreda, Psychiatric Nursing, p. 294.
³ Bernard, Manuel de l'Infirmier en Psychiatrie, p. 60.
⁴ Matheney and Topalis, Psychiatric Nursing, p. 239.
⁵ Joseph Richman, "Family Determinants of Suicide Potential," in Anderson and McLean (eds.), Identifying Suicide Potential, p. 34.
⁶ Frederick and Resnik, "Interventions with Suicidal Patients," p. 107.
facilitate communication with the patient, if — even with guidance and encouragement by the nurse or other outsiders — they can be loving and supportive, they may considerably decrease the suicide risk. They cannot be mere gatekeepers but, primarily, inviters to life and lifesavers.

In Greece, the first positive resource of the patient to be mobilized is his family and "in-group" people. Within the in-group — as it has been discussed earlier — the person is expected to be absolutely loyal, to respect and follow the authority figures, to consult about his own affairs, to entrust his personal troubles. Therefore, the Greek nurse appeals to the patient's in-group, which may need guidance and support but which definitely cares about the suicidal person. Another point which should be emphasized is that unless the Greek nurse develops such an interpersonal trust relationship with the patient that she may be considered — on the basis of her genuine concern for the patient's welfare — an in-group person, she cannot help even with the best plan of therapeutic nursing intervention.

As the patient eventually acquires insight to his suicidal tendency and feelings of guilt are experienced, the chaplain of the hospital or of the parish enters the therapeutic plan, invited or on his own initiative after having been informed of the case, to provide for the spiritual support and confession according to the patient's choice.

The nurse should keep in mind that suicide prevention is a multidisciplinary and multidimensional task in which she is called to play only one part, the nursing part.

In case an actual suicide takes place within the hospital by a patient under treatment, anxiety, feelings of guilt, and related conversations prevail among the hospital personnel. An investigation of the
hospital suicide, referred to as "psychological autopsy," is advisable in order to increase understanding of the factors which contribute to suicide, to prevent future suicides under similar conditions, and to alleviate the anxiety of the staff.\(^1\)

As a conclusion, it may be said that every suicide prevention is a dialogue: some person cries for help and someone else should be sensitive to hear, to understand, and to respond. The nurse who commits herself to genuine listening and caring, to respond to the cry for help, may become an inviter to life and a lifesaver.

**Nursing Approach to Physically Ill Elderly with Mental Health and Behavior Problems**

**Physical Illness and Hospitalization:**
**Precipitators of Mental Health and Behavioral Problems**

It is an inescapable fact that old people experience a decline in physical vigor and stamina, a decline in physical fitness, and an increasing experience of body aches and pains.\(^2\) And disease, whenever it occurs, is a handicap in life, an obstacle to success, a suspension of the adventures in life. Sickness always means an interruption.\(^3\)

Illness and hospitalization are significant changes -- though not the only ones -- in the life of the aged. Aging itself is a process of


\(^3\) Tournier, *The Adventure of Living*, p. 102.
change involving all bio-psycho-social and spiritual aspects of the person and influencing subjective experience, behavior, and adaptation. It is considered worthwhile to transcend the façade of chronological age and speculate on what is going on behind it within the human person when ill, calling for nursing understanding and intervention to make a significant contribution.

Illness in old age intensifies and adds to the already existing emotional problems with which the elderly have to cope. Some of these may be loneliness, loss of prestige, retrospection, introversion, insecurity, and loss of a sense of purpose in life. Illness in old age creates further specific problems which require change in many lifelong habits, and costly emotional adjustments. Acceptance of the illness and the limitations imposed by it, as well as acceptance of his prognosis, involve a real struggle which enlists the whole personality of the aged; it tests his endurance of hardships, his level of maturity, his philosophy of life. A long illness, even without pain, exhausts the mind as well as the body and the patient drifts easily into despair. The most common emotional reactions precipitated by illness seem to be anxiety, fear of pain, fear of disability, fear of death, a number of worries about family problems, finances, needed care, and a reduction in self-esteem and dignity.

3 Lewis, The Problem of Pain, p. 156.
When the elderly person becomes ill, he is particularly apprehensive and worried, probably because his security is more profoundly affected by illness than that of a younger person. And even though fear of death is prevalent, many times fear of chronic illness, which immobilizes the body for a prolonged period without prospect of useful recovery, is of even greater magnitude. It is not the limitation of activity which is dreaded as much as "it is the death-in-life of the bed-ridden state of helpless dependence on others that is the specter that haunts those who grow old."¹

Furthermore, the removal of the older person from his accustomed home surroundings and placement in a strange hospital setting produce disruptive stress on him, almost disconnecting his bond with normal existence, taxing his psychological resources, already depleted in many ways, and often precipitating mental health problems.²,³

When the aged person arrives in a hospital, he enters a noisy, busy, and continually changing environment. He may feel disoriented in the new setting because nothing seems to belong to him. There is a reduction in meaningful and familiar stimuli which often leads to mental confusion. His already poor feelings of self-esteem and dignity may be further lowered by being deprived of his own physical and human environment. As a result his attitudes and behaviors are likely to show more

²Tremblay, Soins Psychiatriques, p. 36.
deteriorative qualities and depressive manifestations.\textsuperscript{1,2,3}

Another aspect of hospitalization that constitutes a cause of apprehension in the older patient is the obligation to assume the sick role with all its consequences, such as loss of customary rights, privileges, satisfactions, and the symbols of status. This presents a real problem, especially for the Greek male patient, because he has to assume the dependent role of illness, which is quite different from the role he plays in everyday life. He has usually been independent, deciding for himself and his family, and having a superordinate role \textit{via-r-via} the female role at home.\textsuperscript{4} His self-esteem is highly bruised by hospitalization, which necessitates dependence and conformity to others' decisions, and consequently his reaction to illness is intensified.

In view of the increasing elderly population and subsequently of the health problems of old age, as well as the social changes in Greece because of which elderly people live more and more alone and apart from their children's families, the public health nurse is likely to have to assume the responsibility to seek out the elderly sick and initiate their entrance to the hospital. This is not an easy task. Based on the foregoing information, we need to develop appropriate criteria for responsible primary or shared decision-making when an elderly person in the community needs hospitalization. The nurse should pay sufficient attention to

\begin{itemize}
\item \textsuperscript{1}Maddison, Day, and Leabeater, \textit{Psychiatric Nursing}, p. 323.
\item \textsuperscript{3}Monique Picard, "L'Hospitalisation du Vieillard," \textit{Présences}, 123, 2\textsuperscript{e} trimestre (1973), 17-22.
\item \textsuperscript{4}Κυμίσης. \textit{Διερεύνησε Κοινωνιολογικών Μεταθέσεων περιεχόμενων εις την στις κλινικές θεατησίας}, σ. 37.
\end{itemize}
weighing the pros and cons for the hospitalization of the elderly and be willing and ready to explore alternatives to hospitalization for them.

In the end, if the chosen solution is hospitalization, the goal of nursing intervention should be not only to shield against the mental health problems precipitated by physical illness and the institutional environment, but also to add meaning to the advanced years of life, namely, to promote mental health development.

Separation and Loneliness

Hospitalization in itself is a cause of loneliness. Loneliness is, of course, a paramount resident of our world. It is felt by the young and by the adult, but most of all by the aged. As the years accumulate, loneliness seems to increase. It resides in the hospitals also, where the separation and uncertainty felt by patients are lonely burdens to bear.¹

Modern society is youth-oriented. It seems that there is no longer a place for old age, no reverence and regard for the wisdom and experience of the aged.² Old age is indeed fertile soil for loneliness and very often the fear of a lonely old age outweighs the fear of death in the hearts of many people.

Loneliness is difficult. It makes the courageous timid and the confident unsure. Moreover, when trouble comes — such as sickness and hospitalization — loneliness can turn to despair. The reserves of energy and adaptability are exhausted. Loneliness does not mean simply being alone. It can be felt even in the presence of other people. The

¹J. M. Roberts, "Loneliness is. . .," Perspectives in Psychiatric Care, 10, 5 (December 1972), 226-231.

hospitalized patient often feels lonely even though he is surrounded by people and, at a superficial level, is interacting with them. Loneliness is the awareness of an absence of meaningful integration with other persons, a consciousness of being excluded from the system of opportunities and rewards, in which other individuals participate.\textsuperscript{1}

Particularly vulnerable to feelings of loneliness are persons who have recently lost a loved one, such as one's spouse. In other words, it is loss rather than isolation which has the closer relationship to loneliness. And, indeed, the losses experienced in old age are numerous. The loss of loved ones through death may be the most difficult, because this creates an empty space impossible to refill and this contributes to a growing social isolation and sometimes to intensively felt loneliness.\textsuperscript{2}

The death of other persons may bring forcefully to mind one's own impending and inevitable death.

Every separation is a reminder of death, and it is felt most acutely when one is surrounded by noise and talk.\textsuperscript{3} The hospitalized older patient is surrounded by strange and frightening noises and unintelligible talk which only revive and increase his feeling of aloneness.

With declining physical vigor, the older person has to rely more and more on family and other personal relationships involving reciprocal rights and obligations. The family is the safest refuge for the aged.

\textsuperscript{1}E. Basse and E. Pfeiffer (eds.), "Functional Psychiatric Disorders in Old Age," \textit{Behavior and Adaptation in Late Life} (Boston: Little, Brown and Co., 1969), pp. 183-235.

\textsuperscript{2} Αλιβιζάτος και Λυκέτσος. "Σύγχρονοι Αντιλήψεις και Προοπτικές των Ψυχοκοινωνικών Προβλημάτων της Γεροντικής Ηλικίας." σ.7.

the most important and long-lasting. However, hospitalization separates the patient from those he loves and those who perhaps know him best and can comfort him most. Being denied this accustomed source of warmth and security increases the patient's anxiety and fear. Moreover, the separation from family and close friends raises disturbing questions about the possibility of being forgotten by them and consequently being deserted, which sometimes is equated with "being nobody." And yet, his needs are the same as those common to us all: the need to love and be loved, to be wanted and useful, respected, to feel secure with a sense of belonging, never to feel superfluous, never to lack significance, and never to be without an outlet for the creative urge.

In general, the maintenance of a stable intimate relationship is closely associated with good mental health and high morale. Further, it may serve as a mediating and alleviating factor in the confrontation with age-linked social losses. Social isolation and loneliness play an important part in the genesis of mental disorder in old age. This leads to the conclusion that physical illness may be the crucial antecedent to isolation and mental illness.

In the foregoing perspective, hospitalization of an elderly person is a serious act, especially when it necessitates his transportation to

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3 Wu, Behavior and Illness, p. 70.
another city, away from his home, as is frequently the case for Greek
patients. Every nurse must be aware that loneliness often dwells within
the elderly patients and depletes them of energy and adaptability, and
often forces them to withdraw from life. She also needs to have her
clinical nursing "antennae" sensitized enough to listen to and grasp the
meaning of the silences in her ward. Furthermore, since meaningful rela-
tionships can sustain the mental health of suffering elderly patients and
can assist them to face the challenge of living as a forward step toward
a goal -- not as the death of youth and a farewell to the past -- the nurse
should consider herself as a person, as a resource available for planned
use in creating beneficial nurse-patient relationships. Finally, our
regulation of visiting hours needs revision to allow more freedom to the
visitors of elderly patients, especially when they travel a long distance
just to see them. The rationale will be to maintain the patient's link
with family and friends -- his link with the real world.

Dependency and Regression

We have already discussed the aged person confronted with strength-
weakening and life-threatening illness and his placement in an unfamiliar
and impersonal environment. He feels lost and reduced in terms of self-
estem and personal dignity. His anxiety narrows his field of perception
and distorts his understanding. He withdraws from outside world inter-
ests and becomes preoccupied with himself. He is not sure about what is
expected of him (the "sick role") and what to expect from others --
whether he has any rights left or not, and if so, whether it is all right
to pursue them. Would it be too much to try to find out? And for what
purpose? He doesn't know anybody in the hospital. How can he trust
anyone? Wouldn't it be a risk? He misses his significant home and social
environment by being hospitalized and feels so lonely. His security-seeking tendency drives him to surrender to the illness, with complete dependence on the hospital staff.

Illness and hospitalization force the elderly person to a role of dependence. The dependence is of varied types: he is dependent on the physician who prescribes the treatment, on the medications themselves, on the demands the illness makes upon him, usually involving a complete change of his pattern of living. Moreover, the elderly patient may have to accept dependence on others for personal care which he previously performed unaided. This manifold dependence may create a psychological struggle to give up an independence achieved at great cost throughout life, or it may be welcome in satisfying chronically unmet needs and wishes, or even may be considered as a way of relieving anxiety, fears, tensions, produced by the strange and threatening circumstances.

The need to give up the right to make decisions for his everyday living and for what will be done to him, the physical incapacitation imposed by illness, and the feeling of helplessness and threat to life experienced within an impersonal and unfamiliar environment, all precipitate withdrawal from socially invested interests, self-centeredness, and regression. Regression is "a process of relieving anxiety or escaping stress by falling back upon the thoughts, feelings or behavior that had worked successfully during an earlier period of life." The regressed person appears to define himself as someone younger and reverts from a higher to a lower level of functioning.

1 Kaplan, Education and Mental Health, p. 290.
Regressive behavior is a usual reaction to all illness, whether physical or psychological, and presents an attempt to re-establish one's vital balance. It may range from extreme self-centeredness, self-preoccupation, and excessive dependence upon others for almost every physical and psychological need, to almost complete passivity, isolation, and alienation. Overdependency may be another instance of regression.

The foregoing information supports the idea that dependency and regression may occur not only in old age but also at any other age, depending upon the stressful and threatening situations with which one is confronted, and the resources he has to draw upon to maintain a dynamic psychological equilibrium. Very often, however, such tendencies are observed in elderly hospitalized patients. Even though such traits sometimes are attributed to a degree of mental deterioration, they also prevail among elderly patients who are lucid and alert.

Nursing studies report that abrupt changes in the environment, coupled with frustration of emotional needs such as the need for recognition, respect, love, and the craving for a sense of security and human worth, constitute a threat to the well-being of elderly persons and precipitate — or even cause — regressive behavior. The point is that regression appears to be a functional condition of no fixed pathology, and the product of environment. It is likely to occur more readily under hospital conditions where subtle disintegration of the human personality is allowed to take place following on the chronic bedfast state.


Indeed, aging into senescence and illness take a heavy toll of patients. An elderly person may find that his world has shrunk physically and mentally. He lives from day to day, thinks and talks of the past, shows little concern about the future, has no interest in current events unless they touch him directly, and loses his purpose for and zest in life. Such a situation calls for genuine and purposeful interest in the patient as the person he once was, with special effort to learn about him, his make-up and life pattern, and what and how much is left of all this.

It is true that it takes a great deal of personal motivation, patience, understanding, and fortitude to care for the aged ill, especially those with pronounced regressive tendencies. The issue is: Should the aged ill be treated on an adult basis or like children? The accumulated nursing experience suggests that therapeutic results are possible for almost any elderly patient who is nursed as an adult rather than as a child. If he is treated like a child, he may regress even further than he already has. A child-like treatment may promote the regressive traits themselves, increase dependency, destroy self-reliance, intensify false feelings of helplessness, and undermine any remaining sense of strength, power, and adult dignity.¹

On the contrary, overdependence and regression of the hospitalized elderly patient as a mental health problem may be prevented by skilled nursing care which provides for the aged person to remain someone of significance, whose body and mind are stimulated in useful activity, where courage is always inspired and self-help and independence are

¹Jaeger and Simmons, The Aged Ill, pp. 45-48.
enhanced within the limitations of his health. If the implementation of nursing care of this caliber is sought by nurses, then in the criteria for the evaluation of nursing practices should be included the effect of such care upon the dependency and regression tendencies of the aged ill, as well as on the environmental factors and policies encouraging such tendencies.

The Nurse-Patient "Psycho-Social System": An Eclectic Approach

Illness and hospitalization as potential precipitators of mental health problems such as psychological isolation, loneliness, over-dependence, and regression in aged patients do in fact accelerate their bio-psycho-social atrophy — a feature of growing old.

The issue is: Can a skilled nursing intervention delay or arrest or even reverse this kind of decline taking place in the aged ill? This is indeed a challenging arena for nursing practice.

Nursing studies in clinical settings have shown that individualized nursing intervention may positively affect the orientation status and the achievement of self-care in aged patients. Also, enriched environments in terms of meaningful human relationships may foster positive bio-psycho-social change whereas depriving environments inhibit the development.


In the design of nursing intervention with the aged ill, a primary goal should be to promote the patient's physical, emotional, and interpersonal improvement. To achieve this goal, a nurse-patient interaction is deliberately and skillfully planned and put into function, defined otherwise as a "psycho-social system."¹

The nurse-patient interactional system consists of an interchange of positive human resources such as physical fitness and stamina, drives and motives, feelings, aptitudes, ideas, and skills. This kind of interaction provides the older patient with an opportunity and a stimulus to become again an active, participating, communicating, reality-oriented person — a more effective, more productive, more outgoing, healthier and perhaps happier member of the larger human society.

The nurse functioning in this "psycho-social system" utilizes nursing techniques, communications, and feelings that are related to intimate activities of daily living and that deal specifically with the bio-psycho-social requirements common to all people, in addition to those unique to each individual patient with personal health problems resulting from disease, disability, disordered function, developmental stage or idiosyncrasy. The nurse does not attempt to control and direct, but rather, to respond to requests or offers. Her commitment is to maintain patient-nurse rapport, to reassure the patient, and rebuild his trust and sense of security.

In this nurse-patient psychosocial system, the nurse as a person is a resource available for planned use in the patient's care. Even when she only incidentally provides emotional support for the patient, or

¹Weiss, Nurse, Patients, and Social Systems, pp. 7-10.
offers him suggestions and directions, or merely gives him information, she is employing herself as a resource, with special emphasis on continuing verbal communication. It is her dependable presence with the patient that forms the occasion for the emergence of clinically beneficial human relationships which provide interchanges through which nursing measures, broadly conceived, can be applied in the direction of modification of the older patient's psychosocial atrophy. Since encouragement of human relationships is a central nursing goal, it needs to be emphasized that in order to achieve it, the sheer physical proximity of the nurse and the patient is a basic requirement for interpersonal inclusion and involvement.

Another important requirement is the need to accomplish some continuity of the nurse-patient interaction; in other words, to provide for stability of the psycho-social environment which is essential to the patient's willingness to risk engaging in it. The same nurse must be available to the same patient consistently over a period of time. Even relatively short, but planned and regular, periods of activity with the patient are superior to random nurse-patient contacts, or to spaced contacts with different nurses each time. Some degree of constancy seems to be fundamental to helping the patient maintain his orientation to person, place, and time.

This type of nurse-patient relationship has proved to have singular value in the bio-psycho-social development of patients, and the lack of such care may be a significant factor in the bio-psycho-social atrophy. But such atrophy constitutes a form of degeneration and death.¹

¹Weiss, Nurses, Patients, and Social Systems, p. 117.
It is obvious that the formation of interpersonal relationships with aged patients, as suggested here, requires that the same nurse be assigned regularly to the same patients. How else can the nurse efficiently perceive the patient's natural and social resources and accurately assess those available in his immediate surroundings in order to incorporate them into the evolving plan for care? How else can the patient come to perceive the human resources offered by the nurse and use them? Without constancy of contact, nursing is likely to become custodial and impersonal rather than therapeutic in orientation.

The time has come when nursing can help older patients return to living, by helping them to become more included, involved, and committed to psychosocial interaction, to exercise more control over their social contacts, to employ resources more appropriately, and to develop a more positive emotional attitude toward their interpersonal environment. And the nurse must always remember that most important is the emotional over-tone in the "way" things are done, conveying to her elderly patients inherent warmth, responsiveness, sensitivity, and understanding. Her understanding, "nursing heart" can be their spiritual wonder drug.

Indeed, the nurse can engage whole-heartedly and be successful not only in delaying or arresting but also in reversing the bio-psycho-social atrophy in aged patients — exemplified here by the problems of illness, hospitalization, separation, loneliness, dependence, and regression — when she believes that old age has its unique meaning, when she envisions old age as a passage from the order of doing to the order of being, and a transition from the accidental to the eternal. In this perspective, then, listening to the philosophy of the sages distilled from seventy or eighty
years of living, can be felt as a special reward of relating with elderly patients in an individualized nurse-patient interaction. Furthermore, sharing their present existence as well as their past world and bits of their lonely lives can be sought as a real honor, a great privilege.
In developing a psychiatric nursing textbook for Greece, the cultural dimension was taken into consideration. This is particularly obvious in the areas of family life, in group relations, and in the tradition and religion of Greek people. It is hoped that this approach will amplify the value of its use in caring for the mental health of Greek people. Thus, it is suggested that textbooks encompass the local cultural perspective of the country where they are to be used.

In preparing the textbook, concepts were traced not exclusively in the nursing field but in other fields as well -- i.e., psychiatry, psychology, psychosomatic medicine -- in order to add depth, breadth, and richness to the content as well as to magnify the educational value of the textbook. Nevertheless, nursing textbooks and other writings were consulted extensively. The accumulated nursing knowledge and experience and the nursing projections into the future were acknowledged as a primary source and the most significant thesaurus to be used in developing a nursing textbook. Thus, it is suggested that in developing a nursing textbook, knowledge, experience, and current orientation of the field should be utilized as a basis for new formulations and new syntheses of concepts applicable to nursing situations.

One of the major difficulties confronted in developing the textbook was the scarcity of Greek nursing literature. The author had to search for nursing concepts mostly in nursing writings of other countries and adapt them, as needed, to Greek nursing situations. Thus, it is recommended that Greek nurses become involved in the production of Greek nursing literature in the perspective of the specific culture of the country.
In developing the textbook, the author used a conceptual approach departing from tentative theoretical formulations (since it was a library study) and ending in the application to nursing. It is suggested that future psychiatric nursing studies depart from the nursing activities characteristic of the field, the goals, and the effects of those activities, and hence arrive at the concepts related to the nursing activities. It is further suggested that future nursing studies attempt to test the tentatively formulated concepts and refine their meaning, leading to new insights and understandings which will be used to promote nursing practice.

In preparing the textbook for a specific area of nursing, namely, psychiatric nursing, deliberate emphasis has been placed on the nursing of the whole person as a unique and intrinsically worthy being, to whom all nursing endeavors, either specialized or general, should be addressed. This approach introduced in the health professions first by Hippocrates, speculated by ancient Greek philosophers and inspired strongly by the Christian Faith, has particular relevance in psychiatric nursing. The nurse, in psychiatric settings, in order to fulfill her psychotherapeutic role, should be able to see behind the disease to the whole person who may lose his productiveness but yet retain his dignity and ultimate worth, and thus deserves the most genuine, considerate, personalized, and scientifically sound nursing care. Furthermore, insight from psychiatric nursing may teach and equip the nurse in general settings — medical or surgical; pediatric, adult, or geriatric; intensive care units or chronic patient units — how to counteract the dehumanizing effects of technological automation and bureaucratic routine introduced into the care and treatment of the sick, by personalizing nursing care, namely, by practicing nursing of the whole person and not only of his malfunctioning parts.
or the disease which afflicts him. This was the perspective in which the present textbook was developed. It is suggested that in the development of future planned nursing textbooks, regardless of their focus area, this hallmark be reflected: the nursing of the whole person.
GLOSSARY

Aggression
In psychiatry, physical, verbal, or symbolic, forceful attacking action. It may be realistic and self-protective, or unrealistic and directed either toward the environment or toward self.

Agitation
Psychomotor expression of emotional tension.

Anxiety
Apprehension, tension, or uneasiness stemming from the anticipation of a danger of unrecognized source. Primarily of intrapsychic origin, in distinction to fear which is the emotional response to a consciously recognized and usually external threat.

Autism (Autistic thinking)
Form of thinking without regard for reality. Objective facts are distorted, obscured, or excluded in varying degrees.

Catatonic state
A state of immobility with muscular rigidity and, occasionally, excitability. Catatonic stupor is a state in which the person does not react to his surroundings and appears unaware of them while in reality he is aware.

Catharsis
Therapeutic release of ideas and feelings through talking them out.

Compulsion
An insistent, repetitive urge to perform an act which is against the person's conscious decision. Failure to perform the compulsive act results in mounting anxiety.

Conflict
A struggle between two opposing emotional forces within the same person or between two or more persons. Conflict is fundamental in the etiology of psychological disorders.
Defense mechanisms

Psychological defensive processes operating out of the person's awareness, designed to release anxiety or protect self-esteem. See also "security operations."

Delusion

An untrue belief contrary to the observed facts, resulting from mental illness, and unmodifiable by logical argument.

Dependency needs

Vital infantile needs for mothering, love, and protection, which may continue beyond infancy in overt or covert forms or may be increased in the adult as manifestations of regression.

Depression

In psychiatry, a morbid sadness or melancholy precipitated by feelings of loss or guilt. It may be a symptom of any mental illness — neurosis or psychosis — or the principal manifestation of it, i.e., the depressed phase of manic-depressive psychosis.

Dissociation

A psychological unconscious process through which emotional significance and affect are separated and detached from an idea, situation, or object, for the protection of one's emotional security. See also "repression."

Empathy

An objective and insightful awareness of the feelings, emotions, and behavior of another person and of their significance.

Hallucination

An untrue sensory perception arising on its own, in the absence of a corresponding objective stimulus.

Illusion

Misinterpretation of a real external sensory experience. Usually a symptom of mental illness.

Manic-depressive reaction

A group of psychiatric disorders characterized by mood swings ranging from normal to elation or to depression or alternating. There is a tendency to remission and recurrence. It is considered as a psychosis, but it may also appear in milder forms.
Milieu therapy

Treatment by environment in a hospital setting. Physical surroundings and personnel attitudes are designed to increase the effectiveness of other therapies and foster the patient's recovery.

Obsession

A persistently recurring idea despite the person's wish and accompanied with severe anxiety. It cannot be eliminated by reasoning.

Psychoneurosis

Psychological maladaptation due to unresolved unconscious conflicts. It constitutes one of the two major categories of mental illness, the other being the psychosis. A neurosis usually is less severe than a psychosis because contact with reality and effectiveness in living are only relatively handicapped.

Psychosis

A major mental illness characterized by loss of contact with reality, distorted perception, regressive behavior, loosened self-control, delusions, and hallucinations.

Regression

The retracing of developmental stages moving backward to earlier patterns of reacting and coping with life. It is manifested in a variety of stressful circumstances such as severe physical illness and in many mental illnesses.

Repression

A defense mechanism which keeps out of awareness unacceptable ideas, feelings, or impulses. See also "dissociation."

Schizophrenia

A major psychosis characterized by a withdrawal from reality with delusion formation, hallucinations, emotional disharmony, and regressive behavior.

Security operations

Anti-anxiety psychological operations, employed unconsciously by the personality for the protection of the self-esteem. See also "defense mechanisms."

Selective inattention

One of the security operations. Unconscious overlooking what arouses anxiety and shifting to other non-threatening, impersonal topics, or to safer activities, encompassing usually the element of regression.
Stress

All processes, originating in the external environment or within the person, which impose a demand upon the person requiring primarily psychological confrontation.

Unconscious

In psychiatry, that mental functioning in which thoughts and emotions are out of the person's awareness and yet continue to affect his behavior.

Withdrawal

In psychiatry, a pathological retreat from other persons or from reality, often seen in schizophrenics.
ENGLISH BIBLIOGRAPHY


Bell, Ruth W. "Activity as a Tool in Group Therapy." Perspectives in Psychiatric Care, 8, 2, 1970, 81-91.


Bodie, Marilyn K. "Suicide." Perspectives in Psychiatric Care, 6, 2, 1968, 76-79.


Cormack, D. "Clinical Teaching in a Psychiatric Hospital, I." Nursing Times, 68, 40, October 5, 1972, 1261-1262.


Evangelismos Hospital. "Opening Ceremony for New Wing" (AXEPA Pavilion), Athens, April 5, 1950.

_________. Objectives of the Course of Psychiatric Nursing in the Basic School of Nursing.


Gregg, Dorothy. "The Therapeutic Roles of the Nurse." Perspectives in Psychiatric Care, 1, 1, January-February 1963, 18-20.


———. "Let's Get the Nurse's Role Into Focus." Prism (Published by the American Medical Association), September 1973.

———. "Nature of Intensive Care Nursing." Nursing Clinics of North America, 3, 1, March 1968, 3-6


Larson, Margaret. "From Psychiatric to Psychosocial Nursing." Nursing Outlook, 21, 8, August 1973, 520-523.


Lyketsos, G. "After Care of Chronic Psychotics in a Community Orientated Mental Hospital." Νευρο-Ψυχιατρικά Χρονικά, 1, Δεκέμβριος 1965, 1-8.


"The Subjective and Objective Definition of Crisis." Perspectives in Psychiatric Care, 9, 6, 1971, 257-268.


Migne, J. P. Patrologiae Graecae, Curcus Completus.


—. "Professional Nursing Practice in Acute Care Settings." In National League for Nursing, Challenge to Nursing Education... Professional Nursing Practice. New York: The League, 1972.


Pourrapoulos, G. C. *The Real Value of Medieval Greek Medicine (Byzantium)*. Communication at the 17th International Congress of the History of Medicine, Athens-Kos, 1960, September.


Roberts, J. M. "Loneliness is...." *Perspectives in Psychiatric Care,* 10, 5, December 1972, 226-231.


Rossman, P. L. "Organic Diseases Resembling Functional Disorders." Hospital Medicine, 5, 1969, 72-76.


Wolff, H. Stress and Disease. Springfield, Ill.: Charles Thomas, Publisher, 1953.


Yap, P. M. "Mental Disorders Peculiar to Certain Cultures: A Survey of Comparative Psychiatry." Journal of Mental Science, 97, 1951, 313.

Zaidi, S.M.H. "Reactions to Stress as a Function of the Level of Intelligence." Genetic Psychology Monographs, 62, 1960, 41-104.

ΕΛΛΗΝΙΚΗ ΒΙΒΛΙΟΓΡΑΦΙΑ

Άγιουτάνης, Γ. Καθηγητής Ιατροδικαστικῆς καί Τοξικολογίας τού Πανεπιστημίου Αθηνῶν. "Τὸ Πρόβλημα τῶν Ναρκωτικῶν εἰς τὴν Ἑλλάδα." Κέντρο Ηθικής Κριτικῆς, 1, 2, Απρίλιος 1973, σσ. 119-121.

Άλμπετάσ, Γ. Π. καί Γ.Κ. "Σύνδρομοι καί Προκλητικὲς τῶν Ψυχοκοινωνικῶν Προβλημάτων τῆς Γεροντικῆς Ηθικῆς." Ελληνική Ιατρική. 37, 2, 1968, σσ. 3-9.

Άλτζερινάκου-Χαρατζοπούλου, Σταυρούλα. "Αντιξοότητες περί τῆς Θεραπείας τοῦ Ψυχοπαθούς Φυματικοῦ." Τύποι Τ. Δρουγουλίνου, 1907.

Άποσπασμα τῆς Διαθήκης τῆς Αειμνήστου Βασιλίσσης "Ολγας." Λεύκωμα Πεντήκοντα θεραπευτηρίου 0 Ευπνημός 1884-1954. Αθήναι, 1960.

Άραβαντινός, Α. Ιατρός. Άσκληπιὸν καί Ασκληπιεῖον. Λείψια; Τύποι Β. Δρουγουλίνου, 1959.

Άραβαντινός, Α.Π. "Ψυχική Ορισμότης τοῦ Ανδρόπου. Ηθική τῆς Ιστοτούτου Ιατρικῆς Ψυχολογίας καί Ψυχικῆς Υγιεινῆς." Άθηνα, 1959.


Βασιλικὸν Διάταγμα. 20 Μαρτίου, 1881, Άθηνα.

Βιβλιοθήκη Β. Ελλήνων Πατέρων καί 'Εκκλησιαστικών Συγγραφέων (ΒΕΠΕΣ) Έκδοσις τής Αποστολικής Διακονίας της Ελλάδος.


Γερουλάνος, Μ. Ψυχιάτρος, Φυγιάτες "Επιδράσεις καί Νοσοκόμος Παράγοντων. Άνθινα: Έκδοσεις "Η Δαμασκός" 1964.

Γεωργανδος, Χρ. καί Φλωραν, Α. Στοιχεία Ψυχιατρικής Βάσει των Παραδείσων του Καθηγητού Ι. Πατρικίου, Άνθινα: 1956.


Δαικος, Γ.Κ. "Η Επίδραση της Ψυχικής Κατάστασης είς τον Οργανισμόν." Μελέται του Ινστιτούτου Ιατρικής Ψυχολογίας και Ψυχικής Υγείας. "Η Δραστηριότητα καί η Ψυχή, Νο. 1. Άνθινα: Έκδοσεις "Η Δαμασκός" 1951, σσ.141-152.

Δημητριέβσης, Α. Κ. "Αλέξης." Περιγραφή των Ανεμοθετημένων Κειρογράφων των Εν Και Βιβλιοθήκη της Ομολογίας Αναπτύξεις Υπομονών. Τόμος 1: Τυπικά, Κέρκυρα: 1895.


Δημητρέουλου, Παν. Χ. "Αυτοκτονία." Επιστημονικά και ιατρικά

Δοξιάδης, Σ. Συντονιστής. "Η Πρόληψη Διαταραχών της Ψυχικής
Υγείας." Συζητήσεις Επινόησης Τραπέζης, 10ον
Παιδιατρικόν Συμπόσιον, 5-6 Δεκ. 1970. Ελληνική
Ιατρική. 19,1, Ιανουάριος 1971, σσ.118-139.

ΕΛΛΗΝΙΚΗ ΛΑΕΑΘΗ. Πανηγυρικόν Τεύχος Α' περιεχόμενον είς τήν
ΗΜΕΡΑΝ ΤΗΣ ΛΑΕΑΘΗ. 12 Μαίου 1972, Τεύχος 41, 1972, Αθήναι.

'Επιστημονική Έκθεση τής έν τον Αγίων Αντιπατρίων Νοσοκομείων
Ψυχιατρικής Κλινικής του Πανεπιστημίου Αθηνών.

Εδάγγελος, Τρόφων Ε. "Η Παιδεία εκ Τοροκρατίας" Ελληνικά
Σχολεία από της Αλβανίας μένιν τον Αλλέντον. Σχολή

'Επιμέλεια Νομοδικής τοῦ Βασιλείου τῆς 'Ελλάδος, 'Αριθ. 86.
Νόμος τῆς Β' Φεβρουαρίου 1824. Αθήναι, 18 Δεκεμβρίου
1826.

'Επιμέλεια Νομοθετικοῦ Διάταγμα 104/
20 Διανομή της Περί Ψυχικής Υγείας και
Περιθαλψίων των Ψυχικών Παιδιών.
Αθήναι, 16 Δεκεμβρίου 1973, σσ.1620-1621.

'Εκδότης, Διαβάζεται Δ. 'Η Χριστιανική "Ανάπτυξις
Α' Διακόσμησις διά τούν Αιώνων. Αθήναι: Βιβλιοθήκη
"Ακαδημική Διακοπή, Η' 17, 1949.

'Εκδότης, Γεωργίου, Ε. "Η Αναπηρία δέν είναι Νόσημα Αλλά
Τρόπος Ζωής." Τό Αριστοφάνης Παιδί.
Αθήναι, "Ετος Α', 4-6, Μάιος-Τούλιος 1958, σσ.25-27.

'Ερωτισμοῦ Χ. Συμμετεχόντα Α' και Ρουτσόγλου Α'. "Αποκατάσταση
Σχολείαν Της Ψυχοθεραπευτικής "Αξιολογήσεως Ομάδων
Ανθρώπων Νευρικών." Ελληνική Ιατρική. Α/36, 9, Ιούνιος
1969, σσ.641-656.

'Ερωτισμοῦ Χ. και Ρουτσόγλου Α'. "Ελληνικά Τοποθετήσεις
Φοιτητών έναντι των Αντικοινωνικών "Ανηλίκων
Συγκριτικά πρός "Αλλάς "Ομάδας," Ελληνική Ιατρική.
Β/38, Αίγους 1969, σσ.940-951.

Καζαμίας, Ν., Κουκουρίδου, Ε. Η "Ψυχολογική διά Συλλογικού Ειδώλου Ψυχοθεραπείας" του "Ομάδος" (Transactional Group Therapy), Επί Προσκυνημένης Έκθεσης "Μελίκας Ασθενών," Ηνερο-Ψυχιατρική Χρονική, 6, 1, Μάρτιος 1969, σσ. 34-45.

Καλαϊτζάκης, Ε. "Αμεσή Δράση κατά των Αυτοκτονιών." Έπικαιρα, 310, 11 Ιουλίου 1974, σσ. 48-49.


Κωναράκης, Ιωάννης Κ. "Η Νεύρωσις κατά την Ποιμαντικήν Θεολογίαν. Διατριβή επί Υφηγεσία. Θεσσαλονίκη: 1966.


Κυμίσης, Παντελής Ί. "Ανθρωπισμός κατά τον 'Ιωάννην Κοινωνιολογικάν Μεταβλητών Υπερτροφομένων είς τήν επ. Ηλιογένη επ. Ηλιογένην Υπερτροφή επί Διδακτορία. Αθήνα: 1972.


"Οργανισμός Νοσοκομείων Παιδιατρική έν το τη Αθήνα από 23.1.1875 καί "Εισαγωγικός Διαγωνισμός στούν από 5.2.1875.


Παπακωνσταντίνου, Νικολάος. "Γενική Φυχιατρική Κατανάλωση των Ενδοοιχογενειακών Προβλημάτων." "Ελληνική Ιατρική 5/37, 10, Οκτώβριος 1968, σσ.1485-1496.


Παναγιωτίδης, ΙΩΑΝΝΗΣ."Η Συμβολή της Διπλωματίας της Αδελφής εις τήν Προαγωγήν της "Υγείας." "Ομιλία από Ραδιοφώνου Δημοσιεύθετα εις Περιοδικόν ΕΛΛΗΝΙΣ ΑΔΕΛΦΗ.. 41, Ιούνιος 1972, σσ.4-6.

"Περί του 'Ορκου καί Γενικότερου περί του Ορκου των "Ιατρών. "Ανέτυπον εκ του Περιοδικού ΠΠΟΚΡΑΤΕΣ. 1, 2, Σεπτ.-"Οκτώβριον 1972, σσ.97-111.

Ραγιά, Αφροδίτη Ἱ. Σημειώσεις Ψυχιατρικής Νοσηλευτικής. Αθήνα: 1968.


Ρασιδάκης, Ν. Κ. Στοιχεία Ψυχιατρικής. Αθήνα: 1967.


Σαμοθράκης, Α. Χ. "Αδελφότητος Κομητέων 1748-1833." Ελληνική Ιατρική, 7, 7, Ιούλιος 1933, σσ. 695-719.

Σιφναίος, Π. "Ο Ρόλος του Εκκλησιαστικού Δικαίου κατά του "Εργασιάν." Σεμινάριον Οικονομικής Οικονομίας, 1, 3, 1962, σσ. 223-224.

Σκούρας, Φ. Σύγχρονος Ψυχιατρικής. Αθήνα: Εκδόσεις Α. Καραβία, 1952.


Τσόμης, Δημήτριος Γ. "Η Προλογολογία των Μεγάλων Βασιλείων. Θεσσαλονίκη: Άγνηθον Βασιλικών Ερευνών, 1970.

Τσιτουρίδου-Χαραβίδα, Α. Παπαμικρούλη, Σ. και Αρχετής-Ταυλερίδου, Δ. "Η Πολιτική δυνατότητα της Ελλάδας." Ραδιοφωνικόν Συμπόσιον 16ης Μαΐου 1972, Δημοσιευθέν εις Περιοδικόν ΕΡΤ. 41, Ιούνιος 1972, σσ. 11-12.


Δυναμική Ψυχιατρική. Αθήνα, Εκδόσεις Α.Καράβια, 1971.


Χαροκόπους, Δ.Ε. "Πρός Νέους Ορίζοντα." Μελέται "Ινστιτούτου Ιατρικές Ψυχολογίας καί Ψυχικής "Υγείας," "Η Αρρώστεια καί Η Υγεία." Νο. 1. Αθήναι Εκδόσεις "Η Δαμασκός" 1951, σσ. 100-114.

Χατζηαποστόλου, Ε. καί Φατούρου, Μ. "'Υπερπροστασία καί Συναισθηματική Άποστέρηση τού Παιδιού." Χατζή, Παιδιατρική Εταιρεία Εορτή της Ελλάδος, σον Παιδιατρικόν Συμπόσιον Θεσσαλονίκης, 1974, Ιούνιος, σσ. 4-5.

APPENDIX A

THE NATURE AND USE OF CONCEPTS

A concept is "An idea or thought, especially a generalized idea of a class of objects; abstract notion." (Webster's New World Dictionary of the American Language, Second ed.; New York: The World Publishing Co., 1970.)

"Conceptions are guiding principles of inquiry, not its immediate fruit." (Joseph J. Schwab, "The Concept of the Structure of a Discipline," The Educational Record, 43, July 1962, 198.)

"Concepts have dimensions... In their development [they] 'move' along various lines of change... Changes occur in their implications, relationships, ramifications, transferability, and figurativeness... What should be sought through teaching, at least in the case of essential concepts, is steady progress toward greater fullness of meaning... in an ever widening variety of new concepts." (National Society for the Study of Education, 49th Yearbook, Part I: Learning and Instruction, Chicago: The University of Chicago Press, 1950, pp. 107, 112, 117.)

"Because it is not possible to describe and prepare for every situation in which the future practitioner may find himself, concepts are the most valuable mode for the acquisition, organization, and utilization
of information he will need." (Alice Crowther Boehret, "Analysis of
Four Concepts of Nursing Care," unpublished Ed.D. dissertation, Teachers
College, Columbia University, 1972, p. 21.)

"Concepts can serve as a broad foundation for the generic educa-
tional preparation of a nurse practitioner. As new facts become known,
the practitioner can integrate new information by subsuming the facts
under the general concepts. . . . Concepts offer a way of thinking. . . .
[They] lend flexibility in the process of structuring knowledge for
teaching, for use in practice, and for generating hypotheses for research."
(Imogene King, "A Conceptual Frame of Reference for Nursing," Nursing
Research, 17, 1, January-February, 1968, 27, 30.)
APPENDIX B

REPRESENTATIVE CONCEPTS PREVAILING IN THE LITERATURE REVIEWED

Mental Health
Mental Illness
Behavior
Communication
Stress
Anxiety
Crisis
Family
Prevention of Mental Illness
Community Mental Health
Nursing Care of the Mental Patient
Rehabilitation
The Concept of Psychosomatic Illness
The Patient as a Whole Person
Suffering
Classification of Mental Illness
Personality Development
Mental Retardation
Learning
Legal Aspects of Psychiatric Nursing
APPENDIX C

CONCEPTS NOT PRESENTED IN THE TEXTBOOK - RATIONALE

The following concepts are not presented in this textbook for the accompanying reasons:

Mental Illness: The classification of mental illness, as taught in a specific course of general psychiatry by a psychiatrist and as presented in books of basic psychiatry to the use of which nursing students are guided.

Personality Development: The concepts of personality development, of mental retardation, and of learning, as taught in the course of general psychology given by a psychologist and as analyzed in basic books of general psychology used by nursing students.

Legal Aspects of Psychiatric Nursing: The concept of legal aspects of psychiatric nursing, as incorporated in a separate course, "Legal Aspects in Nursing."
APPENDIX D

INSCRIPTION ON THE FOUNDATION STONE OF EVANGELISMOS HOSPITAL,

ATHENS, GREECE

ΓΕΩΡΓΙΟΣ Α'
ΒΑΣΙΛΕΥΣ ΤΩΝ ΕΛΛΗΝΩΝ
ΚΑΤΕΘΗΚΕΝ ΕΝ ΕΤΕΙ ΑΩΠΑ' ΚΑΙ ΜΗΝΙ ΜΛΡΤΙΩ
ΗΜΕΡΑ ΕΙΚΟΣΤΗ ΠΕΜΠΤΟΙ ΤΟΝ ΘΕΜΕΛΙΟΝ ΑΙ-
ΘΟΝ ΤΟΥ ΘΕΡΑΠΕΥΤΗΡΙΟΥ ΤΟΥΤΟΥ ΙΔΡΥΜΕ-
ΝΟΥ ΥΠΟ ΤΗΝ ΠΡΟΣΤΑΣΙΑΝ ΤΗΣ ΒΑΣΙΛΙΣ-
ΣΗΣ ΟΛΓΑΣ ΠΟΘΟΥΣΗ ΤΗΝ ΠΑΙΔΕΥΣΙΝ ΓΥΝΑΙ-
ΚΩΝ ΤΕΤΑΓΜΕΝΩΝ ΕΙΣ ΝΟΣΗΛΕΙΑΝ ΑΣΘΕΝΩΝ.

GEORGE A'
KING OF GREEKS

LAID ON THE TWENTY-FIFTH OF MARCH 1881
THE FOUNDATION STONE OF THIS HOSPITAL
ESTABLISHED UNDER THE PATRONAGE OF THE
QUEEN OLGA LONGING FOR THE EDUCATION
OF WOMEN COMMITTED TO NURSING THE SICK

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1 Λεύκωμα Πεντηχονετήρου Θεραπευτηρίου "Ο Εὖαγγελισμός" 1884-1934 ("Αθήναι - "Ανάγνωση" 1934) σ.56.
APPENDIX E

EXTRACT FROM THE WILL OF THE LATE QUEEN OLGA

ΑΠΟΣΠΑΣΜΑ ΤΗΣ ΔΙΑΘΗΚΗΣ ΤΗΣ ΑΕΙΜΝΗΣΤΟΥ ΒΑΣΙΛΙΣΣΗΣ ΟΛΓΑΣ

EXTRACT FROM THE WILL OF THE LATE QUEEN OLGA

"The generous contributions made by benefactors, and my effort for many years have aimed at these: that this sacred institution, which truly has risen to a level that reflects honour on our country, be saved, and that it should continue in its main and original object, as ideal of my soul, that Evangelismos should become one day the ideal nursery to train nurses to become Greek Sisters of Charity, who would go out to every part of Greece, to provide perfect assistance to the sick, and relief and consolation to every aching and suffering soul.

"My soul will rejoice from heaven in the fulfillment of this task, and my heartfelt wishes will accompany its blessed success.

"I write in Athens on February 15, 1922."

OLGA

1 Evangelismos Hospital, "Opening Ceremony for New Wing" (AXEPĂ Pavilion), Athens, April 5, 1950.