People suffering mental disorder nursing essay

Introduction

Auditory hallucinations for some people suffering mental disorder are frequently experienced as alien and under the influence of some external force. These are often experienced as voices that are distressing to the individual and can cause social withdrawal and isolation. Although auditory hallucinations are linked with major mental illnesses such as schizophrenia, it also occurs in people who have not been diagnosed with any mental illness (Coffey and Hewitt 2008). The annual incidence is estimated between 4-5 percent (Tien 1991), with those experiencing voices at least once, estimated between 10-25 percent (Slade & Bentall 1988). The standard professional response to voice hearing has been to label it as characteristic of illness and to prescribe anti-psychotic medication (Leudar & Thomas 2000). However, Romme and Escher (1993) view the hearing of voices as not simply an individual's psychological experience, but as an interaction, reflecting the nature of the individual's relationship with his or her own social environment. In this way, voices are interpreted as being linked to past or present experiences and the emphasis is on accepting the existence of the voices. However, the cause of schizophrenia is unknown; most experts deem that the condition is caused by a combination of genetic and environmental factors (Szas, 1988).

This dissertation will aim to discuss the experience and management of auditory hallucinations in schizophrenia looking into therapeutic relationship, helping approaches, and working towards the ending of a therapeutic relationship discussing discharge.

First chapter will aim to explain what schizophrenia is, the cause of schizophrenia, its symptoms and types with particular focus on auditory hallucinations. The chapter will then discuss what auditory hallucinations are in the diagnosis.

Therapeutic relationship between service user and the nurse is paramount in mental health nursing and is seen to prove long term outcome such as social functioning (Svensson and Hansson 1999). Chapter two will aim to discuss the building of therapeutic relationship in the management of auditory hallucinations using Peplau's interpersonal relations model (1952).

The importance of holistic assessment using a variety of tools, scales and questionnaires that will identify symptoms, risks, management of risk and address the service users needs will be discuss in chapter three.

Chapter four of this dissertation will discuss helping approaches. Gray et al (2003) states that pharmacological and psychosocial interventions have been heavily researched to find the most up to date literature and recommendations for the management of auditory hallucinations in schizophrenia with medication and Cognitive Behavioural Therapy (CBT)..
The final chapter will aim to discuss the ending of the therapeutic relationship between the nurse and the service user looking into discharge planning process and conclusion.

Chapter one

What is Schizophrenia and Auditory Hallucinations?

Introduction to chosen topic

Schizophrenia is one of the terms used to describe a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behaviour. Individuals who develop schizophrenia will each have their own unique combination of symptoms and experiences, the precise pattern of which will be influenced by their particular circumstances (NICE 2010).

Allen et al (2010) define schizophrenia as a chronic and seriously disabling brain disorder that produces significant residual cognitive, functional and social deficits. Schizophrenia is considered the most disabling of all mental disorders (Mueser and McGurk, 2004), it occurs in about 1% of the world population, or more than 20 million people worldwide (Silverstein et al., 2006).

The DSM -IV – TR (American Association of Psychiatry (APA) 2000) defines schizophrenia as a persistent, often chronic and usually serious mental disorder affecting a variety of aspects of behaviour, thinking, and emotion. Patients with delusions or hallucinations may be described as psychotic. However, Tucker (1998) argues that the system of classification developed by the DSM-IV does not actually fit many patients as a whole; the syndromes outlined in DSM-IV are free standing descriptions of symptoms. He said unlike diagnoses of diseases in the rest of medicine, psychiatric diagnoses

still have no proven link to causes and cures; Tucker argues that there is no identified etiological agents for psychiatric disorders.

Schizophrenia is characterized by clusters of positive symptoms (e. g. hallucinations, delusions, and/or catatonia), negative symptoms (e. g. apathy, flat feet, social withdrawal, loss of feelings, lack of motivation and/or poverty of speech), and disorganized symptoms (e. g. formal thought disorder and/or bizarre behaviours). In addition, individuals with schizophrenia often experience substantial cognitive deficits including loss of executive function, as well as social dysfunction (Allen et al., 2010). It is estimated that nearly 75% of people with schizophrenia suffer with auditory hallucinations (Ford et al., 2009).

It is suggested that one of the many symptoms of this disorder is hallucinations. It is put forward that hallucinations takes place when a person experiences a sensation in any form of sensory modality when there is nothing or nobody there to account for it (Green, 2009). There are several types of hallucinations olfactory, tactile, gustatory, cenesthetic, kinesthetic, visual and auditory (Kasper, 2003).

One of many forms of hallucinations is an olfactory hallucination, which relates to smells or odours. They can be particular scents like urine, or involve more general odours like a rotting smell (Blom and Sommer, 2011). Another is a tactile hallucination, which is characterised by a feeling of skin sensations, such as bugs crawling on arms and legs or electric shocks. This type of hallucination is rare in schizophrenia (Vidbeck, 2010). A different form of hallucination is a gustatory hallucination, these are concerning taste,

were the sufferer either has specific taste in the mouth or a food tastes like something else (Campbell, 2009).

In addition there are also cenesthetic hallucinations, which are when the sufferer feels the physical functions that are ordinarily imperceptible like signals going to and from the brain (Sadock and Sadock, 2008). A further different form of hallucination is a kinesthetic hallucination, this is when a sufferer is motionless but reports that their body is moving, for instance floating off the ground, bed or chair (Thornhill, 2011). More commonly reported experiences are visual hallucinations which are when somebody sees something that is not there. Such as a person, object or commonly flashing lights (Kaufman, 2011). A further form of hallucination is an auditory hallucination; this is when a person experiences a sensation where they believe they can hear voices or noises. Sometimes these voices can be commanding and make the person suffering from the hallucination do things that are generally out of character (Joppich, 2009).

The focus of this dissertation is the management of auditory hallucination in schizophrenia for more on schizophrenia see appendix 1.

Auditory hallucinations in diagnosis

Auditory hallucinations are often considered symptomatic of people diagnosed as suffering from schizophrenia (Millham and Easton, 1998). The American Association of Psychiatry (APA 1994, p. 767) defines hallucinations as " a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Auditory hallucinations range from muffled sounds to

complete conversations and can be experienced as coming either from within or from outside ones self (Nayani & David, 1996). However, Stanghellini and Cutting (2003) argue that APA definition of hallucinations is false, they believe an auditory hallucination is not a false perception of sound but is a disorder of self consciousness that becomes conscious. Hearing voices is not only linked to a person's inner experience but can reflect a person's relationship with their own past and present experiences (Romme and Escher, 1996). Beyerstein (1996) suggests that voices are anything that prompts a move from word based thinking to imagistic or pictorial thinking predisposes a person to hallucinating.

Auditory hallucinations, or hearing sounds or voices are the most common and occur in nearly 75 percent of individuals diagnosed with schizophrenia (Ford et al., 2009). Auditory hallucinations are often derogatory or persecutory in nature, and can be heard in the third person, as a running commentary, or as audible thoughts. Some individuals with schizophrenia also experience useful or positive voices that give advice, encourage, remind, and help make decisions, or assist the person in their daily activities (Jenner et al., 2008).

Voice hearers can work with their voices and either choose what to listen to or can completely ignore them (Romme et al., 1992). Sorrell et al (2009) states that some individuals experience positive voices which do not affect the way they function or go about their daily living, these hearers also find that their voices may offer advice and guidance. The hearer's voice can be reported as a little distressful or some go on to report no distress at all (Honig et al., 1998). However Nayani and David (1996) argues that

individuals who experience a constant negative voice found them difficult to control, they found the voice more powerful and attempt to ignore the voice often fail. Chadwick et al (2005) said that those who resist voices or feel the need to argue or shout back are seen as harmful/evil(exhibiting ill will), those who think voices are good and engage with them are seen as kind , they see voices are helping them so they tend to listen and follow advice.

Not all auditory hallucinations are associated with mental illness, and studies show that 10 to 40 percent of people without a psychiatric illness report hallucinatory experiences in the auditory modality (Ohayon, 2000). A range of organic brain disorders is also associated with hallucinations, including temporal lobe epilepsy; delirium; dementia; focal brain lesions; neuro-infections, such as viral encephalitis; and cerebral tumours intoxication or withdrawal from substances such alcohol, cocaine, and amphetamines is also associated with auditory hallucinations (Fricchione et al., 1995)

There is also evidence that delusion formation may distinguish psychotic disorders from non clinical hallucinatory experiences. In other words, the development of delusions in people with auditory hallucinations significantly increases the risk of psychosis when compared with individuals who have hallucinations but not delusions. Auditory hallucinations may be experienced as coming through the ears, in the mind, on the surface of the body, or anywhere in external space. The frequency can range from low (once a month or less) to continuously all day long. Loudness also varies, from whispers to shouts. The intensity and frequency of symptoms fluctuate during the illness, but the factor that determines whether auditory

hallucinations are a central feature of the clinical picture is the degree of interference with activities and mental functions (Waters, 2010)

The most common type of auditory hallucinations in psychiatric illness consists of voices. Voices may be male or female, and with intonations and accents that typically differ from those of the patient. Persons who have auditory hallucinations usually hear more than one voice, and these are sometimes recognized as belonging to someone who is familiar (such as a neighbour, family member or TV personality) or to an imaginary character (God, the devil, an angel). Verbal hallucinations may comprise full sentences, but single words are more often reported. Voices that comment on or discuss the individual's behaviour and that refer to the patient in the third person were thought to be first-rank symptoms and of diagnostic significance for schizophrenia (Schneider, 1959). Studies show that approximately half of patients with schizophrenia experience these symptoms (Waters, 2010).

Waters (2010) says a significant proportion of patients also experience non verbal hallucinations, such as music, tapping, or animal sounds, although these experiences are frequently overlooked in auditory hallucinations research. Another type of hallucination includes the experience of functional hallucinations, in which the person experiences auditory hallucinations simultaneously through another real noise (e. g., a person may perceive auditory hallucinations only when he hears a car engine). The content of voices varies between individuals. Often the voices have a negative and malicious content. They might speak to the patient in a derogatory or insulting manner or give commands to perform an unacceptable behaviour. The experience of negative voices causes considerable distress. However, a

significant proportion of voices are pleasant and positive, and some individuals report feelings of loss when the treatment causes the voices to disappear (Copolov et al., 2004).

The exact processes that underlie auditory hallucinations remain largely unknown. There are two principal avenues of research: one focuses on neuro anatomical networks using techniques such as positron emission tomography and functional Magnetic Resonance Imaging (MRI). The other focuses on cognitive and psychological processes and the exploration of mental events involved in auditory hallucinations. A common formulation suggests that auditory verbal hallucinations represent an impairment in language processing and, particularly, inner speech processes, whereby the internal and silent dialogue that healthy people engage in is no longer interpreted as coming from the self but instead as having an external alien origin. There is support for this language hypothesis of auditory hallucinations from neuro imaging studies. These show that the experience of auditory hallucinations engages brain regions, such as the primary auditory cortex and broca area, which are associated with language comprehension and production. This suggests that hallucinatory experiences are associated with listening to external speech in the absence of external sounds (Waters, 2010)

Frith (2005) says the reason these experiences are not perceived as self-generated facts is that individuals who have the hallucinations fail to distinguish between internal and external events. This arises because of deficits in internal self-monitoring mechanisms that compare the expected with the actual sensations that arise from the patient's intentions. This

abnormality also applies to inner speech processes and leads to the misclassification of internal events as external and misattribution to an external agent. However, Bentall and Slade (1985) suggest that individuals with hallucinations use a different set of judgment criteria from healthy people when deciding whether an event is real, and they are more willing to accept that a perceptual experience is true. This bias essentially involves a greater willingness to believe that an event is real on the basis of less evidence.

According to the context memory hypothesis of auditory hallucinations, the failure to identify events as self-generated arises because of specific deficits in episodic memory for remembering the details associated with particular past memory events. These specific deficits in memory cause confusion about the origins of the experience (Nayani and David, 1996). Patients with auditory hallucinations tend to misidentify the origins and source of stimuli during ongoing events and during memory events (Waters et al., 2006). The lack of voluntary control over the experience is a key feature of auditory hallucinations, which might explain why self-generated inner speech is classified as external in origin (Copolov et al., 2003). Hallucinations are experienced when verbal thoughts are unintended and unwanted. Because deficits in cognitive processes, such as inhibitory control, are thought to render people more susceptible to intrusive and recurrent unwanted thoughts, studies have linked auditory hallucinations with deficits in cognitive inhibition (Waters et al., 2006).

Recent advances in the neurosciences provide clues to why patients report an auditory experience in the absence of any perceptual input. Spontaneous

activity in the early sensory cortices may in fact form the basis for the original signal. Early neuronal computation systems are known to interpret this activity and engage in decision-making processes to determine whether a percept has been detected. A brain system that is abnormally tuned in to internal acoustic experiences may therefore report an auditory perception in the absence of any external sound (Deco and Romo, 2008). Ford et al., (2009) suggested that patients with auditory hallucinations may have excessive attentional focus toward internally generated events: the brains of persons who have auditory hallucinations may therefore be over interpreting spontaneous sensory activity that is largely ignored in healthy brains.

Patients suffering from auditory hallucinations sometimes can not distinguish between what is real and what is not real, it is very important to build a trusting therapeutic relationship with the sufferer. This dissertation will go on to explore the importance of building a therapeutic relationship with a patient; To explore the extent of auditory hallucinations a patient may be experiencing it is important that an appropriate assessment and risk management are carried out, exploring the need for assessment and risk management in auditory hallucinations, It will also look into helping approaches discussing pharmacological and psychosocial approaches in the management of auditory hallucinations and how to end the therapeutic relationship between a service user and the nurse, looking into discharge planning.

CHAPTER TWO

DEVELOPMENT OF THERAPEUTIC RELATIONSHIP

Development of the Therapeutic Relationship

Peplau's theories laid the ground for ascendancy of the relationship as the key context for all subsequent interventions with patients (Ryan & Brooks, 2000). Although the idea of the relationship endures as the paradigm for psychiatric nursing (Barker, Jackson, & Stevenson, 1999a; 1999b; Krauss, 2000; Raingruber, 2003), it does not appear there is any universal consensus on exactly how to frame this relationship. The nurse-patient relationship can be defined as an" ongoing, meaningful communication that fosters honesty, humility, and mutual respect and is based on a negotiated partnership between the patient and the practitioner" (Krauss, 2000, p. 49).

Peplau describes nursing as a therapeutic interpersonal process that aims to identify problems and how to relate to them (Peterson and Bredow 2009). Forster (2001) defines therapeutic relationship as a trusting relationship developed by two or more individuals. However, Jukes and Aldridge (2006) says at first sight therapeutic nursing and the therapeutic relationship may seem relatively easy to define, but once we scrape the surface we find a complex range of ideas and concepts that stem from philosophies, ideologies and individual therapies. Sometimes there are difficulties in applying these definitions to our own work. Not least of these difficulties is the relevance of the concept of ' therapy as healing' to nursing. This begs the question of whether a therapeutic relationship always entails the use of a therapy, or whether there is something more universal and fundamental in therapeutic relationships. It seems important therefore to attempt a workable definition

of the therapeutic relationship that has currency within nursing as a whole. Additionally, it seems that therapeutic nursing has two facets. The first of these, and probably the most apparent, is the emotional and interpersonal aspect, which we might call ' therapeutic nursing as an art'. The second is the more logical and objective aspect, which we might call ' The therapeutic nursing as a science'. Arguably, there is a synergy between the two that leads to a gestalt, and therefore a need to address both aspects if our nursing is to be truly therapeutic in a holistic sense.

Peplau's theory focuses on the nurse, the patient and the relationship between them and is aimed at using interpersonal skills to develop trust and security within the nurse-patient relationship. Therapeutic relationships are the corner stone of nursing practice with people who are experiencing threats to their health, including but not restricted to those people with mental illness (Reynolds 2003). The relationship of one to one of nurse – patient has potential to influence positive outcome for patients. Hildegard Peplau interpersonal relations overlap over four phases namely: Orientation, Identification, Exploitation and Resolution.

Peplau also identify that during the four overlapping phases nurses adopts many roles such as- Resource person: giving specific needed information that aids the patient to understand his/her problem and their new situation. A nurse may function in a counselling relationship, listening to the patient as he/she reviews events that led up to hospitalization and feeling connected with them. The patient may cast the nurse into roles such as surrogate for mother, father, sibling, in which the nurse aids the patient by permitting him/her to re-enact and examine generically older feelings generated in prior

relationships. The nurse also functions as a technical expert who understands various professional devices and can manipulate them with skill and discrimination in the interest of the patient (Clay 1988).

The orientation phase is the initial phase of the relationship where the nurse and the patient get to know each other. The patient begins to trust the nurse. This phase is sometimes called the stranger phase because the nurse and the patient are strangers to each other (Reynolds 2003).

Peplau's (1952) suggest that during this phase early levels of trust are developed and roles and expectation begin to be understood. It is important that during this time that the nurse builds a relationship with the patient by gaining their trust, establishing a therapeutic environment, developing rapport and a level of communication expectable to both the patient and the nurse. During the orientation phase trust and security is supposed to be developed between the nurse and the patient.

Co-ordination of care and treatment of patient while using an effective communication between the MDT is a nurse role. The nurse also acts as an advocate/surrogate for a patient and promotes recovery and self belief. Essential communication skills are deemed to be listening and attending, empathy, information giving and support in the context of a therapeutic relationship (Bach and Grant 2009). Building a therapeutic relationship needs to focus on patient -centred rather than nurse-task focus.

Bach and Grant (2009) say interpersonal relationship describes the connection between two or more people or groups and their involvement with one another, especially as regards the way they behave towards and

feels about one another. Communication is to exchange information between people by means of speaking, writing or using a common system of signs or behaviour. Faulkner (1998) suggested that Rogers (1961) client centred approach conditions can be seen as important factors that contributes to a therapeutic relationship. Rogers (1961) three core conditions are: congruence, empathy and unconditional positive regards.

Congruence means that the nurse should be open and genuine about feelings towards their patient. Having the ability to empathise with the patient would show that the nurse has the ability to understand the patient's thoughts and feelings about their current problem. Unconditional positive regards is viewing them as a person and focusing on positive attributes and behaviour (Forster 2001). The orientation phase also gives the nurse the chance to asses the patient's current health and once the assessment has been carried out the can then move the relationship forward to the identification phase. The identification phase is where the patient's needs are identified through various assessment tools. Assessment will be discussed in detail in the next chapter. Butterworth (1994; DH 1994a; DH 2006a) says that during the identification phase the nurse and the patient will both work together discussing the patient's identified needs, needs that can be met and those that cannot be met. They will also identify risks and how to manage the risks and aim to formulate a care plan. Butterworth said the care plan should focused on the patient's individual needs, long and short term goals and their wishes, whilst being empowered at all times to make informed decisions and choices that matter in their care.

Collaborative working between multi-agencies ensures the needs of the patient are being met through appropriate assessment and treatment under the Care and Treatment Plan (CTP). The Care and Treatment Plan is one of a number of new rights delivered by the Mental Health (Wales) Measure (2010). The Measure also gives people who have been discharged from secondary mental health services the right to make a self referral back for assessment and it extends the right to an Independent Mental Health Advocate to all in-patients. A care co-ordinator must ensure that a care and treatment plan which records all of the outcomes which the provision of mental health services are designed to achieve for a relevant patient is completed in writing in the form set out (Hafal, 2012).

The Sainsbury Centre for Mental Health (Rose 2001) found that patients are often not involved in the care planning process and many service users were not even aware of having a care plan.

The exploitation phase is where interventions are implemented from the needs and goals set out in the identification phase which enables the service user to move forward, these interventions will assist in managing auditory hallucinations, whilst educating the patient and family members about the illness. Helping approaches will be discussed in detail in the next chapter looking at various up to date interventions available for the management of auditory hallucinations.

A trusting relationship can help with recovery and during these interlocking phases is what the nurse and the patient are aiming for (Hewitt and Coffey, 2005). Building of a trusting therapeutic relationship is essential for nursing

interventions to work (Lynch and Trenoweth, 2008). Nurses need to be sensitive, show compassion at all times and understanding to a patient's needs. Nursing interventions needs to address physical, psychological and social needs; this involves having holistic approach (Coleman and Jenkins, 1998). Nurses need to work with the best evidence based therapeutic treatment available, this then being a positive approach to care (NMC 2008). The Chief Nursing Officer (CNO) review of the Mental Health Nursing (2006) noted that to improve quality of life, service users risks need to be managed properly, whilst promoting health, physical care and well being. However, Hall et al., (2008) argues that the CNO review does not take into consideration the great pressure nurses are under and also the complex needs of the service user.

Therapeutic interventions are an important aspect of recovery (Gourney 2005). Recovery can be described as a set of values about the service user's right to build a meaning life for themselves without the continuous presence of mental health symptoms (Shepherd et al., 2008). The purpose of recovery is to work towards self determination and self confidence (Rethink 2005). National Institute for Mental Health in England (NIMHE, 2005) described recovery as a state of wellness after period of illness. Nurse need to provide a holistic view of mental illness with a person centred approach that can work towards the identification of goals and offer the patient appropriate support through interventions like CBT, family therapy and coping skills, this will enable the patient to be at the centre of their own care, thus taking responsibility for their own illness and improve quality of life. Service user who have a full understanding and accept their illness can engage more with

therapies and interventions with the necessary support from professionals, this then leads to self determination and better quality of life (Cunningham et al., 2005). However, Took (2002) says it is important to remember that with a service user experiencing auditory hallucinations, their mood and engagement can fluctuate and also the side effect of prescribed medication can affect this which may slow down the recovery process.

Early intervention is also recognised to improve long term outcomes of auditory hallucinations in schizophrenia (McGorry et al., 2005: NICE 2009). However, not all service users will seek advice when first experiencing symptoms, due to stigma attached to mental illness and fear of admission to hospital (French and Morrison 2004). Some service users have also complained that the hospital has a non therapeutic environment and that they also feel unsafe and in an orison like setting (SCMH 1998, 2005; DoH 2004b). Drury (2006) says that service users felt that some professionals lacked compassion. Mental health nurses are encouraged to adopt a client centre approach, some research suggests nurses lack empathy and have general uncaring attitude (Herdman 2004).

The final phase of Peplau's theory is the resolution phase. This is where the nurse and the service user will end their professional relationship. The relationship can end either through discharge or death. For the purpose of this dissertation the ending of the relationship that will be discussed at a later chapter will be discharge.

Therapeutic relationship is seen as paramount during these interlocking phases of peplau's interpersonal relations theory, nurse's needs to promote

the service users independence whilst treating them with respect, privacy and dignity. By identifying treatment goals, implementing and evaluating treatment plans the service user can move on to interventions that will help them manage and cope with auditory hallucinations.

Chapter 3

Assessment of a patient with Auditory Hallucinations

Assessment of Auditory Hallucinations

Assessment is the decision making process, based upon the collection of relevant information, using a formal set of ethical criteria, that contributes to an overall estimation of a person and his circumstances (Barker 2004). Hall et al (2008) described assessment as one of the first steps to the nursing process; it is also part of care planning and a positive foundation for building a relationship and forming therapeutic alliance. It is an ongoing process that enables professional to gather information that allows them to understand a person's experience.

Most assessments have similar aims. However, how assessments are conducted can vary enormously. Such differences are very important and can influence greatly the value of the information produced (Barker 2004). In Wales, Care and Treatment Plan (CTP) was introduced under the Mental Health (Wales) Measures 2010. CTP means a plan prepared for the purpose of achieving the outcomes which the provision of mental health services for a relevant patient is design to achieve and ensures service users have a care plan, risk assessment and a care co-ordinator to monitor and review their care (see appendix one). NICE (2010) suggest that assessment should

contain the service user's psychiatric, psychological and physical health needs and also include current living