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Review article

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Communication of persons with mental disorders

ABSTRACT

Mental disorders cover a wide spectrum of various diseases, including organic, symptomatic, neurotic, affective diseases, schizophrenic and craziness diseases, mental backwardness and other mental disorders as well as mental disorders and behavioural diseases caused by the use of psychoactive substances, including alcohol, tobacco, drugs and other, traditionally called diseases of addiction.

The problems in communication with the persons with mental disorders are often connected with the nature of their disabilities. The psychotic patients have quite developed and saved senses, but they have difficulties in the processing and interpretation of what they hear, see and touch. The speech of the persons with mental disabilities is poor and with a limited vocabulary. It reflects with a disability in the mental processes, emotions and motivation. The face expression of the persons with acute mental disabilities does not match the verbal message, and is usually expressed as illogical thinking processes in the form of illusions an hallucinations.

To be able to enable persons with mental disabilities to communicate, we should do the following:

- In the communication with the users we have to be patient, with a high level of tolerance and respect towards the personality of the user;
- A shorter transfer of communication is better, a shorter exchange, use of simple, short sentences, giving different shapes of social support e.g. organizing different games, walks in nature, collation of the psychical appearance with the purpose to encourage a certain type of interaction;
- It is not good to interfere with the hallucinogenic contents of the user and
- It's necessary to understand, accept and support their feelings with the purpose to develop a mutual trust.

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With the users who have a certain type of communication limitations regarding their abilities it is necessary:

- To talk loud and clearly with a certain normal speed with the purpose, the user to understand the content of the message easily;
- If we notice that the user has not understood the message we are sending towards him, it is necessary to repeat the message, but use different words;
- It is desirable to accept a certain member of the user's family that would aid as a mediator in the communication of the user and as a source for gaining information;
- To check if the user has understood what we've told him by the repetition or via short summarizing of the conversational content;
- Using other forms of communication (sign language, written messages or pictures);
- Not to make fast conclusions of what the user is saying, but change of the type of communication (use of additional questions of a closed type - yes or no) and
- To motivate the user's memory, to remind him/her of a certain therapy or a certain event that occurred recently.

1. Concept and types of communication

The word communication comes from the Latin word communikare which means talking, bargaining, debate, speech, counselling. In sociological terminology glossary, the term communication is defined as the process of transferring the contents of a message from one to another entity, through symbols (Bozinovska, 2004).

According to Johnson (1993) communication between two people is composed of seven elements:

1. Intentions, ideas and feelings to the one who gives the message, the way you decided to apply and send the message;
2. Coding the message-transmission of ideas, feelings and intentions in the message;
3. Sending the message of the one who receives the message;
4. Channel through which the message is transferred;
5. Decoding the message by the recipient - interpreting the meaning of the message;
6. Internal response to the interpretation of the message recipient and
7. Noise in all phases - it breaks down the communication.

The main basic characteristics of the communication are:

- communication is an inborn trait;
- communication is a universal phenomenon;
- communication is a continuous process;
- communication is a dynamic category;
- communication is a cultural phenomenon and
- communication is a special category.

Depending on which symbols, signals and signs are used in communication, and the means by which it is accomplished, it is divided into:

1. verbal and nonverbal;
2. one-way and mutual;
3. interpersonal and intrapersonal;
4. direct (immediate) and indirect (indirect and mediated) ;
5. mass communication and
6. successful and unsuccessful communication.

Verbal communication or oral communication is established through speech that represents the most important means of communication and as a basis serves the ability to produce enough different voices or phonemes, ability to relate in words (morphemes – signs for something that is definite accepted by society) and further into the systems of the words that form a language.

Use of language in speech is determined by various factors such as:

- The level of education of the speaker;
- From his/her life experience;
- The mental-physical condition and
- Emotional condition, etc.

Non-verbal communication is also very important component of the communication, which is important to comply with verbal communication.

2. Communication with persons with mental disorders

When it comes to communicating with people with mental disorders there are numerous biases such as: that these people are dangerous, irresponsible, incapable of making decisions, people with whom is hard-to-communicate, so it is best that the communication with them to be avoided or limited. These stereotypes are present at the general population mass, but not uncommon among the health care workers and health care assistants who work directly with these patients. They are types of attitudes which are focused on a certain kind of mental disorder, those that are given in advance, before we had enough information for the subject of our opinion and which are based on our personal experience with the people towards whom we have prejudices.

Stigma is a negative stereotype. Agreeing with stereotypes about a particular group of people leads to prejudice in this case towards people with mental disorders. That leads to full discrimination, social isolation, material deprivation, marginalization

and an obstacle in the treatment, rehabilitation and reintegration of these individuals into the community.

Due to this condition, the anti-stigma programs should be directed against the stigmatization and discrimination.

The emergence of a mental disorder as the person who suffers, and about their families is a shock, as members become vulnerable from the weight of the occurred problem. It is hard to find someone ready for such thing. Lack of joint talks, open discussion about their own thoughts, usually upsets the family relationships.

To have accurate and timely information about its own health is fundamental human rights. However, in practice, many of the persons with mental disorders often do not receive timely and accurate information about their health condition. This leads to dissatisfaction of the administered treatment, and violation of the human right to participate in making decisions about their own health. Active participation of patients in their treatment, not only that leads to a feeling that they have control over their health, but also significantly affect improvement and healing.

The in-hospital admission of the patient for hospital care rarely means relief and belief that it is good for the given situation. Often, and especially our region, hospitalization is viewed with a sense of tension and fear that situation is bed. There comes the need for health care workers and health care assistants in the first contact with the patient and his family to make the best possible communication to intensify trust to treatment in order to minimize the trauma.

The relation patient-therapist has fundamental meaning in the therapeutic treatment of persons with mental disorders. The first meeting leaves significant and lasting impressions for both patient and user. On the first meeting it should be established clear and open communication, in relation with the therapist it should actively involve the patient and his/her family in order to establish the positive transfer in cooperation and build mutual trust.

Persons with mental disorders in certain periods are not in a condition to understand the meaning of their actions, can not control their behaviour, as they need psychiatric help. These persons are entitled to protection and promotion of their health, in the same way as everyone else.

When communicating with these people, a person should be careful of the following:

- To find enough time for talking;
- The conversation should take place in an appropriate room;
- To explain the purpose of the conversation;
- To avoid support and facilitation ("I see that you find it hard to talk about it");

- To be aware of verbal and non-verbal signs;
- To use short sentences for giving instructions one at a time;
- The touch during the communication it is calming - often are touched arms, back, shoulders, the touch strengthens the verbal message;
- If the patient repeats constantly the same, you should try to keep to the content you're interested;
- In the case of aggressive outbursts you need to remove the situation that led the person so to the outburst and
- Apply active listening.

According Ewles and Simnett (1995) there are six sets of communication difficulties between healthcare professionals and patients:

1. Social and cultural differences: differences in ethnicity, differences in socio-economic status that can be observed in the dialect, accent, manner of dressing etc.
2. Limited opportunities for communication with the patient: symptoms of illness, fatigue, pain, patient emotional excitement, poor appreciation of their own health, the patient's preoccupation are other concerns, not the disease;
3. The patient's negative attitudes toward health worker, previous bad experiences with healthcare professionals, mistrust towards healthcare workers, contradicting earlier and current advice from the health care workers, fear that is caused by the health care professionals, the patient's belief that he/she already knows everything about his illness and that the conversation is a waste of time, the patient's conviction that the advice that will get from the healthcare professional will not be able to implement due to financial and social obstacles or habits that are hard for him/her to give up (smoking, alcohol, etc.), absence of patient's need to learn more about their disease;
4. Limited understanding and remembering: poor knowledge of the language, dialect or patient illiteracy, use of medical jargon, the patient's poor memory and inability to remember past the doctor's advices;
5. Insufficiently importance to the conversation with the patient: poor highlighting of the importance of talking to the patient during the health care worker education, lack of trust of the health care worker own talk in their about abilities and knowledge to influence patient, overburdened health care workers with a number of patients and medical routine, complaints by superiors of the health care worker that the conversation with the patient is a waste of time, unwillingness of the health care worker to share his/her knowledge with non-qualified people who probably will not understand anything and

6. Contradictory advice and recommendations: receiving different information from different health care professionals (different referrals and advice in relation to the same disease or different interpretations of the causes of the disease), disease information provided by health professionals not in compliance with the new diagnostic information.

According to Ewles and Simnet (1985), the following is recommended in overcoming the designated communication barriers:

1. To speak slowly, clearly and without raising the voice;
2. To repeat sentences if they were incomprehensible by using the same words as before, thus the listener is given a better insight into what was spoken as to the use of new words can further hamper the understanding;
3. Avoid using medical jargon, on contrary explain it in a simple way;
4. Use simple words and sentences;
5. Do not be too serious and official, but immediate and smiling. The health care professional should conform to the cultural level of the patient, with his/her level of education, the ability to understand the message and so on;
6. You should avoid using dialect in conversation and
7. When explaining the recommendations or treatment, the health care professionals should check if they are understood as would indicate the patient to repeat the recommendations and in any case to write them down in an understandable way, by avoiding with professional titles or abbreviations, can make drawings, scheme and diagrams to explain the disease and giving advice (Bozinovska, 2004).

Conclusion

During treatment patients should be allow as much as possible to express their feelings, to encourage confidence in the treatment, to develop their communication and social skills particularly for those whose hospital treatment lasted for a longer period of time.

Given that people with mental disorders, as we all live in their primary or their own families, which represent very important segment of their treatment, of utmost importance is the communication with them. The biggest problem in communication of persons with mental disorders with their family members begins with the acceptance that it is a disease and that should be treated.

It should be encourage the communication and the establishment of social relations not only with patients' primary family but also with other members of the community (friends, relatives, neighbours, colleagues and others). They represent an important social support not only in the phase of treatment, but also in the patient's rehabilitation and reintegration into the community.

Psycho-education of the users of psychiatric services and their families increasingly takes its place in the efforts for improvement of the quality of mental health and it should be composed of: accepting that it is a disease and indication for the treatment, taking active part in taking prescribed drug therapy, identification of symptoms that indicate deterioration or irregularly taking treatment, indicating the importance of continuous contact with the physician where the patient is treated, with the facts and prejudices related to psychic disorders and how to overcome them.

Developing of communications and social skills are very important in terms of building the patients' confidence, in accepting the disease, improving the relationships with family, community, establishing and building positive relations and cooperation with the medical staff during patient treatment.

REFERENCES

1. Backer, D. (1993): Human rights for persons with disabilities U: Nagler, M & Kemp E. J (Ur.) Perspectives on Disability, Paolo Alto, CA:
2. Bolton, R, (1986): People skills: How to assert yourself, listen to others, and resolve the conflicts.
3. Bronfenberrener, U. (1979). The ecology of human development, Cambridge, MA: Hardvard University Press.
4. Beauchamp, T. L& Childress, J.F. (1994): Principles of Biomedical Ethics, Oxford, Oxford University Press.
5. Burns, T (2004). Community Mental Health Teams: A Guide to Current Practices, Oxford: Oxford University Press.
6. Bozinovska, V (2004). Komunikaciski Veshtini,. Univerzitet "Sv. Kliment Ohridski", Bitola.
7. Hinshaw, S. P&Cicchetti, D (2000): Stigma and mental disorders, conceptions of illness, public attitudes, personal disclosure, and social policy.
8. Social Exclusion Unit (2001) Preventing Social Exclusion. Report by the Social Exclusion Unit, March.
9. Somerville, P. (1998) Explanations of Social Exclusion: Where Does Housing Fit in? Housing Studies 13
10. Spicker, P. (1997) Exclusion. Journal of Common Market Studies 35
11. Šporer, Ž. (u tisku) Koncept društvene isključenosti. Društvena istraživanja, Zagreb
12. Sretna obitelj, (2005) Prihvatimo razlicnost, odbacimo predrasude- ziveti sa dusevnom bolescu, Udruga Sretna obitelj, Zagreb

13. Tornikroft, G i Tansela M.(2009). Bolja briga o mentalnom zdravju,Clio, Beograd
14. Williams, C. (2001) Overcoming Depression. Arnold, London.
15. Wolfsan M (1990) Assertive Community Treatment: an evaluation of the experimental evidence. *Hospital & Community Psychiatry 41*
16. World Health Organization (2000), Education for Health, Manual on Health Education in Primary Health Care, Geneva.
17. Wykes T, Tarrier N, Lewis S (1998) *Outcome and Innovation in Psychological Treatment of Schizophrenia.* Wiley & Sons, Chichester.
18. Wykes, T., Tarrier, N., Lewis, S. (1998) Outcome and Innovation in Psychological Treatment of Schizophrenia. Wiley Press, Chichester.