NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF HEALTH SCIENCES

COURSE CODE: PHS 505

COURSE TITLE: COMMUNITY MENTAL HEALTH

PHS 505: COMMUNITY MENTAL HEALTH
(Adapted from NSS 401: Mental Health and Psychiatric for Nurses)

Course Writer — Dr. J. A. Afolayan
Department of Mental Health & Psychiatric Nursing, Faculty of Nursing,
Niger Delta University, Wilberforce Island,
Bayelsa State

Programme Leader — Prof. Femi Peters
School of Science and Technology
National Open University of Nigeria,
Lagos

Course Coordinator — Kayode S. Olubiyi
School of Science and Technology
National Open University of Nigeria,
Lagos

COURSE GUIDE

Contents
Introduction

The Course
Course Aims
Course Objectives

Working through the course
Course Material
Study Units
Text Books

Assessment
Tutor Marked Assignment
End of Course Examination

Summary

References/Further Readings

1.0 Introduction

This course focuses on the study of mental health and psychiatric as an aspect of community health and it is designed to afford students the opportunity of applying the community health knowledge to the care of their patients in any type of setting. It is also designed to help students develop such skills as are required of professionals to handle interpersonal and group problems.

It is believed that primary groups are essential to the welfare of individuals thus attention is paid to the role of the family in the care of the sick. Because the three aspects of health care (preventive, curative and rehabilitative) are complementary, students will have opportunity to participate in rendering the three aspects to their clients/patients.

Psychiatry is a branch of medical science which deals with the study and treatment of mental diseases. It deals with the mind, emotions and behaviour of man scientifically; the least understood aspects of the human/animal. Psychiatry, also known as psychological medicine, is the branch of medicine which deals with the diagnosis, treatment and prevention of mental illnesses. Psychiatric illness is characterized by a breakdown in the normal pattern of thought, emotion and behaviour. Psychiatric symptoms, problems and illness of all kinds are extremely common throughout life while community health is a specialized branch of community health in which the community health practitioners utilizes her own personality, her knowledge of psychiatric theory and the available environment to effect therapeutic changes in her patients' thoughts, feelings and behaviour. Her ability to effect these changes varies according to her experience and education. The therapeutic role of the community health psychiatric officer cannot be described only in terms of attitudes, feelings, relationship and understanding. What the nurse brings as a person to the treatment situation is directly related to her therapeutic effectiveness.

Psychiatry is concerned with the promotion of mental health, prevention of mental disorder and the community health care of patients who suffer from mental disorder. Thus, community health psychiatry is the process whereby the community health practitioners assists persons, as individuals or in groups, in developing a more positive self-concept, a more harmonious pattern of interpersonal relationships and a more productive role in the society.

2.0 What you will learn in this course

The overall aim of CHS 212: Community Mental Health is to enable you have a foreknowledge on the following: Functional Psychiatric Disorders such as Schizophrenia, Mood Disorders, Psychoneuroses, Organic Disorders, Substance Abuse, Alcoholism, Epilepsy, Therapeutic Modalities in Psychiatry, Crisis Intervention, Community Mental Health, Legal Aspects of Mental Health, History Taking of Psychiatric Patients, Electro-Convulsive Therapy, Occupational and Recreational Therapies, Rehabilitation and Psychiatric Pharmacology.

These blocks of knowledge are important as a scientific community health practitioners in order to meet the changing needs of the profession. You will

be given sufficient ground to achieve this, which should provide you with the necessary basis for further study.

3.0 Course aims

The aim of this course can be achieved by adequate response to the following questions:

- Describe various functional psychiatric disorders.
- explain the concept of schizophrenia.
- outline the types of mood disorders.
- discuss the psychoneuroses
- describe organic psychiatric disorders.
- outline the substances commonly abused.
- explain the concept of alcoholism.
- introduce you to the meaning and management of epilepsy.
- discuss various therapeautic modalities in psychiatry.
- explain the concept of crisis intervention.
- describe community mental health.
- discuss the legal aspects of mental health.
- explain how history taking of psychiatric patients is carried out.
- describe Electro-convulsive therapy.
- discuss occupational and recreational therapy.
- explain the concept of rehabilitation.
- outline the various drugs used in psychiatry.

4.0 Course objectives

To achieve the aims set out in this course, there are overall objectives that must be used. Each unit also has specific objectives as contained in the Units as the beginning of each unit, you need to read them carefully and you can always refer to them in the course of your reading to do a self evaluation in order to be sure that you have done what was required of you as a learner by the unit.

Here are wider objectives of the course as by meeting these objectives you should have achieved the aims of the course as a whole.
On successful completion of the course, you should be able to:

- define the concept of functional psychiatric disorder.
- describe schizophrenia.
- list the types of mood disorders.
- explain what psychoneurosis is.
- describe organic psychiatric disorders.

- enumerate the substance abuses.
- define alcoholism
- explain the meaning and management of epilepsy.
- describe various therapeutic modalities in psychiatry.
- discuss legal aspects of mental health.
- explain what crisis intervention is.
- describe history taking of psychiatric patients.
- define electroconvulsive therapy.
- explain occupational and recreational therapies.
- list some drugs used in psychiatry.

5.0 Working through this course

In order to successfully complete this course you are required to read the study units, read reference books and other materials provided by the university. Each unit also contains Tutor Marked assignments which would be of tremendous assistance to you.

6.0 Course materials

Major components of the course are:
- Course Guide
- Study Units
- References/ Further Readings

7.0 Study units

The study units in this course are as follows:
Unit 1: Functional Psychiatric Disorders I – Schizophrenia
Unit 2: Functional Psychiatric Disorder II – Mood Disorders
Unit 3: Psychoneuroses
Unit 4: Organic Mental Disorders
Unit 5: Drug Abuse and Drug Addiction
Unit 6: Alcoholism
Unit 7: Epilepsy
Unit 8: Therapeautic Modalities in Psychiatry I (Somatic)
Unit 9: Therapeautic Modalities in Psychiatry II (Psychological)
Unit 10: Therapeautic Modalities in Psychiatry III (Therapeautic milleu)
Unit 11: Crisis Intervention
Unit 12: Community Mental Health
Unit 13: Legal Aspects of Mental Health
Unit 14: Methods of Assessment in Psychiatry
Unit 15: Electro - Convulsive Therapy (E. C. T)

Unit 16: Rehabilitation
Unit 17: Behavioural Syndromes

8.0 Assessment

There are two aspects of the assessment of the course. Firstly, the tutor marked assessment and secondly, there will be a written examination (final). In dealing with the assignments, you are expected to apply information, knowledge and strategies gathered during the course. The tutor marked assignments are expected to be submitted to your study centre in accordance with the directives of the university.

9.0 Tutor marked assignment

Each unit has tutor marked assignment questions at the end of the units.

10.0 Summary

CHS 212 is a community mental health course and upon completion of this course, you will be equipped with required knowledge of meeting the needs of your mentally disordered clients/patients and families. You will be able to answer these questions:

- define the concept of functional psychiatric disorder.
- describe schizophrenia.
- list the types of mood disorders.
- explain what psychoneurosis is.
- describe organic psychiatric disorders.
- enumerate the substance abuses.
- define alcoholism
- explain the meaning and management of epilepsy.
- describe various therapeautic modalities in psychiatry.
- discuss legal aspects of mental health.
- explain what crisis intervention is.
- describe history taking of psychiatric patients.
- define electroconvulsive therapy.
- explain occupational and recreational therapies.
- list some drugs used in psychiatry.

11.0 References/Further Readings

Adedotun, A. 2000. *Basic Psychiatry and Psychiatric Nursing,* Ile-Ife: Basag (Nig) Enterprises.

Burr, J. 1970. Nursing the Psychiatric Patient 2nd Ed. London: Bailliere Tindall and Cassell.

Fish, F. J. 1967. An outline of Psychiatry, Bristol: John Wright & Sons Ltd.

Morrison – Valfe, M. 2005. *Foundations of Mental Healthcare*. Missouri: Mosby, Inc.

Olatawura, M. O. 2002. Psychology and Psychiatry (Lecture series from Ibadan), Ibadan: Spectrum Books Limited.

Staurt, G. W. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Sreevani, R. 2004. *A Guide to Mental Health and Psychiatric Nursing,* India: Jaypee Brothers Medical Publishers (P) Ltd.

Stellenberg, E. L. and Bruce, J. C. 2007. Nursing Practice Medical-Surgical Nursing for Hospital and Community 2nd Ed. London: Churchill Livingstone.

Udoh, C. O. *Mental and Social Health,* Ibadan: Distance Learning Centre.

Verghese, M. 1994. Essentials of Psychiatric and Mental Health Nursing, New Delhi: Churchill Livingstone PVT Ltd.

Table of Content

Unit 1: Functional Psychiatric Disorders – Affective I (Schizophrenia)

Table of Contents

1.0 Introduction

This unit is on Functional Psychiatric Disorders Affective I and it is based on schizophrenia. Schizophrenia is a major mental disorder which affects the mood.

2.0 Objectives

At the end of this unit, you should be able to:

- define schizophrenia
- enumerate the predisposing factors to schizophrenia
- list the signs and symptoms
- describe the types
- explain the management.

3.0 Schizophrenia

The word "Schizophrenia" was coined in 1908 by the Swiss psychiatrist Eugen Bleuler. It is derived from the Greek words *skhizo* (split) and *phren* (mind).

In ICD10, schizophrenia is classified under the code F2.

3.1 **Definition**

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in the presence of clear consciousness, which usually leads to social withdrawal.

3.2 **Epidemiology**

Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures and in all parts of the world. About 15 percent of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50 percent of all mental hospital beds.

About three to four per 1000 in every community suffer from schizophrenia. About one percent of the general population stands the risk of developing this disease in their lifetime.

Schizophrenia is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 35 years for women.

About two-thirds of cases are in the age group of 15 to 30 years.

The disease is more common in lower socio-economic groups.

3.3 **Etiology**

The cause of schizophrenia is still uncertain. Some of the factors involved may be:

3.3.1 **Genetic Factors**

The disease is more common among people born of consanguineous marriages. Studies show that relatives of schizophrenics have a much higher probability of developing the disease than the general population. The prevalence rate among family members of schizophrenics is as follows:

Children with one schizophrenic parent: 12%

Children with both schizophrenic parents: 40%

Siblings of schizophrenic patient: 8%

Second-degree relatives: 5-6%

Dizygotic twins of schizophrenic patients: 12%

Monozygotic twins of schizophrenic patients: 47%

3.3.2 **Biochemical Factors**

Dopamine hypotheses: This theory suggests that an excess of dopamine-dependent neuronal activity in the brain may cause schizophrenia.

Other biochemical hypotheses: Various other biochemicals have been implicated in the predisposition to schizophrenia. These include abnormalities in the neurotransmitters:- norepinephrine, serotonin, acetylcholine and gamma-aminobutyric acid (GABA), and neuroregulators such as prostaglandins and endorphins.

3.3.3 **Psychological Factors**

Family relationship act as major influence in the development of the illness:

Mother-child relationship: Early theorists characterized the mothers of schizophrenics as cold, over-protective and domineering, thus retarding the ego development of the child.

Dysfunctional family system: Hostility between parents can lead to a schizophrenic daughter (marital skew and schism).

Double-bind communication (Bateson et al, 1956): Parents convey two or more conflicting and incompatible messages at the same time.

3.3.4 **Social Factors**

Studies have shown that schizophrenia is more prevalent in areas of high social mobility and disorganization, especially among members of very low social classes. Stressful life events also can precipitate the disease in predisposed individuals.

3.4 **Schneider's First-Rank Symptoms of Schizophrenia (SFRS)**

Kurt Schneider proposed the first rank symptoms of schizophrenia in 1959. The presence of even one of these symptoms is considered to be strongly suggestive of schizophrenia. They include:

Hearing one's thoughts spoken aloud (audible thoughts or thought echo).

Hallucinatory voices in the form of statement and reply (the patient hears voices discussing him in the third person).

Hallucinatory voices in the form of a running commentary (voices commenting on one's action).

Thought withdrawal (thoughts cease and subject experiences them as removed by an external force).

Thought insertion (subject experiences thoughts imposed by some external force on his passive mind).

Thought broadcasting (subject experiences that his thoughts are escaping the confines of his self and are being experienced by others around).

Delusional perception (normal perception has a private and illogical meaning).

Somatic passivity (bodily sensations especially sensory symptoms are experienced as imposed on body by some external force).

Made volition or acts (one's own acts are experienced as being under the control of some external force, the subject being like a robot).

Made impulses (the subject experiences impulses as being imposed by some external force).

Made feelings or affect (the subject experiences feelings as being imposed by some external force).

3.5 **Clinical Features**

The predominant clinical features in acute schizophrenia are delusions, hallucinations and interference with thinking. Features of this kind are often called positive symptoms or psychotic features while most of the patients recover from the acute illness, some progress to the chronic phase, during which time the main features are affective flattening or blunting, avolition-apathy (lack of initiative), attentional impairment, anhedonia (inability to experience pleasure), asociality, alogia (lack of speech output). These are called as negative symptoms. Once the chronic syndrome is established, few patients recover completely.

The signs and symptoms commonly encountered in schizophrenic patients may be grouped as follows:

3.5.1 **Thought and Speech Disorders**

Autistic thinking (preoccupations totally removing a person from reality).

Loosening of associations (a pattern of spontaneous speech in which the things said in juxtaposition lack a meaningful relationship with each other).

Thought blocking (a sudden interruption in the thought process).

Neologism (a word newly coined, or an everyday word used in a special way, not readily understood by others).

Poverty of speech (decreased speech production).

Poverty of ideation (speech amount is adequate but content conveys little information).

Echolalia (repetition or echo by patient of the words or phrases of examiner).

Perseveration (persistent repetition of words or themes beyond the point of relevance).

Verbigeration (senseless repetition of some words or phrases over and over again).

Delusions of various kinds i.e. delusions of persecution (being persecuted against); delusions of grandeur (belief that one is especially very powerful, rich, born with a special mission in life); delusions of reference (being referred to by others); delusions of control (being controlled by an external force); somatic delusions.

Other thought disorders are over inclusion (tending to include irrelevant items in speech), impaired abstraction, concreteness and ambivalence.

3.5.2 **Disorders of Perception**

Auditory hallucinations (described under SFRS).

Visual hallucinations may sometimes occur along with auditory hallucinations; tactile, gustatory and olfactory types are far less common.

3.5.3 **Disorders of Affect**

These include apathy, emotional blunting, emotional shallowness, anhedonia and inappropriate emotional responses. The incapacity of the patient to establish emotional contact leads to lack of rapport with the examiner.

3.5.4 **Disorders of Motor Behaviour**

There can be either an increase or a decrease in psychomotor activity. Mannerisms, grimacing stereotypes, decreased self-care and po-grooming are common features.

3.5.5 **Other Features**

Decreased functioning in work, social relations and self-care, as compared to earlier life.

Loss of ego boundaries.

Loss of insight.

Poor judgment.

Suicide can occur due to the presence of associated depression, command hallucination, impulsive behaviour, or return of insight that causes the patient to comprehend the devastating nature of the illness and take his life.

There is usually no disturbance of consciousness, orientation, attention, memory and intelligence.

There is no underlying organic cause.

3.6 **Clinical Types**

Schizophrenia can be classified into the following subtypes:

1. Paranoid
2. Hebephrenic (disorganized)
3. Catatonic
4. Residual
5. Undifferentiated
6. Simple
7. Post- schizophrenic depression

3.6.1 **Paranoid Schizophrenia**

The word ‘paranoid’ means ‘delusional’. Paranoid schizophrenia is at present the most common form of schizophrenia. It is characterized by the following features (in addition to the general features already described).

Delusions of persecution: In persecutory delusions, individuals believe that they are being malevolently treated in some way. Frequent themes include being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed or obstructed in the pursuit of long-term goals.

Delusions of jealousy: The content of jealous delusions centres around the theme that the person’s sexual partner is unfaithful. The idea is held on inadequate grounds and is unaffected by rational judgment.

Delusions of grandiosity: Individuals with grandiose delusions have irrational ideas regarding their own worth, talent, knowledge or power. They may believe that they have a special relationship with famous persons, or grandiose delusions of a religious nature may lead to assumption of the identity of a great religious leader.

Hallucinatory voices that threaten or command the patient, or auditory hallucinations without verbal form, such as whistling, humming and laughing.

Other features include disturbance of affect (though affective blunting is less than in other forms of schizophrenia), volition, speech and motor behaviour.

Paranoid schizophrenia has a good prognosis if treated early. Personality deterioration is minimal and most of these patients are productive and can lead a normal life.

3.6.2 **Hebephrenic (disorganized) Schizophrenia**

It has an early and insidious onset and is often associated with poor premorbid personality. The essential features include marked thought disorder, incoherence, severe loosening of associations and extreme social impairment. Delusions and hallucinations are fragmentary and changeable. Other oddities of behaviour include senseless giggling, mirror-gazing, grimacing, mannerisms and so on. The course is chronic and progressively downhill without significant remissions. Recovery classically never occurs and it has one of the worst prognoses among all the subtypes.

3.6.3 **Catatonic Schizophrenia**

Catatonic (Cata-disturbed) schizophrenia is characterized by marked disturbance of motor behaviour. This may take the form of catatonic stupor, catatonic excitement and catatonia alternating between excitement and stupor.

Clinical features of excited catatonia:

Increase in psychomotor activity (ranging from restlessness, agitation, excitement, aggressiveness to at times violent behaviour).

Increase in speech production.

Loosening of associations and frank incoherence.

Sometimes excitement becomes very severe and is accompanied by rigidity, hyperthermia and dehydration and can result in death. It is then known as acute lethal catatonia or pernicious catatonia.

Clinical features of retarded catatonia (catatonic stupor):

Mutism: Absence of speech.

Rigidity: Maintenance of rigid posture against efforts to be moved.

Negativism: A motiveless resistance to all commands and attempts to be moved, or doing just the opposite.

Posturing: Voluntary assumption of an inappropriate and often bizarre posture for long periods of time.

Stupor: Does not react to his surroundings and appears to be unaware of them.

Echolalia: Repetition or mimicking of phrases or words heard.

Echopraxia: Repetition or mimicking of actions observed.

Waxy flexibility: Parts of body can be placed in positions that will be maintained for long periods of time, even if very uncomfortable (flexible like wax).

Ambitendency: A conflict to do or not to do, e.g. on asking to put out tongue, it is slightly protruded but taken back again.

Automatic obedience: Obeys every command though he has first been told not to do so.

3.6.4 **Residual Schizophrenia**

Symptoms of residual schizophrenia include emotional blunting, eccentric behaviour, illogical thinking, social withdrawal and loosening of associations. This category should be used when there has been at least one episode of schizophrenia in the past but without prominent psychotic symptoms at present.

3.6.5 **Undifferentiated Schizophrenia**

This category is diagnosed either when features of no subtype are fully present or features of more than one subtype are exhibited.

3.6.6 **Simple Schizophrenia**

It is characterized by an early and insidious onset, progressive course, presence of characteristic negative symptoms, vague hypochondriacal features, wandering tendency, self-absorbed idleness and aimless activity. It differs from residual schizophrenia in that there never has been an episode with all the typical psychotic symptoms. The prognosis is very poor.

3.6.7 **Post-schizophrenic Depression**

Depressive features develop in the presence of residual or active features of schizophrenia and are associated with an increased risk of suicide.

3.7 Course and Prognosis

The classic course is one of exacerbations and remissions. In general, schizophrenia has been described as the most crippling and devastating of all psychiatric illnesses. Several studies have found that over the 5-10 years period after the first psychiatric hospitalization for schizophrenia, only about 10 to 20 percent of patients can be described as having a good outcome. More than 50 percent of patients have a poor outcome, with repeated hospitalizations.

Prognostic Factors in Schizophrenia

Good prognostic factors	Poor prognostic factors
1. Abrupt or acute onset	Insidious onset
2. Later onset	Younger onset
3. Presence of precipitating factor	Absence of precipitating factor
4. Good premorbid personality	Poor premorbid personality
5. Paranoid and catatonic subtypes	Simple, undifferentiated subtypes
6. Short duration: (<6 months)	Long duration:(>2 years)
7. Predominance of positive symptoms	Predominance of negative symptoms
8. Family history of mood disorders	Family history of schizophrenia
9. Good social support	Poor social support
10. Female sex	Male sex
11. Married	Single, divorced or widowed
12. Out-patient treatment	Institutionalization

3.8 Treatment

3.8.1 Pharmacotherapy

An acute episode of schizophrenia typically responds to treatment with classic antipsychotic agents, which are most effective in its treatment. Some commonly used drugs include:

Chlorpromazine: 300-1500 mg/day PO; 50-100 mg/day IM
Fluphenazine decanoate: 25-50 mg IM every 1-3 weeks
Haloperidol: 5-100 mg/day PO; 5-20 mg/day IM
Trifluoperazine: 15-60 mg/day PO; 1-5 mg/day IM
Clozapine: 25-450 mg/day PO
Risperidone: 2-10mg/day PO

3.8.2 Electroconvulsive Therapy (ECT)

Indications for ECT in schizophrenia include:

Catatonic stupor

Uncontrolled catatonic excitement
Severe side-effects with drugs
Schizophrenia refractory to all other forms of treatment
Usually 8-12 ECTs are needed

3.8.3 **Psychological Therapies**

Group therapy: The social interaction, sense of cohesiveness, identification and reality testing achieved within the group setting have proven to be highly therapeutic for these individuals.

Behaviour therapy: Behaviour therapy is useful in reducing the frequency of bizarre, disturbing and deviant behaviour and increasing appropriate behaviours.

Social skills training: Social skills training addresses behaviours such as poor eye contact, odd facial expressions and lack of spontaneity in social situations through the use of videotapes, role playing and homework assignments.

Cognitive therapy: Used to improve cognitive distortions like reducing distractibility and correcting judgment.

Family therapy: Family therapy typically consists of a brief program of family education about schizophrenia. It has been found that relapse rates of schizophrenia are higher in families with high expressed emotions (EE), where significant others make critical comments, express hostility or show emotional over-involvement. The significant others are, therefore, taught to decrease expectations and family tensions, apart from being given social skills training to enhance communication and problem solving.

3.8.4 **Psychosocial Rehabilitation**

This includes activity therapy to develop the work habit, training in a new vocation or retraining in a previous skill, vocational guidance and independent job placement.

3.9 **Management**

Assessment

Assessment of the schizophrenic patient may be a complex process, based on information gathered from a number of sources. Schizophrenic patients in an acute episode of the illness are seldom able to make a

significant contribution to their history. Data may be obtained from family members if possible, old records if available, or from other individuals who are in a position to report on the progression of the patient's behaviour.

Nursing Diagnosis I

Alteration in thought processes related to inability to trust, panic anxiety, evidenced by delusional thinking, inability to concentrate, impaired volition, extreme suspiciousness of others.

Objective: Patient will eliminate patterns of delusional thinking and demonstrate trust in others.

Intervention:

Interventions	Rationale
(a) Convey acceptance of the patient's need for the false belief, but that you do not share the belief.	The client must understand that you do not view the idea as real.
(b) Do not argue or deny the belief	Arguing or denying serves no useful purpose as delusional ideas are not eliminated by this approach; further, this may adversely affect the development of a trusting relationship.
(c) Reinforce and focus on reality. Discourage long discussions about the irrational thinking. Instead talk about real events and real people.	Discussions that focus on the false ideas are purposeless and useless and may even aggravate the condition.
(d) If the client is highly suspicious, the following interventions may help:	
use same staff as far as possible; be honest and keep all promises	To promote trust
avoid physical contact in the form of touching the patient etc;	To prevent the client from feeling threatened
avoid laughing, whispering or talking quietly where the client can see but cannot hear what is	-do-

being said; avoid competitive activities; use assertive, matter-of-fact yet friendly approach	-do-

Diagnosis II

Sensory-perceptual alteration: Auditory/visual, related to panic anxiety, withdrawal into self, evidenced by inappropriate responses, disordered thought process, poor concentration and disorientation.

Objective: Patient will be able to define and test reality, eliminating the occurrence of hallucinations.

Intervention:

Interventions	Rationale
(a) Observe the client for signs of hallucinations (listening pose, laughing or talking to self, stopping in mid-sentence).	Early intervention may prevent aggressive response to command hallucinations.
(b) Avoid touching the client without warning.	The client may perceive touch as threatening may respond in an aggressive manner.
(c) An attitude of acceptance will encourage the patient to share the consent of the hallucination with you.	This is important to prevent possible injury to the patient or others from command hallucinations.
(d) Do not reinforce the hallucinations. Use "the voices" instead of words like "they" that imply validation. Say "Even though I realize the voices are real to you, I don't hear any voices speaking".	The client should know that you do not share the false perception.
(e) Help the client understand the connection between anxiety and hallucinations.	If the client can learn to interrupt rising anxiety, hallucinations may be prevented.
(f) Try to distract the client away from the hallucinations and involve him in interpersonal activities and actual situations.	This is to bring the client back to reality.

Diagnosis III

Social isolation related to inability to trust, panic anxiety, delusional thinking, evidenced by withdrawal, sad, dull affect, preoccupation with own thoughts, expression of feelings of rejection of aloneness imposed by others. Objective: Patient will voluntarily spend time with other patients and staff members in group activities on the unit.

Intervention:

Interventions	Rationale
(a) Convey an accepting attitude by making brief, frequent contacts. Show unconditional positive regard.	This increases feelings of self-worth and facilitates trust.
(b) Offer to be with the client during group activities that he finds frightening or difficult. Involve the client gradually in different activities on the unit.	The presence of a trusted individual provides emotional security for the client.
(c) Give recognition and positive reinforcement for the client's voluntary interaction with others.	Positive reinforcement enhances self-esteem and encourages repetition of acceptable behaviour.

Diagnosis IV

Potential for violence, self-directed or directed at others, related to extreme suspiciousness, panic anxiety, catatonic excitement, rage reactions, command hallucinations, evidenced by physical violence, destruction of objects in the environment, self-destructive behaviour or active aggressive suicidal acts.

Objectives: Patient will not harm self or others.

Intervention:

Intervention	Rationale
(a) Maintain low level of stimuli in the client's environment (low lighting, low noise, few people, simple decoration, etc).	Anxiety level rises in a stimulating environment and may trigger off aggression.
(b) Observe client's behaviour frequently.	Close observation is necessary so that intervention can occur if required, to ensure client's and other's safety.

Do this while carrying out routine activities.	To avoid creating suspiciousness in the individual.
(c) Remove all dangerous objects from the client's environment.	To prevent the client from using them to harm self or others in an agitated, confused state.
(d) Redirect violent behaviour with physical outlets for the anxiety.	Physical exercise is a safe and effective way of relieving pent-up tension.
(e) Staff should maintain a calm attitude towards the client.	Anxiety is contagious and can be transmitted from staff to client.
(f) Have sufficient staff available to indicate a show of strength to the client if it becomes necessary.	This shows the client evidence of control over the situation and provides some physical security for the staff.
(g) Administer tranquilizers as prescribed. Use of mechanical restraints may become necessary in some cases.	If the client is not calmed by "talking down" or the use of medications, restraints may have to be used as a last resort.

Diagnosis V

Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by loosening of associations, echolalia, verbalizations that reflect concrete thinking and poor eye contact.

Objective: Patient will be able to communicate appropriately and comprehensible by the time of discharge.

Intervention:

Interventions	Rationale
(a) Attempt to decode incomprehensible communication pattern. Seek validation and clarification by stating "Is it what you mean…?" or "I don't understand what you mean by that. Would you please clarify it for me?"	These techniques reveal how the patient is being perceived by others, while the responsibility for not understanding is accepted by the nurse.
(b) Facilitate trust and understanding by maintaining staff assignments as consistently as possible. The techniques of VERBALIZING THE	This approach conveys empathy and encourages the client to disclose painful issues.

IMPLIED is used with the client who is mute (either unable or unwilling to speak). For example, "That must have been a very difficult time for you when your mother left. You must have felt all alone".	
(c) Anticipate and fulfill client's needs until functional communication pattern returns.	Self-care ability may be impaired in some patients who may need assistance initially.

Diagnosis VI

Self-care deficit related to withdrawal, panic anxiety, perceptual or cognitive impairment, evidenced by difficulty in carrying out tasks associated with hygiene, dressing, grooming, eating and toileting.

Objective: Patient will demonstrate ability to meet self-care needs independently.

Intervention:

Interventions	Rationale
(a) Provide assistance with self-care needs as required. Some patients who are severely withdrawn may require total care.	Patient safety and comfort are nursing priorities.
(b) Encourage client to perform independently as many activities as possible. Provide positive reinforcement for independent accomplishments.	Independent accomplishment and reinforcement enhance self-esteem and promote repetition of desirable behaviour.
(c) Creative approaches may need to be used with the client who is not eating because he is suspicious of being poisoned (e.g. allow client to open own canned or packaged foods, etc). If elimination needs are not being met, establish structured schedule to help the client fulfill these needs until he is able to do so independently.	To ensure that self-care needs are met.

Diagnosis VII

Ineffective family coping related to highly ambivalent family relationships, impaired family communication, evidenced by neglectful care of the client, extreme denial or prolonged over-concern regarding his illness.

Objective: Family will identify more adaptive coping strategies for dealing with patient's illness and treatment regimen.

Intervention:

Intervention	Rationale
(a) Identify role of the client in the family and how it is affected by his illness. Identify the level of family functioning. Assess communication patterns, interpersonal relationships between the members, problem solving skills and availability of support systems.	These factors will help to identify how successful the family is in dealing with stressful situations and areas where assistance is required.
(b) Provide information to the family about the client's illness, the treatment regimen, long-term prognosis.	Knowledge and understanding about what to expect may facilitate the family's ability to successfully integrate the schizophrenic patient into the system.
(c) Practice with family members, how to respond to bizarre behaviour and communication patterns and when the client becomes violent.	A plan of action will assist the family to respond adaptively in the face of what they may consider to be a crisis situation.

Evaluation

A few questions that may facilitate the process of evaluation can be:

Has the patient established trust with at least one staff member?

Is delusional thinking still prevalent?

Are hallucinations still evident?

Is the patient able to interact with others appropriately?

Is the patient able to carry out all activities of daily living independently?

3.10 Management of patient who exhibits withdrawn behaviour

The term withdrawn behaviour is used to describe a client's retreat from relating to the external world. Withdrawn behaviour can occur in

conjunction with a number of mental health problems, including schizophrenia, mood disorders and suicidal behaviour.

Characteristics of Withdrawn Behaviour Pattern

Withdrawn behaviour pattern may present the picture of a lonely individual who does not respond to the environment. He may walk up and down talking to himself, or may stand or sit in the corner assuming unusual and most uncomfortable positions.

He has difficulty in expressing his feelings, so he may present the picture of a totally apathetic person, or he may express them in inappropriate ways.

Ambivalence is another characteristic that might be seen in a withdrawn patient. For example, he may love and hate a person at the same time.

Disordered thought process is another feature in this patient. The outward expression of this disorganization can be a meaningless jumble of words/sentences, or making up of new words. The patient can also experience sudden thought block. As he creates his own world, the world becomes filled with his own projected ideas and thoughts.

Regression is another process predominant in a withdrawn patient. When it becomes severe, physical needs like sleep, rest, nutrition and hygiene may be interfered with.

Interventions

In taking care of a withdrawn patient, the nurse might be faced with many problems. Communication and interpersonal relationships are the biggest difficulties because the withdrawn patient tends to use symbolized language, or may prefer to rely on non-verbal behaviour completely. Establishing initial contact using calm, non-threatening and consistent approaches is important. It necessitates a lot of hard work and patience from the health practitioners as the patient needs a long period of testing out before he finally trusts her.

Dealing with hallucinations and delusions may be a problem as this happens in accordance with his own self-created world. Anybody who is trying to destroy that comfortable world may be seen by the patient as a threat to him and to his security. Disintegration in thinking is what makes the withdrawn patient the worst of the mentally ill. As

this process can go on for a long time before it is noticed by others, it is often very late when it is identified. This makes it more difficult for the health practitioners in her efforts to bring the patient back to reality. A lot of tact and expert skill is important, and opportunities should be created for the client to recognize the health practitioners as a safe contact with present reality and to begin to respond.

Regression in the patient causes a difficult practical problem, as the patient has to be considered and taken care of as a child. At the same time he has to be treated as an adult, fostering his adult characteristics. Providing sensory stimulation, meeting the client's physiologic and hygiene needs, and promoting the client's physical activity and interactions with others are important interventions.

Certain general principles in working with these patients are: avoid change of staff, reduce the number of staff who works with them and be available when the patient really needs the nurse. He may perceive the unavailability of the health practitioners as another disappointment in his relationship with people in general.

A one-to-one relationship with the patient is considered most beneficial and least anxiety-producing to the patient. It is necessary to encourage reality contact whenever possible and to discourage him from living in the unreal world. This may be achieved by providing opportunities for interaction with the real environment.

Give the client positive feedback for any response to your attempted interaction or to the external environment. Gradually increase the amount of time the client spends with others and the number of people with whom the client interacts.

Active friendliness: As the patient is withdrawn and does not approach anybody, the approach has to be made from the health practitioner's side and many attempts will have to be made to initiate any conversation or communication.

Kind firmness: This is another attitude that is to be considered essential. The health practitioners assumes firmness in expecting the patient to behave in certain ways but should expect the behaviour in a

kind manner without being authoritative and demanding, showing kindness and understanding while listening to the patient, and helping him handle any difficult situations.

4.0 Conclusion

Sreevani has given us an extensive clinical types of schizophrenia that will guide you in making adequate observation in clinical areas when you go for clinical attachment.

5.0 Summary

You have gone through the meaning of schizophrenia, epidemiology, predisposing factors, clinical features, clinical types, treatment and management. It is of no doubt that the unit is an enrichment of knowledge.

6.0 Tutor Marked Assignment

(1) List and describe the various clinical types of schizophrenia.
(2) Explain the clinical features of each of the types mentioned above.

7.0 References / Further Readings

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Adedotun, A. 2000. Basic Psychology and Psychiatric Nursing, Ile-Ife: Basag (Nig) Enterprises.

Udoh, C. O. 2006. Mental and Social Health Ibadan: Distance Learning Centre.

Unit 2: Functional Psychiatric Disorder II (Mood Disorders)

Contents

1.0 Introduction

This unit will take you through the mood disorders in major mental illness. Mood disorders are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, which is not due to any other physical or mental disorder.

2.0 Objectives

At the end of this unit, you should be able to:

- classify mood disorders
- describe the clinical features of mania
- differentiate between mania and depression
- list the types of depression
- differentiate between endogenous and reactive depression

3.0 Main content

3.1 Mood disorders

Mood disorders are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, which is not due to any other physical or mental disorder.

The prevalence rate of mood disorders is 1.5 percent and it is uniform throughout the world.

Classification

According to ICD10 (F3) mood disorders are classified as follows:

Manic episode
Depressive episode
Bipolar mood (affective) disorders
Recurrent depressive disorder
Persistent mood disorder (including cyclothymia and dysthymia)
Other mood disorders

Etiology

The etiology of mood disorders is currently unknown. However, several theories have been propounded which include:

Biological Theories

Genetic hypothesis: Genetic factors are very important in predisposing an individual to mood disorders. The lifetime risk for the first-degree relatives of patients with bipolar mood disorder is 25 percent and of normal controls is 7 percent. The lifetime risk for the children of one parent with mood disorder is 27 percent and of both parents with mood disorder is 27 percent and of both parents with mood disorder is 74 percent. The concordance rate for monozygotic twins is 65 percent and for dizygotic twins is 15 percent.

Biochemical theories: A deficiency of norepinephrine and serotonin has been found in depressed patients and they are elevated in mania. Dopamine, GABA and acetylcholine are also presumably involved.

Psychosocial Theories

Psychoanalytic theory: According to Freud (1957) depression results due to loss of a "loved object" and fixation in the oral sadistic phase of development. In this model, mania is viewed as a denial of depression.

Behavioural theory: This theory of depression connects depressive phenomena to the experience of uncontrollable events. According to this model, depression is conditioned by repeated losses in the past.

Cognitive theory: According to this theory depression is due to negative cognitions which includes:

Negative expectations of the environment
Negative expectations of the self
Negative expectations of the future

These cognitive distortions arise out of a defect in cognitive development and cause the individual to feel inadequate, worthless and rejected by others.

Sociology theory: Stressful life events, e.g. death, marriage, financial loss before the onset of the disease or a relapse probably have a formative effect.

3.1.1 **Manic episode**

Mania refers to a syndrome in which the central features are over-activity, mood change (which may be towards elation or irritability) and self-important ideas.

The lifetime risk of manic episode is about 0.8-1 percent. This disorder occurs in episodes lasting usually 3 to 4 months, followed by complete recovery.

Classification of Mania (ICD10)

Hypomania
Mania without psychotic symptoms
Mania with psychotic symptoms
Manic episode unspecified

Clinical Features

An acute manic episode is characterized by the following features which should last for at least one week:

Elevated, Expansive or Irritable Mood

Elevated mood in mania has four stages depending on the severity of manic episodes:

Euphoria (Stage I): Increased sense of psychological well-being and happiness not in keeping with ongoing events.

Elation (Stage II): Moderate elevation of mood with increased psychomotor activity.

Exaltation (Stage III): Intense elevation of mood with delusions of grandeur.

Ecstasy (Stage IV): Severe elevation of mood, intense sense of rapture or blissfulness seen in delirious or stuporous mania.

Expansive mood is unceasing and unselective enthusiasm for interacting with people and surrounding environment.

Sometimes irritable mood may be predominant, especially when the person is stopped from doing what he wants.

There may be rapid, short-lasting shifts from euphoria to depression or anger.

Psychomotor Activity

There is an increased psychomotor activity ranging from over activeness and restlessness to manic excitement. The person involves in ceaseless activity. These activities are goal-oriented and based on external environment cues.

Speech and Thought

Flight of ideas: Thoughts racing in mind, rapid shifts from one topic to another.

Pressure of speech: Speech is forceful, strong and difficult to interrupt. Uses playful language with punning, rhyming, joking and teasing and speaks loudly.

Delusions of grandeur.

Delusions of persecution.

Distractibility.

Other Features

Increased sociabilities.

Impulsive behaviour.

Disinhibition.

Hypersexual and promiscuous behaviour.

Poor judgment.

High-risk activities (buying sprees, reckless driving, foolish business investments, distributing money or articles to unknown persons).

Dressed up in gaudy and flamboyant clothes although in severe mania there may be poor self-care.

Decreased need for sleep (<3 hrs).

Decreased food intake due to over-activity.

Decreased attention and concentration.

Poor judgment.

Absent insight.

Treatment

Pharmacotherapy

Lithium: 900-2100 mg/day.

Carbamazepine: 600-1800 mg/day.

Sodium valproate: 600-2600 mg/day.

Other drugs: Clonazepam, calcium channel blockers, etc.

Electroconvulsive Therapy (ECT)

ECT can also be used for acute manic excitement if not adequately responding to antipsychotics and lithium.

Psychosocial Treatment

Family and marital therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors. The main purpose is to ensure continuity of treatment and adequate drug compliance.

Management

Assessment

Assessment of the manic patient should include assessing the severity of the disorder, forming an opinion about the causes, assessing the patient's resources and judging the effects of patient's behaviour on other people. As far as possible all relevant data should be collected from the patient as well as from his relatives, because the patient may not always recognize the extent of his abnormal behaviour.

Diagnosis I

High risk for injury related to extreme hyperactivity and impulsive behaviour, evidenced by lack of control over purposeless and potentially injurious movements.

Objective: Patient will not injure self.

Intervention:

Interventions	Rationale
(a) Keep environmental stimuli to a minimum; assign single room; limit interactions with others; keep lighting and noise level low. Keep his room and immediate environment minimally furnished.	Patient is extremely distractible and responds to even the slightest stimuli.
(b) Remove hazardous objects and substances, caution the patient when there is possibility of an accident.	Rationality is impaired and patient may harm self inadvertently.
(c) Assist patient to engage in activities, such as writing, drawing and other physical exercise.	To bring relief from pent-up tension and dissipate energy.

(d) Stay with patient as hyperactivity increases.	To offer support and provide feeling of security.
(e) Administer medication as prescribed by physician.	For providing rapid relief from symptoms of hyperactivity.

Diagnosis II

High risk for violence, self-directed or directed at others related to manic excitement, delusional thinking and hallucinations.

Objective: Patient will not harm self or others.

Intervention:

Intervention	Rationale
(a) Maintain low level of stimuli in patient's environment, provide unchallenging environment.	To minimize anxiety and suspiciousness.
(b) Observe patient's behaviour at least every 15 minutes.	Early intervention must be taken to ensure patient's and others' safety.
(c) Ensure that all sharp objects, glass or mirror items, belts, ties, matchboxes have been removed from patient's environment.	These may be used to harm self or others.
(d) Redirect violent behaviour with physical outlet.	For relieving pent-up tension and hostility.
(e) Encourage verbal expression of feelings.	For relieving pent-up tension and hostility.
(f) Engage him in some physical exercises like aerobics.	-do-
(g) Maintain and convey a calm attitude to the patient. Respond matter-of-factly to verbal hostility. Talk to him in low, calm voice, use clear and direct speech.	Anxiety is contagious and can be transmitted from staff to patient.
(h) Have sufficient staff to indicate a show of strength to patient if necessary. State limitations and expectations.	This conveys control over the situation and provides physical security for the staff.
(i) Administer tranquilizing medication; if patient refuses, use of restraints may be necessary. In such a case, explain the reason to the	Explaining why the restriction is imposed may ensure some control over his behaviour.

patient.	
(j) Following application of restraints observe patient every 15 minutes.	To ensure that needs for nutrition, hydration and elimination are met.
(k) Remove restraints gradually once at a time.	To minimize potential for injury to patient and staff.

The following are some guidelines for self-protection when handling an aggressive patient:

Never see a potentially violent person alone.

Keep a comfortable distance away from the patient (arm length).

Be prepared to move, violent patient can strike out suddenly.

Maintain a clear exit route for both the staff and patient.

Be sure that the patient has no weapons in his possession before approaching him.

If patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away.

Keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon.

Distract the patient momentarily to remove the weapon (throwing water in the patient's face, yelling etc).

Give prescribed antipsychotic medications.

Diagnosis III

Altered nutrition, less than body requirements related to refusal or inability to sit still long enough to eat, evidenced by weight loss, amenorrhoea.

Objective: Patient will not exhibit signs and symptoms of malnutrition.

Intervention:

Interventions	Rationale
(a) Provide high-protein, high caloric, nutritious finger foods and drinks that can be consumed 'on the run'.	Patient has difficulty sitting still long enough to eat a meal.
(b) Find out patient's likes and dislikes and provide favourite foods.	To encourage the patient to eat.
(c) Provide 6 – 8 glasses of fluids per day. Have juice and snacks on unit at all times.	Intake of nutrients is required on regular basis to compensate for increased caloric requirements due to hyperactivity.

(d) Maintain accurate record of intake, output and calorie count. Weigh the patient regularly.	These are useful data to assess patient's nutritional status.
(e) Supplement diet with vitamins and minerals.	To improve nutritional status.
(f) Walk or sit with patient while he eats.	To offer support and to encourage patient to eat.

Diagnosis IV

Impaired social interaction related to egocentric and narcissistic behaviour, evidenced by inability to develop satisfying relationships and manipulation of others for own desires.

Objective: Patient will interact with others in an appropriate manner.

Intervention:

Interventions	Rationale
(a) Recognize that manipulative behaviour helps to decrease feelings of insecurity by increasing feelings of power and control.	Understanding the rationale behind the behaviour may facilitate greater acceptance of the individual.
(b) Set limits on manipulative behaviour. Explain the consequences if limits are violated. Terms of the limits must be agreed upon by all the staff who will be working with the patient.	Consequences for violation of limits must be consistently administered.
(c) Ignore attempts by patient to argue or bargain his way out of the limit setting.	Lack of feedback may decrease these behaviours.
(d) Give positive reinforcement for non-manipulative behaviours.	To enhance self-esteem and promote repetition of desirable behaviour.
(e) Discuss consequences of patient's behaviour and how attempts are made to attribute them to others.	Patient must accept responsibility for own behaviour before adaptive change can occur.
(f) Help patient identify positive aspects about self, recognize accomplishments and feel good about them.	As self-esteem increases patient will feel lesser need to manipulate others for own gratification.

Diagnosis V

Self-esteem disturbances related to unmet dependency needs, lack of positive feedback, unrealistic self-expectations.

Objective: Patient will have realistic expectations about self.

Interventions:

Interventions	Rationale
(a) Ask how client would like to be addressed. Avoid approaches that imply different perception of the client's importance.	Grandiosity is thought actually to reflect low self-esteem.
(b) Explain rationale for requests by staff unit routine etc; strictly adhere to courteous approaches, matter-of-fact style and friendly attitudes.	Management approaches should reinforce patient's dignity and worth; understanding reasons enhances co-operation with regimen.
(c) Encourage verbalization and identification of feelings related to issues of chronicity, lack of control over self, etc.	Problem solving begins with agreeing on the problem.
(d) Offer matter-of-fact feedback regarding unrealistic plans. Help him to set realistic goals for himself.	Unrealistic goals will increase failures and lower self-esteem even more.
(e) Encourage client to view life after discharge and identity aspects over which control is possible. Through role play, practice how he will demonstrate that control.	Role rehearsal is helpful in returning patient to the level of independent functioning. When the individual is functioning well, sense of self-esteem is enhanced.

Diagnosis VI

Altered family processes related to euphoric mood and grandiose ideas, manipulative behaviour, refusal to accept responsibility for own actions.

Objective: The family members will demonstrate coping ability in dealing with the patient.

Intervention:

Intervention	Rationale
(a) Determine individual situation and feelings of individual family members like guilt, anger, powerlessness, despair and	Living with a family member having bipolar illness fosters a multitude of feelings and problems that can affect interpersonal relationships and may

alienation.	result in dysfunctional responses and family disintegration.
(b) Assess patterns of communication. For example: Are feelings expressed freely? Who makes decisions? What is the interaction between family members?	Provides clues to the degree of problem being experienced by individual family members and coping skills used to handle the crisis.
(c) Determine patterns of behaviour displayed by patient in his relationships with others, e.g. manipulation of self-esteem of others, limit testing etc.	These behaviours are typically used by the manic individual to manipulate others. The result is alienation, guilt, ambivalence and high rates of divorce can occur.
(d) Assess the role of patient in the family, like provider etc, and how the illness affects the roles of other members.	When the role of an ill person is not filled family disintegration can occur.
(e) Provide information about behaviour patterns and expected course of the illness.	Assists family to understand the various aspects of bipolar illness. This may relieve guilt and promote family discussions of the problems and solutions.

Evaluation

In this step, the community health practitioners assesses if the goals of care are achieved. The plan may need to be revised or modified in the light of this evaluation.

3.1.2 Depressive episode

Depression is a widespread mental health problem affecting many people. The lifetime risk of depression in males is 8 to 12 percent and in females is 20 to 26 percent. Depression occurs twice as frequently in women as in men.

Classification (ICD10)

Mild depression
Moderate depression
Severe depression
Severe depression with psychotic symptoms

Clinical Features

The typical depressive episode is characterized by the following features, which should last for at least two weeks in order to make a diagnosis:

Depressed mood: Sadness of mood or loss of interest and loss of pleasure in almost all activities (pervasive sadness), present throughout the day (persistent sadness).

Depressive cognitions: Hopelessness (a feeling of 'no hope in future' due to pessimism), helplessness (the patient feels that no help is possible), worthlessness (a feeling of inadequacy and inferiority), unreasonable guilt and self-blame over trivial matters in the past.

Suicidal thoughts: Ideas of hopelessness are often accompanied by the thought that life is no longer worth living and that death had come as a welcome release. These gloomy preoccupations may progress to thoughts of and plans for suicide.

Psychomotor activity: Psychomotor retardation is frequent. The retarded patient thinks, walks and acts slowly. Slowing of thought is reflected in the patient's speech; questions are often answered after a long delay and in a monotonous voice. In older patients agitation is common with marked anxiety, restlessness and feelings of uneasiness.

Psychotic features: Some patients have delusions and hallucinations (the disorder may then be termed as psychotic depression); these are often mood congruent i.e. they are related to depressive themes and reflect the patient's dysphoric mood. For example, nihilistic delusions (beliefs about the non-existence of some person or thing), delusions of guilt, delusions of poverty etc may be present.

Some patients experience delusions and hallucinations that are not clearly related to depressive themes (mood incongruent), for example, delusion of control. The prognosis then appears to be much worse.

Somatic symptoms of depression, according to ICD10 (these are called as "melancholic features" in DSMIV):

Significant decrease in appetite or weight.

Early morning awakening, at least 2 or more hours before the usual time of waking up.

Diurnal variation, with depression being worst in the morning.

Pervasive lack of interest and lack of reactivity to pleasurable stimuli.

Psychomotor agitation or retardation.

Other Features

Difficulties in thinking and concentration.

Subjective poor memory.

Menstrual or sexual disturbances.

Vague physical symptoms such as fatigue, aching discomfort, constipation etc.

Treatment

Pharmacotherapy

Antidepressants are the treatment of choice for a vast majority of depressive episodes.

Electroconvulsive therapy (ECT)

Severe depression with suicidal risk is the most important indication for ECT.

Psychosocial Treatment

Cognitive therapy: It aims at correcting the depressive negative cognitions like hopelessness, worthlessness, helplessness and pessimistic ideas and replacing them with new cognitive and behavioural responses.

Supportive psychotherapy: Various techniques are employed to support the patient. They are reassurance, ventilation, occupational therapy, relaxation and other activity therapies.

Group therapy: Group therapy is useful for mild cases of depression. In group therapy negative feelings such as anxiety anger, guilt, despair are recognized and emotional growth is improved through expression of their feelings.

Family therapy: Family therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors, which may help in faster and more complete recovery.

Behaviour therapy: It includes social skills training, problem solving techniques, assertiveness training, self-control therapy, activity scheduling and decision making techniques.

Course and Prognosis of Mood Disorders

An average manic episode lasts for 3-4 months, while a depressive episode lasts for 4-9 months.

Good Prognostic Factors

Abrupt or acute onset
Severe depression
Typical clinical features
Well-adjusted premorbid personality
Good response to treatment.

Poor Prognostic Factors

Double depression
Co-morbid physical disease, personality disorders or alcohol dependence.
Chronic ongoing stress.
Poor drug compliance
Marked hypochondriacal features or mood incongruent psychotic features.

3.1.3 **Other mood disorders**

Bipolar Mood Disorder

This is characterized by recurrent episodes of mania and depression in the same patient at different times.

Bipolar mood disorders is further classified into bipolar I and bipolar II disorder (DSMIV).

Bipolar I: Episodes of severe mania and severe depression
Bipolar II: Episodes of hypomania and severe depression

Recurrent Depressive Disorder

This disorder is characterized by recurrent depressive episodes. The current episode is specified as mild, moderate, severe, severe with psychotic symptoms.

Persistent Mood Disorder
(Cyclothymia and Dysthymia)

These disorders are characterized by persistent mood symptoms that last for more than 2 years. Cyclothymia refers to a persistent instability in mood in which there are numerous periods of mild elation or mild depression.

Dysthymia (neurotic/reactive depression) is a chronic, mild depressive state persisting for months or years. It is more common in females with an average age of onset in late third decade. An episode of major depression may sometimes become super-imposed on an underlying neurotic depression. This is known as 'double depression'.

Endogenous	Reactive
(a) Caused by factors within the individual	Caused by stressful events.
(b) Premorbid personality: cyclothymic or dysthymic	Premorbid personality: anxious or obsessive
(c) Early morning awakening (late insomnia)	Difficulty in falling asleep (early insomnia)
(d) Patient feels more sad in the morning	Patient feels more sad in the evening.
(e) Feels better when alone.	Feels better when in a group
(f) Psychotic features like psychomotor retardation, suicidal tendencies, delusions etc are common	Usually psychomotor agitation and no other psychotic features.
(g) Relapses are common	Relapses are uncommon
(h) ECT and antidepressants are used for management	Psychotherapy and antidepressants are used for management.
(i) Insight is absent	Insight is present

Management of Major Depressive Episode

Assessment

Assessment should focus on judging the severity of the disorder including the risk of suicide, identifying the possible causes, the social resources available to the patient and the effects of the disorder on other people. Although there is a risk of suicide in every depressed patient, the risk is much more in the presence of the following factors:

Presence of marked helplessness

Male sex

More than 40 years of age

Unmarried, widowed or divorced

Written or verbal communication of suicidal intent or plan

Early stages of depression

Recovery from depression (at the peak of depression the patient is usually either too depressed or too retarded to commit suicide).
Period of three months from recovery

The community health practitioners should routinely enquire about the patient's work, financies, family life, social activities, general living conditions and physical health. It is also important to consider whether the patient could endanger other people, particularly if there are depressive delusions and the patient may act on them.

Diagnosis I

High risk for self-directed violence related to depressed mood, feelings of worthlessness and anger directed inward on the self.
Objective: Patient will not harm self.
Intervention:

Interventions	Rationale
(a) Ask the patient directly "Have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan?"	The risk of suicide is greatly increased if the patient has developed a plan and if means exist for the patient to execute the plan.
(b) Create a safe environment for the patient. Remove all potentially harmful objects from patient's vicinity (sharp objects, straps, belts, glass items, alcohol etc), supervise closely during meals and medication administration.	Patient's safety is the community health practitioner priority
(c) Formulate a short-term verbal or written contract that the patient will not harm self. Secure a promise that the patient will seek out staff when feeling suicidal.	A degree of the responsibility for his safety is given to the patient. Increased feelings of self-worth may be experienced when patient feels accepted unconditionally regardless of behaviour.
(d) Do not leave the patient alone. Observe for passive suicide – the patient may starve or fall asleep in the bath-tub or sink.	Patient's safety is the community health practitioner priority

(e) Close observation is especially required when the patient is recovering from the disease.	At the peak of depression the patient is usually too retarded to carry out his suicidal plans.
(f) Do not allow the patient to put the bolt on his side of the door bathroom or toilet.	Patient's safety is the community health practitioners priority
(g) If the patient suddenly becomes unusually happy or gives any other clues of suicide, special observation may be necessary.	-do-
(h) Encourage the patient to express his feelings, including anger.	Depression and suicidal behaviour may be viewed as anger turned inward on the self. If the anger can be verbalized in a non-threatening environment, the patient may be able to eventually resolve these feelings.

Diagnosis II

Dysfunctional grieving related to real or perceived loss, bereavement, evidenced by denial of loss, inappropriate expression of anger, inability to carry out activities of daily living.

Objective: Patient will be able to verbalize normal behaviours associated with grieving.

Intervention:

Intervention	Rationale
(a) Assess stage of fixation in grief process	Accurate baseline data is required to plan accurate care.
(b) Be accepting of patient and spend time with him. Show empathy, care and unconditional, positive regard.	These interventions provide the basis for a therapeutic relationship.
(c) Explore feelings of anger and help patient direct them towards the intended object or person.	Until patient can recognize and accept personal feelings regarding the loss, grief work cannot progress.
(d) Provide simple activities which can be easily and quickly accomplished. Gradually increase the amount and complexity of activities.	Physical activities are a safe and effective way of relieving anger.

Diagnosis III

Powerlessness related to dysfunctional grieving process, life-style of helplessness, evidenced by feelings of lack of control over life situations, over-dependence on others to fulfill needs.

Objective: The patient will be able to take control of life situations

Intervention:

Interventions	Rationale
(a) Allow the patient to take decisions regarding own care.	Providing patient with choices will increase his feelings of control.
(b) Ensure that goals are realistic and that patient is able to identify life situations that are realistically under his control	To avoid repeated failures which further increase his sense of powerlessness.
(c) Encourage the patient to verbalize feelings about areas that are not in his ability to control.	Verbalization of unresolved issues may help the patient to accept what cannot be changed.

Diagnosis IV

Self-esteem disturbance related to learned helplessness, impaired cognition, negative view of self, evidenced by expression of worthlessness, sensitivity to criticism, negative and pessimistic outlook.

Objective: Patient will be able to verbalize positive aspects about self and attempt new activities without fear of failure.

Intervention:

Interventions	Rationale
(a) Be accepting of patient and spend time with him, even though pessimism and negativism may seem objectionable.	These interventions contribute toward feelings of self-worth.
(b) Focus on strengths and accomplishments and minimize failures.	-do-
(c) Provide him with simple and easily achievable activity. Encourage the patient to perform his activities without assistance.	Success and independent promote feelings of self-worth.
(d) Encourage patient to recognize areas of change and provide assistance toward this effort.	To facilitate problem solving.

(e) Teach assertiveness and coping skills.	Their use can serve to enhance self-esteem.

Diagnosis V

Altered communication process related to depressive cognitions, evidenced by being able to interact with others, withdrawn, expressing fear of failure or rejection.

Objective: Patient will communicate or interact with staff or other patients in the unit.

Intervention:

Intervention	Rationale
(a) Observe for non-verbal communication. The patient may say that he is happy but look sad. Point out this discrepancy in what he is saying and actually feeling.	To facilitate better responses and communication.
(b) Use short sentences. Ask any questions in such a way that the patient will have to answer in more than one word.	-do-
(c) Use silence appropriately without communicating anxiety or discomfort in doing so.	Using silence when the situation demands can be therapeutic.
(d) Introduce the patient to another patient who is quiet and possibly convalescing from depression.	There is less anxiety in relating to a person other than staff.
(e) As he improves, take him to the other patients and see that he is actually included as part of the group.	Group support is important in facilitating communication.

Diagnosis VI

Altered sleep and rest, related to depressed mood and depressive cognitions evidenced by difficulty in falling asleep, early morning awakening, verbal complaints of not feeling well-rested.

Objective: Patient will improve sleep pattern.

Intervention:

Intervention	Rationale
(a) Plan daytime activities according to the patient's interests, do not allow him to sit idle.	To improve sleep during night.
(b) Ensure a quiet and peaceful environment when the patient is preparing for sleep.	-do-
(c) Provide comfort measures (back, rub, tipid bath, warm milk etc)	-do-
(d) Do not allow the patient to sleep fro long time during the day.	-do-
(e) Give p.r.n. sedatives as prescribed	-do-
(f) Talk to the patient for a brief period at bedtime. Do not enter into lengthy conversations.	Talking to the patient helps to relieve his anxiety, but engaging in long talks may increase depressive thinking.

Diagnosis VIII

Altered nutrition, less than body requirements related to depressed mood, lack of appetite or lack of interest in food, evidenced by weight loss, poor muscle tone, pale conjunctiva, poor skin turgor.

Objective: Patient's nutritional status will improve.

Intervention:

Intervention	Rationale
(a) Closely monitor the client's food and fluid nutritional intake; maintain intake and output chart	These are useful data for assessing nutritional status
(b) Record patient's weight regularly	-do-
(c) Find out the likes and dislikes of the person before he was sick and serve the best preferred food.	To encourage eating and improve nutritional status.
(d) Serve small amounts frequently of a light or liquid diet that is nourishing	-do-
(e) Record the client's patterns of bowel elimination.	To assess for constipation.

(f) Encourage more fluid intake, roughage diet and green leafy vegetables.	For relief of constipation if present

Diagnosis VIII

Self-care deficit related to depressed mood, feelings of worthlessness, evidenced by poor personal hygiene and grooming.

Objective: Patient will maintain adequate personal hygiene.

Intervention:

Intervention	Rationale
(a) Ensure that he takes his bath regularly	Depressive patient will not have any interest for self-care and may need assistance.
(b) Do not ask the patient's permission for a wash or bath. For instance, do not ask "Do you want to have a bath?" Instead, lead the patient to the action with positive suggestions e.g. "The water is ready, let me take you for a bath".	Positive suggestions will usually enhance patient's cooperation
(c) When the patient has taken care of himself, express realistic appreciation.	Positive reinforcement will improve desirable behaviour.

Evaluation

Evaluation is facilitated by using the following types of questions:

Has self-harm to the individual been avoided?

Have suicidal ideations subsided?

Does patient set realistic goals for self?

Is he able to verbalize positive aspects about self, past accomplishments and future prospects?

4.0 Conclusion

Mood disorders were explored by this unit and some diagnoses were identified and managed for your benefit.

5.0 Summary

The learners have gone through mood disorders in this unit, it's an opportunity for each learner to have better understanding of mood disorders so that positive mental health can be promoted.

6.0 Tutor Marked Assignment

(1) Discuss the differences between endogenous and reactive depressive illness.

(2) What are the preventive measures that can be taken to avoid depressive illness.

7.0 References / Further Readings

Verghese, M. 1994. Essentials of Psychiatric and Mental Health Nursing, New Delhi: Churchill Livingstone PVT Ltd.

Morrison, M. 1997. Foundation of Mental Health Nursing, Philadelphia: Mosby.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 3: Psychoneuroses

Contents

1.0 Introduction

Neurosis is a less severe form of psychiatric disorder where patients show either excessive or prolonged emotional reaction to any given stress. In this unit, the learners will go through the differences between psychosis ad neurosis, classification of psychoneurosis and management of these mental disorders.

2.0 Objectives

At the end of this unit, the learners should be able to:

- differentiate between psychosis and neurosis
- classify psychoneurosis
- describe phobic anxiety disorder
- explain what somatoform disorders are.

3.0 Main content

3.1 Differences between psychosis and neurosis

Etiology	Psychotic disorder	Neurotic disorder
Genetic factors	More important	Less important
Stressful life events	Less important	More important
Clinical features		

Disturbances of thinking and perception	Common	Rare
Disturbances in cognitive function	Common	Rare
Behaviour	Markedly affected	Not affected
Judgment	Impaired	Intact
Insight	Lost	Present
Reality testing	Lost	Present
Treatment		
Drugs	Major tranquilizers commonly used	Minor tranquilizers and anti-depressants are commonly used
ECT	Very useful	Not useful
Psychotherapy	Not much useful	Very useful
Prognosis	Difficult to treat; relapses are common; complete recovery may not be possible	Relatively easy to treat; relapses are uncommon; complete recovery is possible.

3.2 **Classification**

3.2.1 **Phobic anxiety disorder**

Anxiety is a normal phenomenon, which is characterized by a state of apprehension or uneasiness arising out of anticipation of danger. Normal anxiety becomes pathological when it causes significant subject distress and impairment of functioning of the individual.

Anxiety disorders are abnormal states in which the most striking features are mental and physical symptoms of anxiety, which are not caused by organic brain disease or any other psychiatric disorder.

A phobia is an unreasonable fear of a specific object, activity or situation. This irrational fear is characterized by the following features:

It is disappropriate to the circumstances that precipitate it.

It cannot be dealt with by reasoning or controlled through will power.

The individual avoids the feared object or situation.

In phobic anxiety disorders, the individual experiences intermittent anxiety which arises in particular circumstances i.e. in response to the phobic object or situation.

Types of Phobia

Simple phobia
Social phobia
Agoraphobia

Simple phobia (Specific phobia): Simple phobia is an irrational fear of a specific object or stimulus. Simple phobias are common in childhood. By early teenage most of these fears are lost, but a few persist till adult life. Sometimes they may reappear after a symptom-free period. Exposure to the phobic object often results in panic attacks.

Examples of some specific phobias: Acrophobia – fear of heights Hematophobia - fear of the sight of blood Claustrophobia - fear of closed spaces Gamophobia - fear of marriage Insectophobia - fear of insects AIDS phobia - fear of AIDS

Social phobia: Social phobia is an irrational fear of performing activities in the presence of other people or interacting with others. The patient is afraid of his own actions being viewed by others critically, resulting in embarrassment or humiliation.

Agoraphobia: It is characterized by an irrational fear of being in places away from the familiar setting of home, in crowds, or in situations that the patient cannot leave easily.

As the agoraphobia increases in severity, there is a gradual restriction in normal day-to-day activities. The activity may become so severely restricted that the person becomes self-imprisoned at home.

In all the above-mentioned phobias, the individual experiences the same core symptoms as in generalized anxiety disorders.

Etiology

Psychodynamic theory: According to this theory, anxiety is usually dealt with repression. When repression fails to function adequately, other

secondary defense mechanisms of ego come into action. In phobia, this secondary defence mechanism is displacement. By displacement, anxiety is transferred from a really dangerous or frightening object to a neutral object. These two objects are connected by symbolic associations. The neutral object chosen unconsciously is the one that can be easily avoided in day-to-day activities, in contrast to the frightening object.

Learning theory: According to classical conditioning, a stressful stimulus produces an unconditioned response – fear. When the stressful stimulus is repeatedly paired with a harmless object, eventually the harmless object alone produces the fear, which is now a conditioned response. If the person avoids the harmless object to avoid fear, the fear becomes a phobia.

Cognitive theory: Anxiety is the product of faulty cognitions or anxiety-inducing self-instructions. Cognitive theorists believe that some individuals engage in negative and irrational thinking that produce anxiety reactions. The individual begins to seek out avoidance behaviours to prevent the anxiety reactions and phobias result.

Course

The phobias are more common in women with an onset in late second decade or early third decade. Onset is sudden without any cause. The course is usually chronic. Sometimes phobias are spontaneous remitting.

Treatment

Pharmacotherapy

Benzodiazepines (e.g. alprazolam, clonazepam, lorazepam, diazepam)
Antidepressants (e.g. imipramine, sertraline, phenelzine)

Behaviour therapy

Flooding
Systematic desensitization
Exposure and response prevention
Relaxation techniques.

Cognitive therapy

This therapy is used to break the anxiety patterns in phobic disorders.
Psychotherapy: Supportive psychotherapy is a helpful adjunct to behaviour and drug treatment.

Management

Assessment

Assessment parameters focus on physical symptoms, precipitating factors, avoidance behaviour associated with phobia, impact of anxiety on physical functioning, normal coping ability, thought content and social support systems.

Diagnosis I

Fear related to a specific stimulus (simple phobia) or causing embarrassment to self in front of others, evidenced by behaviour directed towards avoidance of the feared object/situation.

Objective: Patient will be able to function in the presence of phobic object or situation without experiencing panic anxiety.

Intervention:

Intervention	Rationale
(a) Reassure the patient that he is safe.	At the panic level of anxiety patient may fear for his own life.
(b) Explore patient's perception of the threat to physical integrity or threat to self concept.	It is important to understand patient's perception of the phobic object or situation to assist with the desensitization process.
(c) Include patient in making decisions related to selection of alternative coping strategies (e.g. patient may choose either to avoid the phobic stimulus or attempt to eliminate the fear associated with it).	Allowing the patient choices provides a measure of control and serves to increase feelings of self-worth.
(d) If the patient elects to work on eliminating the fear, techniques of desensitization or implosion therapy may be employed.	Fear decreases as the physical and psychological sensations diminish in response to repeated exposure to the phobic stimulus under non-threatening conditions.
(e) Encourage patient to explore underlying feelings that may be contributing to irrational fears.	Facing these feelings rather than suppressing them may result in more adaptive coping abilities.

Diagnosis II

Social isolation related to fear of being in a place from which one is unable to escape, evidenced by staying alone, refusing to leave the room/home.

Objective: Patient will voluntarily participate in group activities with peers.
Intervention:

Interventions	Rationale
(a) Convey an accepting attitude and unconditional positive regard. Make brief, frequent contacts. Be honest and keep all promises.	These interventions increase feelings of self-worth and facilitate a trusting relationship.
(b) Attend group activities with the patient that may be frightening for him.	The presence of a trusted individual provides emotional security.
(c) Administer anti-anxiety medications as ordered by the physician, monitor for effectiveness and adverse affects.	Anti-anxiety medications help to reduce the level of anxiety in most individuals, thereby facilitating interaction with others.
(d) Discuss with the patient signs and symptoms of increasing anxiety and techniques to interrupt the response (e.g. the relaxation exercises, thought stopping).	Maladaptive behaviour such as withdrawal and suspiciousness are manifested during times of increased anxiety.
(e) Give recognition and positive reinforcement for voluntary interactions with others.	To enhance self-esteem and encourage repetition of acceptable behaviours.

3.2.2 **Generalized anxiety disorder**

Generalized anxiety disorders are those in which anxiety is unvarying and persistent (unlike phobic anxiety disorders where anxiety is intermittent and occurs only in the presence of a particular stimulus). It is the most common neurotic disorder and it occurs more frequently in women. The prevalence rate of generalized anxiety disorders is about 2.5-8 percent.

Clinical Features

Generalized anxiety disorder (GAD) is manifested by the following signs of motor tension, autonomic hyperactivity, apprehension and vigilance, which should last for at least 6 months in order to make a diagnosis:

Psychological: fearful anticipation, irritability, sensitivity to noise, restlessness, poor concentration, worrying thoughts and apprehension.
Physical:

Gastrointestinal – dry mouth, difficulty in swallowing, epigastric discomfort, frequent or loose motions.

Respiratory – constriction in the chest, difficulty inhaling, overbreathing.

Cardiovascular – palpitations, discomfort in chest.

Genitourinary – frequency or urgent micturition, failure of erection, menstrual discomfort, amenorrhea

Neuromuscular system – tremor, prickling sensations, tinnitus, dizziness, headache, aching muscles.

Sleep disturbances – insomnia, night terror.

Other symptoms: depression, obsessions, depersonalization, derealization

Course

It is characterized by an insidious onset in the third decade and usually runs a chronic course.

3.2.3 Panic disorder

Panic disorder is characterized by anxiety, which is intermittent and unrelated to particular circumstances (unlike phobic anxiety disorders where, though anxiety is intermittent, it occurs only in particular situations). The central feature is the occurrence of panic attacks i.e. sudden attacks of anxiety in which physical symptoms predominate and are accompanied by fear of a serious consequence such as a heart attack. The lifetime prevalence of panic disorder is 1.5 to 2 percent. It is seen 2 to 3 times more often in females.

Clinical Features

Shortness of breath and smothering sensations

Choking, chest discomfort or pain

Palpitations

Sweating, dizziness, unsteady feelings or faintness

Nausea or abdominal discomfort

Depersonalization or derealization

Numbness or tingling sensations

Flushes or chills

Trembling or shaking

Fear of dying

Fear of going crazy or doing something uncontrolled.

Course

The onset is usually in early third decade with often a chronic course. It occurs recurrently every few days. The episode is usually sudden in onset and lasts for a few minutes.

Etiology of Anxiety Disorders (both GAD and panic disorder)

Genetic theory: Anxiety disorder is most frequent among relatives of patients with this condition. About 15 to 20 percent of the first-degree relatives of patients with anxiety disorder exhibit anxiety disorders themselves. The concordance rate in monozygotic twins of patients with panic disorder is 80 percent.

Biochemical factors: Alteration in GABA levels may lead to production of clinical anxiety.

Psychodynamic theory: According to this theory, anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanisms of ego come into action. In anxiety repression fails to function adequately and the secondary defense mechanisms are not activated. Hence anxiety comes to the forefront.

Behavioural theory: Anxiety is viewed as an unconditional inherent response of the organism to a painful stimulus.

Cognitive theory: According to this theory anxiety is related to cognitive distortions and negative automatic thoughts.

Treatment

Pharmacotherapy

Benzodiazepines (e.g. alprazolam, clonazepam)

Antidepressants for panic disorder

Betablockers to control severe palpitations that have not responded to anxiolytics (e.g. propranolol)

Behavioural therapies Bio-

feedback

Hyperventilation control

Other psychological therapies

Jacobson's progressive muscle relaxation technique, yoga, pranayama, meditation and self-hypnosis

Supportive psychotherapy

Management

Assessment

Assessment should focus on collection of physical, psychological and social data. The community health practitioners should be particularly aware of the fact that major physical symptoms are often associated with autonomic nervous system stimulation. Specific symptoms should be noted, along with statements made by the client about subjective distress. The nurse must use clinical judgment to determine the level of anxiety being experienced by the client.

Diagnosis I

Panic anxiety related to real and perceived threat to biological integrity or self-concept, evidenced by various physical and psychological manifestations.

Objective: Patient will be able to recognize symptoms of onset on anxiety and intervene before reaching panic level.

Intervention:

Intervention	Rationale
(a) Stay with the patient and offer reassurance of safety and security.	Presence of trusted individual provides feeling of security and assurance of personal safety.
(b) Maintain a calm, non-threatening matter-of-fact approach.	Anxiety is contagious and may be transferred from staff to patient or vice-versa.
(c) Use simple words and brief messages, spoken calmly and clearly to explain hospital experiences.	In an intensely anxious situation, patient is unable to comprehend anything but the most elementary communication.
(d) Keep immediate surroundings low in stimuli (dim lighting, few people).	A stimulating environment may increase anxiety level.
(e) Administer tranquilizing medication as prescribed by physician. Assess for effectiveness and for side-effects.	Anti-anxiety medication provides relief from the immobilizing effects of anxiety.
(f) When level of anxiety has been reduced, explore possible reasons for occurrences.	Recognition of precipitating factors is the first step in teaching patient to interrupt escalating anxiety.
(g) Teach signs and symptoms of	The first three of these activities

escalating anxiety and ways to interrupt its progression (relaxation techniques, deep-breathing exercises and medication, or physical exercise like brisk walls and jogging.	result in physiologic response opposite of the anxiety response i.e. a sense of calm, slowed heart rate etc. The latter activities discharge energy in a healthy manner.

Diagnosis II

Powerlessness related to impaired cognition, evidenced by verbal expression of lack of control over life situations and non-participation in decision-making related to own care or significant life issues.

Objective: Patient will be able to effectively solve problems and take control of his life.

Intervention:

Intervention	Rationale
(a) Allow patient to take as much responsibility as possible for self-care activities, provide positive feedback for decisions made.	Providing choices will increase patient's feeling of control.
(b) Assist patient to set realistic goals.	Unrealistic goals set the patient up for failure and reinforce feelings of powerlessness.
(c) Help identify life situations that are within patient's control.	Patient's emotional condition interferes with the ability to solve problems.
(d) Help patient identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability.	Assistance is required to perceive the benefits and consequences of available alternatives accurately, to deal with unresolved issues and accept what cannot be changed.

Evaluation

Identified objectives serve as the basis for evaluation. In general, evaluation of objectives for clients with anxiety disorders deals with questions such as the following:

Is the client experiencing a reduced level of anxiety?

Does the client recognize symptoms as anxiety-related?

Is the client able to use newly learned behaviours to manage anxiety?

3.2.4 **Obsessive-compulsive disorder**

Definition

According to ICD9, obsessive-compulsive disorder is a state in which "the outstanding symptom is a feeling of subjective compulsion – which must be resisted – to carry out some action, to dwell on an idea, to recall an experience, or ruminate on an abstract topic. Unwanted thoughts, which include the insistency of words or ideas are perceived by the patient to be inappropriate or nonsensical. The obsessional urge or idea is recognized as alien to the personality, but as coming from within the self. Obsessional rituals are designed to relieve anxiety e.g. washing the hands to deal with contamination. Attempts to dispel the unwelcome thoughts or urges may lead to a severe inner struggle, with intense anxiety.

From the above, obsessions and compulsions should have the following characteristics:

They are ideas, impulses or images, which intrude into conscious awareness repeatedly.

They are recognized as the individual's own thoughts or impulses.

They are unpleasant and recognized as irrational.

Patient tries to resist them but is unable to.

Failure to resist leads to marked distress.

Rituals (compulsions) are performed with a sense of subjective compulsion (urge to act).

They are aimed at either preventing or neutralizing the distress or fear arising out of obsessions.

The disorder may begin in childhood, but more often begins in adolescence or early adulthood. It is equally common among men and women. The course is usually chronic.

Classification (ICD10)

OCD with predominantly obsessive thoughts or ruminations.

OCD with predominantly compulsive acts.

OCD with mixed obsessional thoughts and acts.

Etiology

Genetic Factors

Twin studies have consistently found a significantly higher concordance rate for monozygotic twins than for dizygotic twins. Family studies of these patients have shown that 35 percent of the first-degree relatives of obsessive-compulsive disorder patients are also affected with the disorder.

Biochemical Influences

A number of studies suggest that the neuro-transmitter serotonin (5-HT) may be abnormal in individuals with obsessive-compulsive disorder.

Psychoanalytic Theory

The psychoanalytic concept (Freud) views patients with obsessive-compulsive disorder (OCD) as having regressed to developmentally earlier stages of the infantile superego, whose harsh, exacting punitive characteristics now reappear as part of the psychopathology.

Freud also proposed that regression to the pre-oedipal anal sadistic phase combined with the use of specific ego defense mechanisms like isolation, undoing, displacement and reaction formation, may lead to OCD.

Behaviour Theory

This theory explains obsessions as a conditioned stimulus to anxiety. Compulsions have been described as learned behaviour that decreases the anxiety associated with obsessions. This decrease in anxiety positively reinforces the compulsive acts and they become stable learned behaviour. This theory is more useful for treatment purposes.

Clinical Picture

Obsessional thoughts: These are words, ideas and beliefs that intrude forcibly into the patient's mind. They are usually unpleasant and shocking to the patient, and may be obscene or blasphemous.

Obsessional images: These are vividly imagined scenes, often of a violent or disgusting kind, involving abnormal sexual practices, for example.

Obsessional ruminations: These involve internal debates in which arguments for and against even the simplest everyday actions are reviewed endlessly.

Obsessional doubts: These may concern actions that may not have been completed adequately. The obsession often implies some danger such as forgetting to turn off the stove or not locking a door. It may be followed by a compulsive act, such as the person making multiple trips back into the house to check if the stove has been turned off.

Sometimes these may take the form of doubting the very fundamentals of beliefs, such as, doubting the existence of God and so on.

Obsessional impulses: These are urges to perform acts, usually of a violent or embarrassing kind, such as injuring a child, shouting in church etc.

Obsessional rituals: These may include both mental activities counting repeatedly in a special way or repeating a certain form of words, and repeated but senseless behaviours such as washing hands 20 or more times a day. Sometimes such compulsive acts may be preceded by obsessional thoughts; for example, repeated hand washing may be preceded by thoughts of contamination. These patients usually believe that the contamination is spread from object to object or person to person even by slight contact and may literally rub the skin off their hands by excessive hand washing.

Obsessive slowness: Severe obsessive ideas or extensive compulsive rituals characterize obsessional slowness in the relative absence of manifested anxiety. This leads to marked slowness in daily activities.

Course and Prognosis

Course is usually long and fluctuating. About two-thirds of patients improve by the end of a year. A good prognosis is indicated by good social and occupational adjustment, the presence of a precipitating event and an episodic nature of symptoms.

Prognosis appears to be worse when the onset is in childhood, the personality is obsessional, symptoms are severe, compulsions are bizarre or there is a coexisting major depressive disorder.

Treatment

Pharmacotherapy

Antidepressants (e.g. fluvoxamine, sertraline, etc.)

Anxiolytics (e.g. benzodiazepines)

Behaviour Therapy

Exposure and response prevention
Thought stoppage
Desensitization
Aversive conditioning

Exposure and response prevention: This is vivo exposure procedure combined with response prevention techniques. For example compulsive handwashers are encouraged to touch contaminated objects and then refrain from washing in order to break the negative reinforcement chain (hand washing reducing the anxiety i.e. negative reinforcement).

Thought stoppage: Thought stopping is a technique to help an individual to learn to stop thinking unwanted thoughts. Following are the steps in thought stopping:

Sit in a comfortable chair, bring to mind the unwanted thought concentrating on only one thought per procedure.

As soon as the thought forms give the command 'Stop!' Follow this with calm and deliberate relaxation of muscles and diversion of thought to something pleasant.

Repeat the procedure to bring the unwanted thought under control.

Other Therapies

Supportive psychotherapy.
ECT – for patients refractory to other forms of treatment.

Management

Assessment

Assessment should focus on the collection of physical, psychological and social data. The nurse should be particularly aware of the impact of obsessions and compulsions on physical functioning, mood, self-esteem and normal coping ability. The defense mechanisms used, thought content or process, potential for suicide, ability to function and social support systems available should also be noted.

Diagnosis I

Ineffective individual coping related to under-developed ego, punitive superego, avoidance learning, possible biochemical changes, evidenced by ritualistic behaviour or obsessive thoughts.

Objective: Patient will demonstrate ability to cope effectively without resorting to obsessive-compulsive behaviour.

Intervention:

Intervention	Rationale
(a) Work with patient to determine types of situations that increase anxiety and result in ritualistic behaviours.	Recognition of precipitating factors is the first step in teaching the patient to interrupt escalating anxiety.
(b) Initially meet the patient's dependency needs. Encourage independence and give positive reinforcement for independent behaviours.	Sudden and complete elimination of all avenues for dependency would create intense anxiety on the part of the patient. Positive reinforcement enhances self-esteem and encourages repetition of desired behaviours.
(c) In the beginning of treatment, allow plenty of time for rituals. Do not be judgmental or verbalize disapproval of the behaviour.	Denying patient this activity may precipitate panic anxiety.
(d) Support patient's efforts to explore the meaning and purpose of the behaviour.	Patient may be unaware of the relationship between emotional problems and compulsive behaviours. Recognition is important before change can occur.
(e) Provide structured schedule of activities for patient, including adequate time for completion of rituals.	Structure provides a feeling of security for the anxious patient.
(f) Gradually begin to limit amount of time allotted for ritualistic behaviour as patient becomes more involved in unit activities.	Anxiety is minimized when patient is able to replace ritualistic behaviour.
(g) Give positive reinforcement for non-ritualistic behaviours.	Positive reinforcement encourages repetition of desired behaviour.
(h) Help patient learn ways of interrupting obsessive thoughts and ritualistic behaviour with techniques such as thought stopping, relaxation and exercise.	These activities help in interruption of obsessive thoughts.

Diagnosis II

Altered role performance related to need to perform rituals, evidenced by inability to fulfill usual patterns of responsibility.

Objective: Patient will be able to resume role-related responsibilities.

Intervention:

Intervention	Rationale
(a) Determine patient's previous role within the family and the extent to which this role is altered by the illness. Identify roles of other family members.	This is important assessment data for formulating an appropriate plan of care.
(b) Encourage patient to discuss conflicts evident within the family system. Identify how patient and other family members have responded to this conflict.	Identifying specific stressors, as well as adaptive and maladaptive responses within the system, is necessary before assistance can be provided in an effort to facilitate change.
(c) Explore available options for changes or adjustment in role. Practice through role play.	Planning and rehearsal of potential role transitions can reduce anxiety.
(d) Give patient lots of positive reinforcement for ability to resume role responsibilities by decreasing need for ritualistic behaviours.	Positive reinforcement enhances self-esteem and promotes repetition of desired behaviours.

Evaluation

Evaluation of client with obsessive-compulsive disorder may be done by asking the following questions:

Does the client continue to display obsessive-compulsive symptoms?

Is the client able to use newly learned behaviours to manage anxiety?

Can the client adequately perform self-care activities?

3.2.5 Reaction to stress and adjustment disorder

This category includes:

Acute stress reaction

Post-traumatic stress disorder (PTSD)

Adjustment disorders

Acute Stress Reaction

It is characterized by symptoms like anxiety, despair and anger or over activity. These symptoms are clearly related to the stressor. If removal from the stressful environment is possible, the symptoms resolve rapidly.

Post-traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder is characterized by hyperarousal, re-experiencing of images of the stressful events and avoidance of reminders.

Post-traumatic stress disorder is of a reaction to extreme stressors such as floods, earthquakes, war, rape or serious physical assault. The main symptoms are persistent anxiety, irritability, insomnia, intense intrusive imagery (flashbacks) recurring distressing dreams, inability to feel emotion and diminished interest in activities.

The symptoms may develop after a period of latency, within 6 months after the stress or may be delayed. The general approach is to provide emotional support, to encourage recall of the traumatic events. Benzodiazepine drugs may be needed to reduce anxiety.

Adjustment Disorders

It is characterized by predominant disturbance of emotions and conduct. This disorder usually occurs within one month of a significant life change.

Treatment of Stress and Adjustment Disorders

Drug treatment

Antidepressants
Benzodiazepine

Psychological therapies

Supportive psychotherapy
Crisis intervention
Stress management training.

3.2.6 **Dissociative (Conversion) disorder**

Conversion disorder is characterized by the presence of one or more symptoms suggesting the presence of a neurological disorder that cannot be

explained by any known neurological or medical disorder. Instead, psychological factors like stress and conflicts are associated with onset or exacerbation of the symptoms. Patients are unaware of the psychological basis and are thus not able to control their symptoms.

Some features of the disorder include:

The symptoms are produced because they reduce the anxiety of the patient by keeping the psychologic conflict out of conscious awareness, a process called as primary gain.

These symptoms of conversion are often advantageous to the patient. For example, a woman who develops psychogenic paralysis of the arm may escape from taking care of an elderly relative. Such an advantage is called secondary gain.

The patient does not produce the symptoms intentionally.

The patient shows less distress or shows lack of concern about the symptoms, called as belle indifference.

Physical examination and investigations do not reveal any medical or neurological abnormalities.

Conversion disorders were formally called ‘hysteria’, the term is now changed because the word ‘hysteria’ is used in everyday speech when referring to any extravagant behaviour, and it is confusing to use the same word for the different phenomena that come under this syndrome.

Dissociative Amnesia

Most often, dissociative amnesia follows a traumatic or stressful life situation. There is sudden inability to recall important personal information particularly concerning the stressful life event. The extent of the disturbance is too great to be explained by ordinary forgetfulness. The amnesia may be localized, generalized, selective or continuing in nature.

Dissociative Fugue

Psychogenic fugue is a sudden, unexpected travel away from home or workplace, with the assumption of a new identity and an inability to recall the past. The onset is sudden, often in the presence of severe stress. Following recovery there is no recollection of the events that took place during the fugue. The course is typically a few hours to days and sometimes months.

Dissociative Stupor

In this, patients are motionless and mute and do not respond to stimulation, but they are aware of their surroundings. It is a rare condition.

Ganser's Syndrome

Ganser's syndrome is a rare condition with four features: giving 'approximate answers' to questions designed to test intellectual functions, psychogenic physical symptoms, hallucinations and apparent clouding of consciousness. The term 'approximate answers' denotes answers (to simple questions) that are plainly wrong, but are clearly related to the correct answers in a way that suggest that the latter is known. For example, when asked to add three and three a patient might answer seven and when asked four and five, might answer ten; each answer is one greater than the correct answer. Hallucinations are usually visual and may be elaborate.

Multiple Personality Disorder (Dissociative Identity Disorder)

In this disorder, the person is dominated by two or more personalities of which only one is manifest at a time. Usually one personality is not aware of the existence of the other personalities. Each personality has a full range of higher mental functions and performs complex behaviour patterns. Transition from one personality to another is sudden, and the behaviour usually contrasts strikingly with the patient's normal state.

Trance and Possession Disorders

This disorder is very common in India. It is characterized by a temporary loss of both the sense of personal identity and full awareness of the person's surroundings. When the condition is induced by religious rituals, the person may feel taken over by a deity or spirit. The focus of attention is narrowed to a few aspects of the immediate environment and there is often a limited but repeated set of movements, postures and utterances.

Dissociative Motor Disorders

It is characterized by motor disturbances like paralysis or abnormal movements. Paralysis may be a monoplegia, paraplegia or quadriplegia. The abnormal movement may be tremors, choreiform movements or gait disturbances which increase when attention is directed towards them. Examination reveals normal tone and reflexes.

Dissociative Convulsions (hysterical fits or pseudo-seizures)

It is characterized by convulsive movements and partial loss of consciousness. Differential diagnosis with true seizures is important. Some differences are illustrated below:

Clinical points	Epileptic seizures	Dissociative convulsions
Aura (warning)	Usual	Unusual
Attack pattern	Stereotyped known clinical pattern	Purposive body movements; absence of any established clinical pattern
Tongue bite	Present	Absent
Incontinence of urine and feces	Can occur	Very rare
Injury	Can occur	Very rare
Duration	Usually about 30-70 sec	20-800 sec (prolonged)
Amnesia	Complete	Partial
Time of day	Anytime; can occur during sleep also	Never occurs during sleep
Place of occurrence	Anywhere	Usually indoors or in safe places
Post-ictal confusion	Present	Absent
Neurological signs	Present	Absent

Dissociative Sensory Loss and Anesthesia

It is characterized by sensory disturbances like hemianesthesia, blindness, deafness and glove and stocking anesthesia (absence of sensations at wrists and ankles).

The disturbance is usually based on patient's knowledge of that particular illness whose symptoms are produced. A detailed examination does not reveal any abnormalities.

Etiology of Conversion Disorders

Psychodynamic Theory

In conversion disorder, the ego defense mechanisms involved are repression and conversion. Conversion symptoms allow a forbidden wish or urge to be partly expressed, but sufficiently disguised so that the individual does not have to face the unacceptable wish. The symptoms are symbolically related to the conflict.

Behaviour Theory

According to this theory the symptoms are learnt from the surrounding environment. These symptoms bring about psychological relief by avoidance of stress. Conversion disorder is more common in people with histrionic personality traits.

Treatment

Free association

Hypnosis

Abreaction therapy

Supportive psychotherapy

Behaviour therapy (aversion therapy, operant conditioning etc.)

Drug therapy: Drugs have a very limited role. A few patients have anxiety and may need short-term treatment with benzodiazepines.

Intervention

Monitor physician's ongoing assessments, laboratory reports and other data to rule out organic pathology.

Identify primary and secondary gains.

Do not focus on the disability; encourage patient to perform self-care activities as independently as possible. Intervene only when patient requires assistance.

Do not allow the patient to use the disability as a manipulative tool to avoid participation in the therapeutic activities.

Withdraw attention if the patient continues to focus on physical limitations.

Encourage patient to verbalize fears and anxieties.

Positive reinforcement for identification or demonstration of alternative adaptive coping strategies.

Identify specific conflicts that remain unresolved and assist patient to identify possible solutions.

Assist the patient to set realistic goals for the future.

Help the patient to identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability.

3.2.7 Somatoform disorders

These disorders are characterized by repeated presentation with physical symptoms which do not have any physical basis, and a persistent

request for investigations and treatment despite repeated assurances by the treating doctors.

These disorders are divided into following categories:
Somatization disorder
Hypochondriasis
Somatoform autonomic dysfunction
Persistent somatoform pain disorder

Somatization Disorder

Somatization disorder is characterized by chronic multiple somatic symptoms in the absence of physical disorder. The symptoms are vague, presented in a dramatic manner and involve multiple organ system.

Hypochondriasis

Hypochondriasis is defined as a persistent pre-occupation with a fear or belief of having a serious disease despite repeated medical reassurance.

Somatoform Autonomic Dysfunction

In this disorder, the symptoms are predominantly under autonomic control, as if they were due to a physical disorder. Some of them include palpitations, hiccoughs, hyperventilation, irritable bowel, dysuria etc.

Persistent Somatoform Pain Disorder

The main feature in this disorder is severe, persistent pain without any physical basis. It may be of sufficient severity so as to cause social or occupational impairment. Preoccupation with the pain is common.

Treatment

Drug therapy

Antidepressants
benzodiazepines

Psychological treatment

Supportive psychotherapy
Relaxation therapy

4.0 Conclusion

The individual is said to exhibit neurotic behaviour if he frequently misevaluates adjustive demands, becomes anxious in situation that most people would not regard as threatening and tends to develop behaviour patterns aimed at avoiding rather than coping with his problems. Curiously, the individual may realize his behaviour is irrational and maladaptive as in the case of a severe phobia for germs – but he seems unable to alter it. Although neurotic behaviour is maladaptive, it does not involve gross distortion of reality or gross personality disorganization, nor is it likely to result in violence to the individual or to others.

5.0 Summary

In this unit, we looked at psychoneuroses, differences between psychosis and neurosis and forms of neuroses. It is hoped that the learners have been exposed to adequate information in this unit.

6.0 Tutor Marked Assignment

(1) Differentiate between psychosis and neurosis.
(2) How can neuroses be prevented in our society today?

7.0 References / Further Readings

Morrison-Valfre, M. 2005. Foundations of Mental Healthcare Mission: Mosby.

Burr, J. 1970. Nursing the Psychiatric Patient 2nd Ed. London: Bailliere Tindall and Cassell.

Staurt, G. W. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Unit 4: Organic Mental Disorders

Contents

1.0 Introduction

It is usual to differentiate the organic reaction types into acute and chronic. In the acute illnesses, such as occur in the delirium associated with alcohol, there is a temporary poisoning of the brain cells by the toxins, while in the chronic reaction types there is a progressive degeneration of the nervous tissue as in general paralysis. In the organic reaction type, there are usually present intellectual impairment with defects in memory, judgment and orientation, affective disturbances with emotional instability and character changes in which the finer feelings deteriorate and may lead to anti-social behaviour. In this unit, you will be exposed to organic mental disorders and how to prevent and manage these cases.

2.0 Objectives

At the end of this unit, you should be able to:

- classify organic mental disorders
- describe the manifestations of elements
- explain what delirium is
- describe mental disorders due to brain damage.

3.0 **Main content**

3.1 Organic mental disorders are behavioural or psychological disorders associated with transient or permanent brain dysfunction. These disorders have a demonstrable and independently diagnosable cerebral disease or disorder. They are classified under Fo in ICD10.

3.2 **Classification of organic mental disorder**

Dementia

Delirium

Organic amnestic syndrome

Mental disorders due to brain damage, dysfunction and physical disease

Personality and behavioural disorders due to brain disease, damage and dysfunction

3.2.1 **Dementia (Chronic Organ Brain Syndrome)**

Dementia is an acquired global impairment of intellect, memory and personality but without impairment of consciousness.

Incidence

Dementia occurs more commonly in the elderly than in the middle-aged. It increases with age from 0.1 percent in those below 60 years of age to 15 to 20 percent in those who are 80 years of age.

Etiology

Untreatable and irreversible causes:

Degenerating disorders of CNS

- Alzheimer's disease (this is the most common of all dementing illnesses)
- Pick's disease
- Huntington's disease
- Parkinson's disease

Treatable and reversible causes: Vascular

– multi-infarct dementia Intracranial

space occupying lesions

Metabolic disorders – hepatic failure, renal failure

Endocrine disorders – myxedema, Addison's disease

Infections – AIDS, meningitis, encephalitis

Intoxication – alcohol, heavy metals (lead, arsenic), chronic barbiturate poisoning
Anoxia – anemia, post-anesthetia, chronic respiratory failure
Vitamin deficiency, especially deficiency of thiamine and nicotine
Miscellaneous – heatstroke, epilepsy, electric injury.

Stages of dementia

Stage I: Early stage (2 to 4 years)
Forgetfulness
Declining interest in environment
Hesitancy in initiating actions
Poor performance at work

Stage II: Middle stage (2 to 12 years)
Progressive memory loss
Hesitates in response to questions
Has difficulty in following simple instructions
Irritable, anxious
Wandering
Neglects personal hygiene
Social isolation

Stage III: Final stage (up to a year)
Marked loss of weight because of inadequate intake of food
Unable to communicate Does not
recognize family Incontinence of
urine and feces Loses the ability to
stand and walk
Death is usually caused by aspiration pneumonia

Clinical Features (for Alzheimer's Type)
Personality changes: lack of interest in day-to-day activities, easy mental fatiguability, self-centered, withdrawn, decreased self-care
Memory impairment: recent memory is prominently affected
Cognitive impairment: disorientation, poor judgment, difficulty in abstraction, decreased attention span.
Affective impairment: labile mood, irritableness, depression

Behavioural impairment: stereotyped behaviour, alteration in sexual drives and activities, neurotic/psychotic behaviour

Neurological impairment: aphasia, apraxia, agnosia, seizures, headache

Catastrophic reaction: agitation, attempt to compensate for defects by using strategies to avoid demonstrating failures in intellectual performances, such as changing the subject, cracking jokes or otherwise diverting the interviewer.

Sundowner syndrome: It is characterized by drowsiness, confusion, ataxia; accidental falls may occur at night when external stimuli such as light and interpersonal orienting cues are diminished

Course and Prognosis

Insidious onset but slow progressive deterioration occurs.

Treatment

Until now, no specific medicine is available to treat Alzheimer's disease. A drug called 'Tacrine' is being used in western countries. Tacrine (Tetra hydro amino acridine) is a long-acting inhibitor of acetylcholine and also delays the progression of the illness.

The following drugs may be of some use in causing symptomatic relief:

benzodiazepines for insomnia and anxiety

antidepressants for depression

antipsychotics to alleviate hallucinations and delusions

anticonvulsants to control seizures

Intervention

1. Provide a safe environment:
   make sure that lights are bright enough
   keep matches, bleach, paints out of reach
   structure environment to minimize hazards and prevent falls
   do not allow the person to take medications alone

2. Establish good interpersonal relationships:
   verbal communication should be clear and unhurried
   questions that require 'yes' or 'no' answers are best

3. Facilitate adequate grooming hygiene and other activities of daily living
   compliment the person when he/she looks good
   remember to check finger and toe nails regularly, cut them if the person cannot do it by himself
   encourage and help in cleaning teeth and bathing
   people with dementia may have problems with the lock on the bathroom door; if this happens it is advisable to remove the lock
   remind the person to go to the toilet at regular intervals, just leave the toilet door open, and leave a light at nighttimes to find the way.

4. Maintain adequate food and fluid intake:
   allow plenty of time for meals
   a well balanced diet with plenty of fibre such as fruits, vegetables, whole wheat should be used to prevent constipation
   tell the person which meal it is and what there is to eat; food served should be neither too hot or too cold.

5. Facilitate adequate rest and sleep:
   provide calm and quiet environment for sleep
   keep him clean and dry
   provide regular exercises to improve sleep

6. Facilitate orientation:
   orient the client to reality in order to decrease confusion
   clock with large faces aid in orientation to time
   use calendar with large writing and a separate page for each day
   provide newspapers which stimulate interest in current events
   orientation of place, person and time should be given before approaching the patient

7. Decrease socially inappropriate behaviour and facilitate the development of acceptable social skills:
   reinforce socially acceptable skills
   over-correction should be avoided
   give necessary information repeatedly
   focus on the things the person does well rather than on mistakes or failures

ignore unacceptable behaviour.

8. Increase interest in surroundings:
   try to make sure that each day has something of interest for the person with dementia – it might be going for a walk, listening to music; talk about the day's activities
   try to involve him/her with old friends for a chat, reminiscing about the past.

9. Involve the family and community in treatment and rehabilitation programme:
   provide information about the disease process; refer to appropriate organizations – for example, the Alzheimer's and Related Disorders Society of India (ARDSI) started in 1992, a national organization dedicated to dementia care, support and research
   since wandering is a common problem, the patient must always carry an identity card in case he/she gets lost
   for anger and hallucinations prescribed medications should be administered time to time

3.2.2 **Delirium (Acute Organic Brain Syndrome)**

Delirium is an acute organic mental disorder characterized by impairment of consciousness, disorientation and disturbances in perception and restlessness.

Incidence

Delirium has the highest incidence among organic mental disorders. About 10 to 25 percent of medical-surgical inpatients and about 20 to 40 percent of geriatric patients meet the criteria for delirium during hospitalization. This percentage is higher in post-operative patients.

Etiology

Vascular: hypertensive encephalopathy, cerebral arteriosclerosis, intracranial hemorrhage

Infections: encephalitis, meningitis

Neoplastic: space occupying lesions

Intoxication: chronic intoxication or withdrawal effect of sedative-hypnotic drugs

Traumatic: subdural and epidural hematoma, confusion, laceration, post-operative, heatstroke

Vitamin deficiency e.g. thiamine

Endocrine and metabolic: diabetic coma and shock, uremia, myxedema, hyperthyroidism, hepatic failure

Metals: heavy metals (lead, manganese, mercury), carbon monoxide and toxins

Anoxia: anemia, pulmonary or cardiac failure.

Clinical Features

Impairment of consciousness: clouding of consciousness ranging from drowsiness to stupor and coma.

Impairment of attention: difficulty in shifting, focusing and sustaining attention.

Perceptual disturbances: illusions and hallucinations, most often visual.

Disturbance of cognition: impairment of abstract thinking and comprehension, impairment of immediate and recent memory, increased reaction time.

Psychomotor disturbance: hypo and hyperactivity, aimless groping or picking at the bed clothes (flocculation), enhanced startle reaction.

Disturbance of the sleep-wake cycle: insomnia or in severe cases total sleep loss or reversal of sleep-wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams and nightmares, which may continue as hallucinations after awakening.

Emotional disturbances: depression, anxiety, fear, irritability, euphoria, apathy or wondering perplexity.

Course and Prognosis

The onset is usually abrupt. The duration of an episode is usually brief, lasting for about a week.

Treatment

Identification of cause and its immediate correction, e.g. 50 mg of 50 percent dextrose IV for hypoglycemia, O_2 for hypoxia, 100 mg of B1 IV for thiamine deficiency, IV fluids for fluids and electrolyte imbalance.

Symptomatic measures: benzodiazepines (10 mg diazepam or 2 mg lorazepam IV) or antipsychotics (5 mg haloperidol or 50 mg chlorpromazine IM) may be given.

Intervention

1. Providing safe environment:
   restrict environmental stimuli, keep unit calm and well-illuminated
   there should always be somebody at the patient's bedside, reassuring and supporting
   as the patient is responding to a terrifying unrealistic world of hallucinatory illusions and delusions, special precautions are needed to protect him from himself and to protect others.

2. Alleviating patient's fear and anxiety:
   remove any object in the room that seems to be a source of misinterpreted perception
   as much as possible have the same person all the time by the patient's bedside
   keep the room well lighted especially at night

3. Meeting the physical needs of the patient:
   appropriate care should be provided after the physical assessment
   use appropriate management measures to reduce high fever, if present
   maintain intake and output chart
   mouth and skin should be taken care of
   monitor vital signs
   observe the patient for any extreme drowsiness and sleep as this may be an indication that the patient is slipping into a coma.

4. Facilitate orientation:
   repeatedly explain to the patient where he is and what date, day and time it is
   introduce people with name even if the patient misidentifies the people
   have a calendar in the room and tell him what day it is
   when the acute stage is over take the patient out and introduce him to others

3.2.3 **Organic Amnestic Syndrome**

Organic amnestic syndrome is characterized by impairment of memory and global intellectual functioning due to an underlying organic cause. There is no disturbance of consciousness.

Etiology

Thiamine deficiency, the most common cause being chronic alcoholism. It is called "Wernicke-Korsakoff syndrome". Wernicke's encephalopathy is the acute phase of delirium preceding the amnestic syndrome, while Korsakoff's syndrome is the chronic phase of amnestic syndrome.

Head trauma

Bilateral temporal lobectomy

Hypoxia

Brain tumors

Herpes simplex encephalitis

Stroke

Clinical Features

Recent memory impairment

Anterograde and retrograde amnesia

There is no impairment of immediate memory

Management

Treatment for underlying cause

3.2.4 **Mental Disorders to Brain Damage, Dysfunction and Physical Disease**

These are mental disorders, which are casually related to brain dysfunction due to primary cerebral disease, systemic disease or toxic substances.

Primary cerebral diseases: Epilepsy, encephalitis, head trauma, brain neoplasms, vascular cerebral disease and cerebral malformations.

Systemic disorders: Hypothyroidism, Cushing's disease, hypoxia, hypoglycemia, systemic lupus erythematosis and extracranial neoplasm.

Drugs: Steriods, antihypertensives, antimalarias, alcohol and psychoactive substances.

The following mental disorders come under this category:

Organic hallucinations

Organic catatonic disorder

Organic delusional disorder

Organic mood disorder

Organic anxiety disorder

3.2.5 **Personality and Behavioural Disorders Due to Brain Disease, Damage and Dysfunction**

These disorders are characterized by significant alteration of the premorbid personality due to underlying organic cause. There is no disturbance of consciousness and global intellectual function. The personality change may be characterized by emotional lability, poor impulse control, apathy, hostility or accentuation of earlier personality traits.

Etiology

Complex partial seizures (temporal lobe seizures)
Cerebral neoplasm
Cerebrovascular disease
Head injury

Management

Treatment for the underlying cause.
Symptomatic treatment with lithium, carbamazepine or with antipsychotics.

4.0 **Conclusion**

In this unit, you have learnt that organic mental disorders are behavioural or psychological disorders associated with transient or permanent brain damage or brain dysfunction. But it should be noted that preventive measure is crucial in these disorders and prompt and adequate management when diagnosed could be helpful to avoid permanent damage.

5.0 **Summary**

There is the need to maintain positive health seeking behaviour in order to promote and maintain our health status as this could remedy a lot of problems that may be permanent in the nearest future.

7.0 **References / Further Readings**

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing, Ile-Ife: Basag (Nig) Enterprises.

Sreevani, R. A Guide to Mental Health and Psychiatric Nursing. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Staurt, G. W. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Unit 5: Drug Abuse and Drug Addiction

Contents

1.0 Introduction

In the last unit, we went through organic mental disorders, we saw the effect of drugs on mental health, in this unit the learners will be exposed to substance abuse (drug abuse and drug addiction).

2.0 Objectives

At the end of this unit, the learners should be able to:

- define drug abuse and drug addiction
- differentiate between drug abuse and drug addiction
- list five drugs commonly abused
- enumerate some causes of drug abuse
- state the principles of diagnosis
- describe the guide to the management of substance abuse crisis
- methods of combating drug abuse and drug addiction
- list four socio-economic and psychological problems of drug abuse and drug addiction

3.0 Main content

3.1 Introduction

Drug abuse is defined by WHO has to be a persistent or sporadic excessive use of a drug and that use of drug is inconsistent with or unrelated to acceptable medical practice. With this definition, it shows that any drug can be abused. Drug abuse itself is not an illness but it may and usually leads to an illness.

Although marijuana is the drug most extensively resorted to, the sedatives, stimulants and hallucinogens are widely abused and addiction to the "hard" narcotics has increased considerably.

The variety of drug effects and the constant introduction of new drugs and agents and rediscovery of old ones have led to some confusion in the terminology of inappropriate or inadvisable drug use.

Misuse implies overzealous or indiscreet administration of drugs by physicians. To misuse a drug might be to take it for the wrong indication, in the wrong dosage, or for too long a period, to mention only a few obvious examples.

Abuse implies the use of drugs for other legitimate medical purposes. That is, abuse might be construed as any use of a drug for nonmedical purposes, almost always for altering consciousness.

Drug dependence: Dependence is a biologic phenomenon. Psychic Dependence is manifested by compulsive drug-seeking behaviour in which the individual uses the drug repetitively for personal satisfaction. Heavy cigarette smoking is an example. Physical Dependence is present when the withdrawal of the drug produces symptoms that are frequently the opposite of those sought by the user. It has been suggested that the body adjusts to a new level of homoeostasis during the period of drug use and reacts in opposite fashion when the new equilibrium is disturbed.

Addiction is usually taken to mean a state of physical and psychic dependence, but the word is too precise to be useful.

Addiction as defined by 'WHO' is a "behavioural pattern of drug use characterized by overwhelming involvement with the use of a drug, compulsive drug-seeking behaviour, and a high tendency to relapse after

withdrawal". The W.H.O. stresses that "addiction should be viewed on a continuum relative to the degree where drug use affects the total life quality of the drug use and to the range of circumstances in which it controls his behaviour".

3.2 **Effects of drug abuse**

Some drugs when abused produce dependence with the following characteristics:

(i) Compulsion to take the drug on a continuous or sporadic basis in order to experience its psychic effects (psychological dependence).
(ii) Presence of physical symptoms when the drug is suddenly withdrawn (withdrawal symptom).
(iii) Tolerance.
(iv) Detrimental effect on the individual and the society.

3.3 **Examples of drugs commonly abused**

(a) Common analgesics – e.g. aspirin
(b) Stimulants e.g. kolanuts, coffee
(c) Alcohol
(d) Sedatives e.g. barbiturates
(e) Amphetamine
(f) Cannabis (Indian hemp).

Note: (c)-(f) above produce dependence.

3.4 **Causes of drug abuse**

1. Habit formation
2. Peer group
3. Self-medication
4. Over-prescription of drugs by some doctors
5. Environment
6. Illnesses particularly emotional disorders.

3.5 **Principles of diagnosis**

3.5.1 **Substance abuse**

Abuse is characterized by a pattern of pathologic use lasting for at least a month and causing impairment in social and occupational functioning.

(i) Pattern of Pathologic Use: Although the pattern varies depending upon the substance used, it may be characterized by "intoxication throughout the day", inability to cut down or stop use, repeated efforts

to control use through periods of temporary abstinence or restriction of use to certain times of the day, continuation of substance use despite a serious physical disorder that the individual knows is exacerbated by use of the substance, need for daily use of the substance for adequate functioning and episodes of a complication of the substance intoxication (e.g. alcoholic blackouts, opioid overdose).

(ii) Impairment in Social or Occupational-functioning: Behaviour may include erratic, impulsive, or aggressive actions and failure to meet important obligations to friends and family. Disturbed social interaction is a consequence of intoxicated behaviour and personality changes that may be produced by the psychoactive drug. There may also be legal difficulties associated with behaviour during the intoxicated state (e.g. car accidents) or criminal behaviour to obtain money to purchase the substance. It is important to distinguish criminal activity (e.g. theft) to perpetuate drug intoxication from recreational drug use in conflict with local customs and laws.

Signs of impairment in occupational functioning may include missing work or school and inability to function effectively because of intoxication. If impairment is severe, the individual's life can become dominated by use of the substance and physical and psychologic functioning may deteriorate markedly.

3.5.2 **Substance Dependence**

Substance dependence is a more severe form of substance abuse, with diagnosis based on physiologic dependence as demonstrated by tolerance or withdrawal, as defined below. Also, there is usually a pattern of pathologic use that causes a disturbance in social or occupational functioning.

(i) Tolerance: Tolerance means markedly increased amounts of the substance are required to achieve the desired effect, or there is markedly diminished effect with regular use of the same dose.

(ii) Withdrawal: "In withdrawal, a substance specific syndrome follows cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiologic state of intoxication". Characteristics of the withdrawal syndrome vary with the substance used. Frequently observed symptoms are anxiety, restlessness, irritability, insomnia and impaired attention.

3.5.3 **Multiple Drug Abuse**

When the history includes use of more than one substance, multiple diagnosis of substance use disorders should be made, except under the following conditions:

1. when the specific substances cannot be identified;
2. when the substances used are from different (non-alcoholic) categories or
3. when the substances abused cannot be classified – it is thus designated as "unspecified, mixed, or other substances abuse" respectively. Multiple drug abuse is common among drug abusers, and the resulting – spectrum of symptoms often makes diagnosis and treatment difficult.

Drug tolerance is associated with some (but not all) patterns of drug abuse. This diagnosis is complicated when multiple drugs are used, some of which (e.g. sedative-hypnotics) may manifest cross-tolerance. An abuser of a sedative-hypnotic such as a short-acting barbiturate or benzodiazepine may combine use of drugs and alcohol, producing mixed addiction. Individuals who abuse various drugs in the same group may develop substantial tolerance but are not immune to the life-threatening consequences of the drugs – e.g. they are often seen in emergency room after overdose or associated dysfunction such as having a blackout while driving. These serious consequences of substance abuse may be the first symptom of addictive disease seen by the physician.

3.6 **Underlying Psychopathologic Disorders**

Individuals with primary substance use disorders should be evaluated for underlying psychopathologic conditions such as an affective disorder or thought disorder (or both problems such as medical diseases or complications). Following detoxification from drug dependence, individuals whose only problem is the primary addictive disease are better managed in an abstinence-oriented treatment approach. Individuals who have both an addictive disease and an underlying psychopathologic disorder may require psychotropic medication following detoxification and are less well suited to abstinence-oriented treatment.

3.7 **Guide to management of substance abuse crisis**

A. Assessment

This should include the following:

(1) Substance Used:

- Type of substance (or availability of sample for identification or testing if the patient does not know the type).
- Route of administration (inhaled, ingested, injected etc.)

(2) Pattern and circumstances of substance use

- self-medication because of physical, mental or emotional problem
- concomitant use of prescription or over-the-counter medications
- Alternating or concomitant use of other drugs in the same drug group.
- Identifiable events, such as loss or celebration, precipitating the substance abuse crisis.
- If the drug is used habitually, pattern of development and method of maintenance of habit.

(3) Extent of potential support system

- Family or friends available to help the patient follow through on treatment
- Community groups or agencies specifically addressing the patient's abuse pattern.

(4) History of previous treatment

- Type and duration of treatment
- Results

(5) Other

- Effects of drug use on the patient's life (e.g. financial problems, changes in physical appearance).
- Physical infirmity that could exacerbate the problem
- Willingness to change abuse habits.

B. Initial Management of the Crisis

Before treatment is begun, it is important to assure the patient of confidentiality and explain the rationale for treatment and what to expect. The patient's behaviour is observed carefully; vital signs are monitored, and the patient is given only symptomatic treatment before the substance is identified. No medication should be given if there is any question about identification of the drug.

The goal of the 3 approaches listed is to achieve an alteration in the patient's status or a favourable resolution of the crisis. Judgement must be used in selecting the most appropriate approach in the circumstances.

(i) Assistance: The involvement of another individual or authority in the substance abuse crisis often helps patients endure the crisis and workout

a personal solution. This gives them an opportunity for growth through mastery of the crisis. Psychiatric emergency clinicians often directly involve others or ask patients to recommend someone with whom they are comfortable to reassure and guide them during the crisis.

(ii) Complete Management: Some cases require complete management of the crisis by the clinician, as in the active treatment of drug overdoes.

(iii) Patient Education: In some instances, clinicians provide additional information or resources so that patient can resolve their own substance abuse crisis.

C. Follow-up Strategies

After crisis intervention for the drug overdose, medical management of the complications and appropriate detoxification procedures, the physician should evaluate the patient to determine if there are any associated physical problems, persistent organic mental disorder or major underlying psychopathological conditions. In most cases, the substance use disorder must be viewed as the primary disease process. Fewer than 10% of patients who have addictive disease have a major underlying psychopathologic condition.

However, if an underlying problem exists it is difficult to follow a drug-free-abstinence-oriented approach to treatment, since the patient will often require psychotropic medication for management of the psychopathologic disorder. Antidepressants may be prescribed for a major depressive episode, or an antipsychotic drug may be given for an underlying thought disorder. For some patients with primary addictive disease, a drug maintenance programme (e.g. with methadone) may be implemented, but abstinence-based recovery-oriented strategies should be tried first.

Most follow-up strategies are psychosocial in nature and include family therapy and individual psychotherapy. Successful strategies include participation in non-medical self-help groups, such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous. These programmes focus on abstinence and emphasize the principles of recovery, with the group process supporting and maintaining recovery. On occasion, the addict will require residential therapy, typically in a highly structured behaviour modification self-help community.

Follow-up care must be tailored to the individual's addictive disease process and must be flexible enough to change as the patient's needs change. The physician should recognize that addiction is a chronic, relapsing disease with potentially fatal and consequences but that recovery is possible.

3.8 Methods of combating drug abuse and drug addiction

1. Legal Penalties: The government should make provision for penalties that await offenders. Those who sell out dangerous drugs should be adequately punished. There should be legal codes controlling buying and selling of drugs. The Ports and Customs should be adequately controlled. Adequate laws should be enacted.
2. Law Enforcement Agents: The Police together with the Pharmacists should inspect shops, chemist shops and see to adequate storage and dispensing of drugs. Offenders should be planned.
3. Health Education: The public should be educated regarding the use of certain drugs especially without valid Doctor's prescription. The public could be educated via Radio, Television, Public lectures and mounting of Posters.
4. Provision of Effective and Efficient Health Care Delivery: There is no doubt that if effective and efficient Health Care delivery is provided by the Government, it will go a long way to reduce or discourage self-medication and minimize risk of drug abuse and drug dependence.

3.9 Socio-economic and psychological problems of drug abuse and drug addiction

(i) Deviant Behaviours: Some people abuse drug in order to carry out some deviant activities to the detriment of the health of the other members of the society. For example, most of the vices are committed under the influence of drug. Some people break into some houses after taking some drugs.

(ii) Mental Illness: Some of the mentally sick in our society today have abused drugs – sometimes in their life. Drug abuse and drug dependence may result in any form of mental illness; and the more mentally sick we have in the society, the more dangerous the society will be for the rest of the populace.

(iii) Broken Homes: Experiences have shown that drug abuse and drug dependence could result in broken homes.

(iv) Low Productivity: When many people who could have been engaged in meaningful production are mentally sick, there will be a generally low productivity output.

(v) Late Diagnosis of Disease: Some people treat themselves at home, ignorantly and later come to the hospital when the disease would have gone in an advanced stage. Some of them ed up staying in the hospital for a very long time while others die.

(vi) Death: Intake of an overdose of some drugs could easily lead to death.

4.0 Conclusion

The effects of drug abuse and drug addiction are preventable in any society. In Nigeria, the Federal Government set up agencies in this direction like NAFDAC so as to curb the incidence of substance abuse and its menace but the success depends on every member of the society. Drugs have also played a role in political history. For example, the opium wars of the nineteenth century between China and Britain and the drug movement of the 1970s in the United States changed the course of history. Even today, we are struggling with political and social events that relate to drugs and other illicit substances.

5.0 Summary

In this unit, the learner has gone through lecture on substance abuse (what, how, who, where, when of substance abuse and its effects). The devastating effects of substance abuse is alarming in our society, the prevention requires the concerted efforts of all and sundry as the world of substance use and abuse is always changing. As health care providers become more familiar with current chemical fads, new and more potent drugs are introduced.

6.0 Tutor Marked Assignment

(1) Describe the effects of substance abuse to the development of Nigerian society.

(2) How can substance abuse be curbed in our society?

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing, Ile-Ife: Basag (Nig) Enterprises.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Morrison-Valfre, M. 2005. Foundations of Mental Care Missouri: Mosby.

Staurt, G. W. and Laraia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Stellenberg, E. L. and Bruce, J. C. 2007. Nursing Practice Medical-Surgical Nursing for Hospital and Community 2nd Ed. London: Churchill Livingstone.

Unit 6: Alcoholism

Contents

1.0 Introduction

Alcohol is brewed in all cultures from time immemorial and is known to have high abuse potential in all cultures so it should be considered with rapt attention. This unit will expose you to the subject matter of alcoholism, what it means, types of alcoholism, causes, effects, stages, complication and treatment of alcoholism.

2.0 Objectives

At the end of this unit, you should be able to:

- describe what alcoholism is
- state the types of alcoholism
- list the cause of alcoholism
- explain the effects of alcoholism
- enumerate the stages of alcoholism
- describe the complications and treatment of alcoholism

3.0 Main content

3.1 Introduction

Alcoholism is a syndrome consisting of 2 phases:

Problem drinking and alcohol addiction. Problem drinking is the repetitive use of alcohol often to alleviate tension or solve other emotional

problems. Alcohol addiction similar to that which occurs following the repeated use of barbiturates or similar drugs.

Definition: The term 'ALCOHOLISM' is a very general one and is used to describe a state in which excessive indulgence in alcohol has become harmful to the individual's physical or mental health, to his inter-personal relations, or to his social or economic functioning. An 'alcoholic' is a person whose drinking is having these consequences or beginning to show the signs of their development. In contrast to the self-indulgent heavy drinker who drinks because he likes it, the alcoholic is dependent on alcohol and drinks because he must. Alcoholism is a major problem world-wide.

Diagnostic Criteria for disorders associated with alcohol abuse and dependence is stated below.

ALCOHOL ABUSE: is characterized by 3 criteria.

(1) A pattern of pathologic alcohol use, such as the need for daily drinks or the presence of binges or blackouts.
(2) Impairment in social or occupational functioning due to alcohol use, such as loss of a job or legal difficulties; and
(3) Duration of disturbance of at least one month.

ALCOHOL DEPENDENCE: is characterized by 2 criteria.

(1) Either a pattern of pathologic alcohol use or impairment in social or occupational functioning due to alcohol; and
(2) Either tolerance or withdrawal

TOLERANCE: is defined as a need for increased amount of alcohol to achieve a desired effect or as a markedly diminished effect with regular use of the same amount of alcohol.

WITHDRAWAL: is defined as the development of alcohol withdrawal (certain characteristic sign and symptoms, such as tremor, tachycardia, restlessness) after cessation of or reduction in drinking.

3.2 Types of alcoholism

Alcoholism is not a uniform disorder, and a number of different types may be recognized.

Various methods of classification are known, but the following represent the main groups.

(a) **Habitual Excessive Drinkers:** These people drink for pleasure or social reasons and become habituated to it. They grow tolerance, and no physical or mental complications except that in some people, there may be outbursts of disturbed behaviour loss of employment, financial difficulties and disruption of family.

(b) **Habitual Symptomatic Excessive Drinkers:** There is a psychological dependence o alcohol which is needed to relieve physical or emotional discomfort. The drinking is thus a symptom of a disturbance in another field.

(c) **Periodic Excessive Drinkers:** Some alcoholics are subject to periodic bouts of heavy drinking (sometimes called "DIPSOMANIA") but in the intervals can often abstain or drink only moderately. Severe recurrent anxiety or depression is sometimes the basis of such drinking.

(d) **Alcohol Addiction:** In the fully established addict, the bodily metabolism has become adapted to the presence of alcohol. Physical dependency has developed and sudden interruption of alcohol consumption may lead to severe physical withdrawal symptoms. At first there may be weakness, sweating, anorexia, nauses, irritability and restlessness; later tremors, severe apprehension, hallucinations and convulsions may occur.

3.3 Causes of alcoholism

There is no single cause of alcoholism. Biomedical, psychologic and social factors all play a role in its development and stressful events, sometimes serve as catalysts of drinking behaviour.

The following factors contribute:

(i) National differences in drinking habits, cost of alcohol, licensing laws and wine production.
(ii) Social factors – probably make it more commoner in men than women.
(iii) It sometimes run in family but definitely not inherited.
(iv) The predisposing unstable personality may have some genetic basis, the influence of the parental example is probably an important factor.
(v) Some shy and oversensitive individuals drink to be able to mix more freely.
(vi) Some use as a sedative to reduce tension. It is also used to reduce tension. It is also used to reduce various mental conflicts or to escape from difficult life situations.

3.4 Effects of alcoholism

Increased alcohol use can lead to both physical and psychologic dependence, which result in a number of important biomedical psychologic, and social sequelae such as cirrhosis, depression, marital problems and occupational problems. These sequelae themselves are stressful and lead to more drinking, further dependence and additional sequelae - and the cycle continues.

Other effects of alcoholism are classified into two:

Physical: Diminishing appetite with nausea and vomiting, especially in the morning is commonly present and is due to "chronic gastritis". This is to some extent responsible for the vitamin B deficiency.

Mental: The alcoholic eventually may become selfish, inconsiderate, deceitful and unrealiable in his behaviour. His mood may vary between self-pity, remorse and outbursts of violence. He's often suspicious of the wife and accuses her of infedility.

3.5 Stages of alcoholism

1. Pre-alcoholic: It is characterized by a gradual change in socially motivated drinking to a means of relieving personal tension.
2. Prodomal phase: Begins when the need for alcohol is no more social, rather it is psychological. It is characterized by sudden onset of black-outs. They have guilty feelings and avoid reference to alcohol in social gatherings.
3. The Crucial Phase: There is loss of behavioural control, drinking become conspicuous. He tries to stop, but cannot stop. He is critical of others, he does not like correction and becomes aggressive. He may loose his job, friends and there is a decrease in sexual drive and malnutrition sets in.
4. The Chronic Phase: There is marked ethical deterioration, impairment of thinking and can drink with anyone regardless of status. He has lost complete control and he gets hopelessly and helplessly drunk. He starts to loose tolerance for alcohol because of Liver damage. He now accepts defeat and is ready for treatment.

3.6 Complications

(1) **Alcoholic Hallucinosis:** This syndrome occurs either during heavy drinking or on withdrawal and is characterized by a paranoid psychosis without the tremulousness, confusion and

clouded sensorium seen in withdrawal syndromes. The patient appears normal except for the auditory hallucinations, which are frequently persecutory and may cause the patient to behave aggressively.

(2) **Delirium Tremens:** It is an acute organic psychosis that is usually manifest within 24-72 hours after the last drink (but may occur up to 7-10 days later). It is characterized by mental confusion tremor, sensory hyperactivity, visual hallucinations (often of snakes, bugs etc), automatic hyperactivity, diaphoresis, dehydration, electrolyte disturbances (hypokalemia, hypomagnesemia), seizures and cardiovascular abnormalities.

Delirium tremens is therefore a toxic state that occurs in response to withdrawal or diminution of alcoholic intake. It is particularly common in patients who are withdrawn from alcohol when admitted to the hospital for treatment of phenmonia or fractures. Patient can be treated with sedation, such as chlorpromazine, 100 mg 4 times daily orally; and paraldehyde 12-16mls orally, in cold fruit juice or cracked ice. The duration of delirium tremens is 2-7 days.

If patient is dehydrated, rehadrate with oral fluids or give dextrose and saline solution intravenously; add vit. Bco intramuscularly. Because of the frequency of convulsions, diphenylhydantoin (Dilantin), 100mg 3 times a day orally, should be considered.

It has been suggested that the mental symptoms in alcoholic illnesses are not due to poisoning by the alcohol but to vitamin B deficiency as a result of faulty absorption from the stomach due to the alcoholic, gastritis usually present.

NOTE: If alcohol is taken over long periods in large quantities permanent structural damage may be done to the central nervous system resulting in some permanent intellectual reduction and probably other mental symptoms.

Large quantities take over short periods, on the other hand, produce symptoms of acute intoxication or poisoning which tend to clear-up fairly rapidly and completely.

(3) **Withdrawal Syndrome:** When an alcoholic suddenly stops drinking (especially the addicts) withdrawal syndrome results, acute withdrawal syndrome results/occurs when the patient has been hospitalized for some unrelated problem and presents as a diagnostic problem.

(4) **Korsakoff Psychosis:** It's an organic brain damage that is irreversible. It consists of marked loss of memory for recent events, disorientation, confabulations.

(5) **Wernicke's Encephalopathy:** There is disorientation, associated with paralysis of ocular muscles, nystagmus, ataxia. It is due to acute deficiency of vitamin B1.

Other complications are:

Liver Cirrhosis
Gastritis
Peripheral Neuritis
Cardiomyopathy

Chronic Brain Syndromes; Cerebellar degeneration; and Peripheral neuropathies.

3.7 Treatment

Treatment should be directed first at the stage of dependence of drinking and finally should attempt to explore and modify predisposing causes.

(i) Acute Stage: Unless the patient is in a very poor stage of health, alcohol is usually withdrawn abruptly.

In heavy drinkers – prevent risk of fits and delirium tremens with anticonvulsant drug and tranquilizers.

Presence of weight loss, salt depletion and malnutrition necessitates liberal administration of fluids, salts, vitamins (often given parenterally in very large doses) and glucose with small doses of insulin.

Tension and restlessness are controlled by tranquilizers of the Phenothiazine group e.g. Largactil (given by injection). Large doses of Chlormethiazole 1-2g in divided doses is given for delirium in heavy drinkers.

(ii) Long Term Treatment:

(a) APOMORPHINE

This therapy attempts to induce a conditioned aversion to alcohol by associating drinking with repeated nausea and vomiting. This treatment is carried out in hospital and only if patient's condition is alright.

Patient is given in the morning 1/10gr. apomorphine injection (or EMETINE) at the same time 4 oz of 50% alcohol by mouth. Apomorphine is a powerful emetic and induces nausea and vomiting.

Apomorphine injection and alcohol by mouth are repeated 2 hourly until the evening of the third day. During this time, the patient is given injections of vitamin B but is allowed no food and no fluids except alcohol.

On the evening of the 3rd day he has a normal meal and thereafter is given a full diet and if necessary a course of modified insulin. He is given no more alcohol and injections of apomorphine are tapered off by giving him 1/40gr 4 hourly for 24 hours and 1/80gr 6 hourly for 24 hours. The treatment requires skilled nursing and vital signs are monitored regularly and charted.

(b) ANTABUSE (Disulfiram)

This is a drug which interferes with the breakdown of alcohol in the body so that the toxic substance acetaldehyde accumulates in the blood and causes unpleasant side effects. The effects of alcohol on a patient taking Antabuse is usually dramatic.

Within a few minutes, his face becomes very flushed, his pulse rate rises and he usually complains of headache, palpitation and breathlessness. The patient having had this experience develops a negative attitude to alcohol intake.

(c) Psychotherapy: Patient benefits from individual and group psychotherapy. Either method aims at discouraging patient in drinking (i.e. Apomorphine and Antabuse).

(d) Alcoholics Anonymous (A.A.)

The alcoholics who generally feel misunderstood, rejected and ostracized by society finds in this fellowship a body of people who have undergone experiences very similar to his own. He feels understood, accepted and achieves a feeling of belonging. He assists other alcoholics and in so doing helps himself, gradually regarding his self-respect and self-confidence. Alcoholic Anonymous (A.A.) is therefore a directive and inspirational form of group therapy for Alcoholics.

(e) Other cares:

Nurses roles include: Psychological care, physical care, diet general observations of rehabilitation of patient.

4.0 Conclusion

The practice of using substances to make one feel better is as old as humans themselves. Even animals have been seen eating certain plants that change their behaviours. Alcohol has played a role in many cultures throughout recorded time. Many people think of alcohol as a stimulant because they feel relaxation, alertness and pleasure when they drink. Actually these feelings are caused by the depressant effects of alcohol on the central nervous system. Once swallowed, alcohol is rapidly diffused to all the body's organs.

5.0 Summary

With continued use of alcohol, tolerance develops and individuals become dependent on alcohol. If drinking does not stop, death from multiple organ failure (especially the liver) results, usually after a series of assorted chronic health problems.

6.0 Tutor Marked Assignment

What are the effects of alcoholism on the development of the nation?

7.0 References / Further Readings

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Morrison-Valfre, M. 2005. Foundations of Mental Care Missouri: Mosby.

Staurt, G. W. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Stellenberg, E. L. and Bruce, J. C. 2007. Nursing Practice Medical-Surgical Nursing for Hospital and Community 2nd Ed. London: Churchill Livingstone.

Unit 7: Epilepsy

Contents

1.0 Introduction

Epilepsy and all seizure disorders illustrate the most basic relationship between the brain and behaviour. These disorders result in intermittent paroxysmal dysfunction of the brain, which is manifested by synchronous high-voltage electrical discharges and by a variety of motor, sensory and behavioural phenomena.

2.0 Objectives

At the end of this unit, the learners should be able to:

- describe what epilepsy is
- identify the causes of epilepsy
- list the clinical types of epilepsy
- how is epilepsy diagnosed
- explain the management of epilepsy

3.0 Main content

3.1 Introduction

The term epilepsy denotes any disorder characterized by recurrent seizures. A seizure is a transient disturbance of cerebral function due to an abnormal paroxysmal neuronal discharge in the brain.

Epilepsy can be defined as "an episodic involuntary disorder of behaviour and/or consciousness, which is associated with an abnormal electrical discharge in the grey matter of the brain". Here "episodic" means that the disturbance comes on from time to time and passes off after a certain period; "involuntary" indicates that the symptom cannot be controlled by any effort of the will.

Epilepsy and all seizure disorders illustrate the most basic relationship between the brain and behaviour. These disorders result in intermittent paroxysmal dysfunction of the brain, which is manifested by synchronous high-voltage electrical discharges and by a variety of motor, sensory and behavioural phenomena. Once called "the sacred disease", epilepsy has served as a scientific model for understanding the role of the brain in huma behaviour.

3.2 Causes of epilepsy

Epilepsy has several causes. The following causes are identified:

(a) Constitutional (or Idiopathic Epilepsy)
(b) Symptomatic Epilepsy.

Constitutional (or Idiopathic Epilepsy)

Seizures usually begin between 5 and 20 years of age but may start later in life. No specific cause can be identified and there is no other neurologic abnormalities.

Symptomatic Epilepsy

There are many causes

(i) Congenital abnormalities and perinatal injuries may result in seizures presenting in infancy or childhood.
(ii) Metabolic disorders – e.g. hypocalcemia, hypoglycemia, pyridoxine deficiency and ketonuria – all cause epilepsy (seizures) in newborns and infants.
(iii) Trauma – e.g. birth injuries to the skull (e.g. forceps delivery), road traffic accident affecting the skull, especially.
(iv) Tumors and other space-occupying lesions.
(v) Vascular diseases – they cause seizures especially in the elderly.
(vi) Infectious diseases – must be considered in all age groups as potentially reversible causes of seizures. Seizures may occur in the context of an acute infective or inflammatory illness, such as bacterial meningitis or herpes encephalitis. Also in conditions like

neurosyphilis, or cerebral cysticercosis, brain abscess and chronic kidney disease.

3.3 Clinical types of epilepsy

Seizures can be categorized in various ways, but the descriptive classification proposed by the International League Against Epilepsy is clinically the most useful. Seizures are divided into:

(1) those that are generalized, and

(2) those affecting only part of the brain (partial seizures).

A. Generalised Seizures (Epilepsy)

(1) Petit mal seizures (or absence seizures)
(2) Grand mal (or major epilepsy)
(3) Tonic, clonic or atonic seizures
(4) Atypical absences
(5) Myoclonic seizures.

B. Partial Seizures

(1) Simple partial seizures
(2) Complex partial seizures

A. Generalised Seizures (Epilepsy)

(1) Petit mal (or absence seizures)

Absence seizures are characterized by impairment of consciousness, sometimes with mild clonic, tonic or atonic components (i.e. reduction or loss of postural tone), autonomic components (e.g. enuresis), or accompanying automatisms. Onset and termination of attacks are abrupt. If attacks occur during conversation, the patient may miss a few words or may break off in mid sentence for a few seconds. The impairment of external awareness is so brief that the patient is unaware of it. Absence seizures almost always begin in childhood and frequently cease by the age of 20 years, although occasionally they are then replaced by other forms of generalized seizures.

(2) Grand mal seizures (or major epilepsy)

Five phases (stages) are usually characteristics of grand mal (or major) epilepsy.

Aura (or warning): This precedes loss of consciousness and lasts only for 2 seconds. The patient experiences something which "warns" him that the convulsion is to follow. It is not present in all cases; it may take many

forms but it is usually constant in each individual patient who, therefore, easily recognizes its nature.

The patient has an indescribable “feeling” in the stomach which rises to the throat. It may even be an unpleasant taste in the mouth, an unpleasant smell, or a flash of light.

Tonic Phase: This starts with loss of consciousness and patient falls to the ground and may injure himself. The muscles become rigid with the hands and teeth clenched. Breathing becomes obstructed by the tonic contraction of the respiratory muscles. The last few inspirations being stridulous give rise to the so-called “epileptic cry”. The face becomes cyanosed and the veins become engorged. This stage lasts for about 30 seconds.

Clonic Phase: The rigid muscles relax and then contract again rapidly so that the whole body is convulsed with clonic twitching and jerking. The tongue may be badly bitten and he begins to foam at the mouth. There may be incontinence of urine and faeces. This stage lasts for about one minute.

Sequela: Following the recovery of consciousness, there may be a state of mental confusion with vomiting and headache. In other cases, patients will behave in an abnormal fashion in the immediate postictal period, without subsequent awareness or memory of events.

Note: Immediately after the seizures, the patient may either recover consciousness, drift into sleep, have further convulsion without recovery of consciousness between the attacks (status epilepticus), or after recovering consciousness have a further convulsion (serial seizures). In other cases, patients will behave in an abnormal fashion in the immediate postictal period, without subsequent awareness or memory of events (postepileptic automatism).

(3) Tonic, clonic or atonic seizures

Loss of consciousness may occur with either the tonic or clonic accompaniments, especially in children. Atonic seizures (epileptic drop attacks) have been described.

(4) Atypical absences

There may be more marked changes in tone, or attacks may have a more gradual onset and termination than in typical absences.

(5) Myoclonic seizures

Myoclonic seizures consist of single or multiple myoclonic jerks. It is a familial convulsive disorder manifested by generalized seizures. It occurs usually in prepuberal girls. After several years, myoclonia (irregular, lightning-like, arrhythmic jerks of muscle groups, unaccompanied by movements of the extremities) becomes progressively more intense and widespread and is associated with gradual dementia and perhaps signs of a bulbar disorder.

Psychomotor Seizures

This category now include practically all types of attacks which do not conform to the classic descriptions of grandmal focal, Jacksonian seizure or petit mal. Automatisma, patterned movements, apparently purposeful movements, incoherent speech, turnings of the head and eyes, smacking of the slips twisting and writhing movements of the extremities, clouding of consciousness and amnesia commonly occur.

It has been postulated that "equivalent states" exist in which the patient exhibits a behaviour disturbance rather than the classic convulsion. Temporal lobe foci (spikes, sharp waves or combinations) are frequently associated with this type of epilepsy.

B. Partial Seizures (that is focal, local epilepsies)

The initial clinical and electroencephalographic manifestations of partial seizures indicate that only a restricted part of one cerebral hemisphere has been activated. The ictal manifestations depend upon the area of the brain involved.

Partial seizures are subdivided into simple seizures in which consciousness is preserved and complex seizures, in which it is impaired. Partial seizures of either type sometimes become secondarily generalized, leading to a tonic, clonic or tonic-clonic attack. Examples of partial seizures include – Jacksonian, temporal lobe and psychomotor seizures.

Simple Partial Seizures

Simple seizures may be manifested by focal motor symptoms (convulsive jerking) or somatosensory symptoms (e.g. paresthesias or tingling) that spread (or "march") to different parts of the limb or body depending upon their cortical representation. In other instances, special sensory symptoms (e.g. light flashes or buzzing) indicate involvement of visual auditory, olfactory, or gustatory regions of the brain, or there may be autonomic symptoms or signs (e.g. abnormal epigastric sensations, sweating, flushing papillary-dilation). When psychic symptoms occur, they are usually accompanied by impairment of consciousness.

Complex Partial Seizures

Impaired consciousness may be proceeded, accompanied or followed by the psychic symptoms mentioned and automatisms may occur. Such seizures may also begin with some of the other simple symptoms mentioned above.

3.4 **Diagnosis of epilepsy**

1. History (of illness): With reference to signs and symptoms e.g. nonspecific changes such as headache, mood alterations, lethargy and myoclonic jerking alert some patients to an impending seizure hours before it occurs. These parodromal symptoms are distinct from the aura which may precede a generalized seizure by a few seconds or minutes and which is itself a part of the attack, arising locally from a restricted region of the brain.
2. Electroencephalography (E.E.G.): The findings may support the clinical diagnosis of epilepsy – by demonstration paroxysmal abnormalities containing spikes or sharp waves; may provide a guide to prognosis and may help classification of the disorder, is important for determining the most appropriate anticonvulsant drug with which to start treatment. (Special attention to temporal lobe leads (in EEG) confirms psychomotor epilepsy's diagnosis).
3. Laboratory tests – e.g. full blood count, blood glucose determination, liver and renal function tests and serologic tests for syphilis.
4. X-ray – especially of the skull.
5. Pneumoencephalographic – introduction of "air or oxygen" to the subdural space surrounding the brain and also into the ventricles of the brain. X-ray photographs are then taken and these shows the outline ventricles.

3.5 **Management of epilepsy**

(A) Management of Seizures

(B) Other management Care – including those with other psychiatric problems (in the hospital)

(C) Medical treatment

(A) Management of Seizures

Management during a fit is dependent on accurate observation, adequate support or assistance of the patient, during fit and specific and accurate report of the fit.

When the epileptics suffer from fits, the nurse should loosen the clothing above the neck and chest to permit free respiration. Take away dangerous objects on which the patient may knock his head or body and sustain injury. In order to prevent the patient from biting his tongue, the should place in between patient's lower and upper set of teeth, a wooden spatular or some protecting article such as spoon handle, around which an handkerchief is wrapped. It is as well to let the patient lie down where he has fallen provided there are no objects against which he may strike the head or extremities during fits.

As pillow may be placed beneath his head, the nurse should not try to restrain the movements. It is well to turn the patient's head to one side to help clear the mouth of saliva. If the patient has just eaten before the fits, care should be taken to remove any food from his mouth. He should be kept under observation until he sleeps quietly or he has become clear mentally. After fits have ceased, an ice-bag (or hard pillow) may be placed on the head.

After waking, the patient may require dry clothing because of excessive perspiration on his cloth during the fit.

As soon as possible after the fit, the health practitioner must find time to write down her observations. While the fit is actually in progress she should give a verbal running commentary to herself of what is happening. This helps the later writing of the report.

As soon as she observes a patient who has a fit, the health practitioner should note the time, because she should report accurately on the total length of the fit and the length of each stage. Time may seem very long when she is

helplessly watching a patient and the period during which the patient is not breathing may seem endless, when in fact it may last only thirty seconds.

The health practitioner should prepare a summary of the condition of the ward as she finds it and remember what the patient had been doing just prior to the fit.

Fits may occur more frequently when a patient is upset or it may have some relation to the intake of food and it is a help if the existence of recurrent antecedent activity can be established. Some patients, for example are most likely to have fits when there has been some quarrel or unpleasant scene in the ward. Others regularly have fits during hospital concerts or in the wards when someone plays the piano.

Loss of consciousness or disturbance of consciousness should be reported and the nurse should practice making the necessary observations swiftly and in correct order. She should call the patient's name, noting any utterances which may give evidence of his having heard or observed the health practitioner.

She should report posture or the succession of postures, the movement of the head and eyes, the direction of movement. The direction of fall should be noted. The exact length of time of each stage of the attack is important. Muscle tone should be observed, whether the tonic, or rigid, stage is unilateral or bilateral, whether it starts simultaneously throughout the whole body, or on which side or which part of the body it appears first.

Twitching may start at one particular point and spread from there, and the order in which various parts of the body are affected should be noted. The eyes should be observed. The reaction of pupils to light corneal reflexes and eye movements must be mentioned.

As soon as the attack has ceased, temperature, pulse and respiration with blood pressure are recorded, colour is noted. Biting of the tongue and incontinence are reported, knee jerks and Babinski reflexes are tested (Babinski's sign is an upward movement of the big toe when the sole of the feet is stroked).

After the attack, it is necessary to note the depth of the sleep which follows, how easy it is to arouse the patient and the duration of sleep if the

patient is left undisturbed. Any complaints made, by the patient are recorded, e.g. headache or vomiting, so it is any evidence of confusion in speech or action. It is very important to establish the length of time during which the patient remains confused because during it he requires supervision and is not responsible for his actions.

(B) Other Management Care of Epileptic Patient in the Hospital

Although epilepsy is a physical illness and not a mental illness; and most of them are able to live a normal life, some patients are in mental hospitals because they suffer from such mental disorder as schizophrenia or depression as well as epilepsy. The nursing care of these is determined by the nature of the mental disorder, although the occurrence of fits creates additional problems. Fits are very terrifying to witness. Both the epilepsy and the mental illness require appropriate treatment. Many epileptic patients have mental disorders which are in some way caused by their epilepsy or related directly to it.

Some epileptic patients, at the time of fits, or even at other times, find it increasingly difficult to control any emotional reactions which may perhaps unwillingly be aroused by people in the environment. The patient may be irritable, experience hate or anger and, not being able to keep himself under control, may become violent, abusive and dangerous. Moreover, if he feels that he is losing control he may become extremely frightened. Tension mounts until he becomes intolerable, and an uncontrollable outburst of violence occurs.

Nobody enjoys violence least of all the patients, who afterwards feels guilty and ashamed. He hates himself and hates others for causing him to loose control over himself. Such a patient requires someone who understands him and so can prevent an outburst before it reaches a peak. In mental hospital this is quite possible. When the nurse knows the patient really well, she can usually detect when he is becoming more irritable and tense and can persuade him to relax.

The most important of various methods is for the health practitioner to remain calm, not to show anger or hostility and not to become frightened. This is only possible if she knows the patient well, realizes that he is ill, and treats his aggression as a symptom of his illness. Outside mental hospitals it is not always possible for calmness to reign in the face of a patient's

aggressive behaviour. The patient and his environment react on each other until real danger exists which in hospital can be prevented.

Other specific nursing cares include:

(a) Epileptic patients are better admitted in an open ward where they can be properly observed. The patient may sleep on a low bed so that he would not be injured if he fell out, but this is seldom necessary. He has a hard pillow, in order not to suffocate if his face happened to be covered by the pillow during a fit.

(b) During a fit, the most important duty of the nurse is to prevent injury. Epileptic patients in the hospital are kept under fairly constant observation day and night. Record patient's fits and observations made in ward report and "epileptic (seizure) chart" – if opened for patient. Certain obvious dangers are avoided. Fires are guarded so that burns, the most common injuries outside hospital, rarely occur.

(c) Feeding: Meals are supervised in case a fit occurs, and the patient is encouraged to cut up his food into small pieces because he might choke if a fit occurred while large pieces of food were in his mouth. Food given must be a balanced diet.

(d) Patient's Psychological Needs: The patient's psychological needs must be met. Most of them do have insight into their problems. Relate positively with the patient. Give him a warm, friendly and reassuring reception. Listen to patient and attend to him promptly. He is emotionally relieved, and he has sense of good security.

(e) Physical Care: The physical care of the patient must be ensured. Encourage him to bath and stay around to observe patient for possible attack of fit (seizure).

(f) Drugs: Serve and record same in patient's chart. Watch for toxic effects of each drug.

Finally, success in caring for the institutionalized epileptic requires that the nurse possesses or cultivates a genuine interest in her patient, and the latter's problems. This is not always easy since at times he may not be an amiable individual.

Some patients are intolerable, moody, quarrelsome, stubborn and inclined to express dissatisfaction with the nurse and to charge her with neglect or abuse.

(C) Medical Treatment

For patients with recurrent seizures, drug treatment is prescribed with the goal of preventing further attacks, and is usually continued until there have been no seizures for at least 4 years.

Anti-Convulsants are drugs of choice in the treatment of Epilepsy. Some of these include:

(i) Epanutin (Phenytoin sodium) Dose: 300-400mg daily
(ii) Phenobarbitone
(iii) Primidone (Mysoline) Dose: 500-1,500mg daily
(iv) Phenytoin (Dilantin) Dose: (adult) 300mg daily
(v) Carbamazepine (Tegretol) Dose: 15-25mg/kg in children 1g or 2mg (tolerated)

Other Anticonvulsants are:
Donazepam 4-8mg (in 3-4 divided doses only)
Ethosuximide 1000-2000mg daily
Valproate 100-1600mg daily

Note: Never withdraw anticonvulsant drugs suddenly. Although the objective of therapy is complete suppression of symptoms, in many cases this is not possible.

Most epileptic must continue to receive anticonvulsant therapy throughout life. However, if seizures are entirely controlled for 3-5 years the dosage may be slowly reduced (over a period of 1-2 years) and finally withdrawn to ascertain if seizures will recur.

Advice on Discharge (Epileptic Patients)

(1) Occupation – Epileptic finds life just as difficult. Many jobs are out of question for him. It would be most unwise for an epileptic to drive a bus or a car, or to choose any occupation which requires climbing ladders or handling dangerous machinery.
(2) Epileptic Attack Card – If given in the hospital, an epileptic patient should carry Epileptic Attack Card whenever he is going out. This card often introduces the patient to the public. Usually kept in his pocket, it helps the public to have an idea about patient's problem.
(3) Drugs and Hospital Appointments – Often patients are given hospital appointments for Hospital's follow-up medical check-up. Patient should try to keep appointment. He should also use drugs given to him so as to stabilize his improvement.

(4) Finally, Epileptic Patients should be advised to avoid activities or situations that provoke attacks (e.g. alcohol ingestion or prolonged periods of food or sleep deprivation) and situations that could be dangerous or life-threatening if further seizures should occur.

3.6 **Status epilepticus**

This serious disorder consists of a train of severe seizures with relatively short intervals or no intervals between. The patient becomes exhausted and frequently hyperthermic. Death not uncommonly occurs during attacks.

There are many forms of status epilepticus. The most common, generalized tonic-clonic status epilepticus, is a life-threatening emergency, requiring immediate cardiovascular, respiratory and metabolic management as well as pharmacologic therapy. The latter virtually always requires intraveneous administration of antiepileptic medications.

Poor compliance with the anticonvulsant drug regimen is the most common cause of tonic-clonic status epilepticus. Other causes include alcohol withdrawal, intracranial infection or neoplasms, metabolic disorders and drug overdose. The mortality rate may be as high as 20% and among survivors the incidence of neurologic and mental sequelae may be high. The prognosis relates to the length of time between onset of status epilepticus and the start of effective treatment.

MANAGEMENT (of patient with status epilepticus)

Status epilepticus is a medical emergency. Management includes maintenance of the airway to ensure adequate pulmonary ventilation.

(1) In adults, unless the cause of the seizure is obvious, 50% dextrose (25-50ml) is routinely given intravenously in case hypoglycemia is responsible.

If seizures continue, 10mg of diazepam is given intravenously over the course of 2 minutes and the dose is repeated after 10 minutes if necessary. This is usually effective in halting seizures for a brief period, but a long-acting anticonvulsant may also be given to provide continuing control.

Intravenous diazepam may depress respiration (less frequently cardiovascular function) and facilities for resuscitation must be immediately at hand during its administration. The effect of diazepam is not lasting, but the 30-40 minutes seizure-free interval allows more definitive therapy to be initiated.

(2) Amobarbital sodium (sodium amytal), 0.5-1g. I.V. may be given. Phenobarbital sodium, 0.4-0.8g, injected slowly I.V. may be used. Paraldehyde, 1-2ml. diluted in a triple volume of saline and given slowly I.V. is an effective alternative. If the convulsion continues, repeat the intravenous dose "very slowly and cautiously", or give 8-12ml. I.M. Diphenylhydantoin sodium (Dilantin Sodium) may be injected intravenously at a rate not to exceed 50mg/minutes: a total dosage of 150-250mg may be required.

(3) The mainstay of continuing therapy for status epilepticus is intravenous phenytoin, which is effective and non-sedative. It should be given as a loading dose of 13-18mg/kg. in adults; the usual error is to give too little of the drug. Administration should be at a maximum rate of 50mg/min. It is safest to give the drug directly by intravenous push but it can also be diluted in saline; it precipitates rapidly in the presence of glucose.

Especially in elderly people, careful monitoring of cardiac rhythm and blood pressure is necessary. At least part of the cardiotoxicity is from the diluent, propylene glycol, in which the phenytoin is dissolved.

NOTE:

(a) In previously treated epileptic patients, the administration of a large loading dose of phenytoin may cause some dose-related toxicity such as ataxia. This is usually a relatively minor problem during the acute status episode and is easily alleviated by the later adjustment of plasma levels.

(b) For patients who do not respond to phenytoin, phenobarbitone can be given in large doses; 100-200mg. I.V., to a total of 400-600mg. respiratory depression is a common complication, especially if diazepam has already been give and there should be no hesitation in instituting intubation and ventilation (by-Anaesthetist).

(c) General anaesthesia may be necessary in highly resistant cases.

3.7 Febrile convulsions

Fever and convulsions are commonly encountered in the very young ones. A febrile convulsion is apt to be the first convulsion of an epileptic child, and febrile convulsions are said to be about twice as common among children with a family history of epilepsy.

Various explanations of this relationship have been offered, including the following:

1. Fever results from the liberation of heat and energy which occurs during muscular contractions caused by the seizure.
2. Fever results from hypothalamic seizure discharge.
3. Fever and convulsions both are caused by an infectious organism.
4. Excessive hydration and drugs to combat infection may cause convulsions.
5. Convulsions may result from a pathologic brain reaction induced by an infection.
6. The immature brain may respond to high fever and an infectious agent with a convulsion.

MANAGEMENT (of patient with Febrile Convulsions)

Management depends on the cause. If the febrile convulsion for example, is due to infectious microorganism, the use of anti-pyretic and antibiotic agents may have to be combined with anti-convulsant drugs to obtain a desirable effect. Rehydration is required in some cases.

PROGNOSIS

a. The Prognosis of febrile convulsions varies. Many children subsequently develop Psychomotor seizures.
b. Nonfebrile convulsions also occur in a majority of patients with a history of febrile convulsions.
c. Most children with a history of febrile convulsions have had only 1-2 such febrile seizures.

3.8 Withdrawal of use of antiepileptic drugs

Withdrawal of antiepileptic drugs, whether by accident or by design, can cause increased seizure frequency and severity. There are two factors to consider: The effects of the withdrawal itself and the need for continued drug suppression of seizures in the individual patient. In many patients, both factors must be considered and dealt with. It is important to note, however, that the abrupt discontinuation of antiepileptic drugs ordinarily does not

cause seizures in nonepileptic patients, provided that the drug levels are not above the usual therapeutic range when the drug is stopped.

Some drugs are more easily withdrawn than others. In general, withdrawal of anti-absence drugs is easier than withdrawal of drugs needed for partial or generalized tonic-clonic seizures. "Barbiturates and benzodiazepines are the most difficult to discontinue"; weeks or months may be required, with very gradual dosage decrements to accomplish their complete removal, especially if patient is not hospitalized.

Because of the heterogeneity of epileptic, consideration of the complete removal of antiepileptic drugs is especially difficult problem. If a patient is seizure-free for 3 or 4 years, gradual discontinuation is usually warranted.

Children whose seizures have always been infrequent and whose EEGs are normal, are candidates for gradual removal of drugs after 4 seizure-free years.

4.0 **Conclusion**

Epilepsy is a physical illness and not a mental illness and most of the victims are able to live a normal life, some patients are in mental hospitals because they suffer from such mental disorders as schizophrenia or depression as well as epilepsy as over a period of time the patient's behaviour may have become so difficult that it is impossible for him to remain in the community. It may be that some forms of epileptic illness leads to a progressive deterioration in behaviour and to a characteristic kind of personality disorder.

5.0 **Summary**

In this unit, we looked at what epilepsy is, causes, clinical types of epilepsy, the diagnosis and management of epilepsy. No doubt the knowledge is enriching. Now we can answer some questions in the TMA

6.0 **Tutor Marked Assignment**

(1) Describe the clinical types of epilepsy
(2) How can epilepsy be diagnosed?
(3) Explain how epileptic patient can be managed by you as a clinical nurse?

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing, Ile-Ife: Basag (Nig) Enterprises.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Fish, F. J. 1967. An outline of Psychiatry, Bristol: John Wright & Sons Ltd.

Henderson, D. and Gillespie, R. D. A. 1950. A textbook in Psychiatry. 7th Ed. New York: Oxford University Press.

Staurt, G. W. and Laraia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Unit 8: Therapeautic Modalities in Psychiatry I (Somatic therapies)

Contents

1.0 Introduction

Patients suffering from physical illnesses are given specific treatment because the causes are specific and the signs and symptoms are specific. In a psychiatric setting, the treatment may not be so specific and most patients are given more than one treatment. Some patients do not want treatment and may not cooperate with the doctors, nurse and community health practitioners. Some do not realize that they are ill and may actively resist all forms of treatment.

2.0 Objectives

At the end of this unit, the learners should be able to:

- list the examples of psychopharmacology
- describe electroconvulsive therapy
- state the indications and contra-indications of ECT
- discuss the management of a patient undergoing ECT.

3.0 Main content

3.1 Introduction

The community health practitioner has an extremely important role to play in the treatment of the mentally ill. She is the one who has closer contact with the patient than any other members of the hospital team. She also has a greater opportunity to get to know him and report on his improvement.

The various treatment modalities in psychiatry are broadly divided as:
Somatic (physical) therapies
Psychological therapies

Other therapies are: Milieu therapy Therapeutic community Activity therapy

3.2 Somatic (Physical) Therapies

3.2.1 Psychopharmacology

The understanding of the biological regulation of thought, behaviour and mood is the basis of all somatic therapies used in modern psychiatry. Psychopharmacology agents are now the first-line treatment for almost every psychiatric ailment. With the growing availability of a wide range of drugs to treat mental illness, the health practitioner practicing in modern psychiatric settings needs to have a sound knowledge of the pharmacokinetics involved, the benefits and potential risks of pharmacotherapy, as well as her own roles and responsibilities.

The various drugs used in psychiatry are called psychotropic (or psychoactive) drugs. They are so called because of their significant effect on higher mental functions. There are about seven classes of psychotropic drugs. Before going into a detailed description of each, a few guidelines are given below regarding the administration of drugs in psychiatry in general. The specific responsibilities are mentioned separately under each case.

General Guidelines Regarding Drug Administration in Psychiatry

The community health practitioner should not administer any drug unless there is a written order. Do not hesitate to consult the doctor when in doubt about any medication.

All medications given must be charted on the patient's case record sheet.

In giving medication:

- always address the patient by name and make certain of his identification.
- do not leave the patient until the drug is swallowed
- do not permit the patient to go to the bathroom to take the medication
- do not allow one patient to carry medicine to another.

If it is necessary to leave the patient to get water, do not leave the tray within the reach of the patient.

Do not force oral medication because of the danger of aspiration. This is especially important in stuporous patients.

Check drugs daily for any change in colour, odour and number

Bottles should be tightly closed and labeled. Labels should be written legibly and in bold lettering. Poison drugs are to be legibly labeled and to be kept in separate cupboard.

Make sure that an adequate supply of drugs is on hand, but do not overstock.

Make sure no patient has access to the drug cupboard.

Drug cupboards should always be kept locked when not in use. Never allow a patient or worker to clean the drug cupboard. The drug cupboard keys should not be given to patients.

Classification of Psychotic Drugs

Antipsychotics

Antidepressants

Mood stabilizing drugs

Anxiolytics and hypnosedatives

Antiepileptic drugs

Antiparkinsonian drugs

Miscellaneous drugs which include stimulants, drugs used in eating disorders, drugs used in deaddiction, drugs used in child psychiatry, vitamins, calcium channel blockers etc.

3.2.1.1 **Antipsychotics**

Antipsychotics are those psychotropic drugs, which are used for the treatment of psychotic symptoms. These are also known as neuroleptics (as they produce neurological side-effects), major tranquilizers, D2-receptor blockers and anti-schizophrenic drugs.

Indications

Organic psychiatric disorders

Delirium

Dementia

Delirium tremens

Drug-induced psychosis and other organic mental disorders

Functional disorders

Schizophrenia

Schizoaffective disorder

Paranoid disorders

Mood disorders
- Mania
- Major depression with psychotic symptoms

Childhood disorders
- Attention-deficit hyperactivity disorder
- Autism
- Enuresis
- Conduct disorder

Neurotic and other psychiatric disorders
- Anorexia nervosa
- Intractable obsessive-compulsive disorder
- Severe, intractable and disabling anxiety

Medical disorders
- Huntington's chorea
- Intractable hiccough
- Nausea and vomiting
- Tic disorder
- Eclampsia
- Heat stroke
- Severe pain in malignancy
- Tetanus

Pharmacokinetics

Antipsychotics when administered orally are absorbed variably from the gastrointestinal tract, with uneven blood vessels. They are highly bound to plasma as well as tissue proteins. Brain concentration is higher than plasma concentration. They are metabolized in the liver, and excreted mainly through the kidneys. The elimination half-life varies from 10 to 24 hours.

Most of the antipsychotics tend to have a therapeutic window. If the blood level is below this window, the drug is ineffective. If the blood level is higher than the upper limit of the window, there is toxicity or the drug is again ineffective.

Mechanism of Action

Antipsychotics drugs block D2 receptors in the mesobimbic and mesofrontal systems (concerned with emotional reactions). Sedation is caused by alpha-adrenergic blockade. Anti dopaminergic actions on basal ganglia are responsible for causing EPS (extrapyramidal symptoms).

Atypical antipsychotics have antiserotonergic (5-hydroxytryptamine or 5-HT) antiadrenergic and antihistaminergic actions. These are therefore called serotonin-dopamine antagonists.

Adverse Effects of Antipsychotic Drugs

I. Extrapyramidal symptoms (EPS)

1. Neuroleptic-induced parkinsonism: Symptoms include rigidity, tremors, bradykinesia, stooped posture, drooling, akinesia, ataxia etc. the disorder can be treated with anticholinergic agents.
2. Acute dystonia: Dystonic movements results from a slow sustained muscular spasm that lead to an involuntary movement. Dystonia can involve the neck, jaw, tongue and the entire body (opisthotonos). There is also involvement of eyes leading to upward lateral movement of the eye known as oculogyric crisis. Dystonias can be prevented by anticholinergics, antihistaminergics, dopamine agonists, beta-adrenergic antagonists, benzodiazepines etc.
3. Akathisia: Akathisia is a subjective feeling of muscular discomfort that can cause patients to be agitated, restless and feel generally dysphoric. Akathisia can be treated with propranolo, benzodiazepines and clonidine.
4. Tardive dyskinesia: It is a delayed adverse effect of antipsychotics. It consists of abnormal, irregular choreoathetoid movements of the muscles of the head, limbs and trunk. It is characterized by chewing, sucking, grimacing and peri-oral movements.
5. Neuroleptic malignant syndrome: This is a rare but serious disorder occurring in a small minority of patients taking neuroleptics, especially high-potency compounds.

The onset is often, but not invariably, in the first 10 days of treatment. The clinical picture includes the rapid onset (usually over 24-72 hours) of severe motor, mental and autonomic disorders. The prominent motor symptom is generalized muscular hypertonicity. Stiffness of the muscles in the throat and chest may cause dysphasia and dyspnea. The mental symptoms include akinetic mutism, stupor

or impaired consciousness. Hyperpyrexia develops with evidence of autonomic disturbances in the form of unstable blood pressure, tachycardia, excessive sweating, salivation and urinary incontinence. In the blood, creatinine phosphokinase [CPK] levels may be raised to very high levels, and the white cell count may be increased. Secondary features may include pneumonia, thromboembolism, cardiovascular collapse and renal failure.

The syndrome lasts for one or two weeks after stopping the drug.

II. Autonomic side-effects: Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence and impaired ejaculation.
III. Seizures
IV. Sedation
V. Other effects

Agranulocytosis (especially for clozapine)
Sialorrhoea or increased salivation (especially for clozapine)
Weight gain
Jaundice
Dermatological effects (contact dermatitis, photosensitive reaction)

Community Health Practitioner's Responsibility for a Patient Receiving Antipsychotics

Instruct the patient to take sips of water frequently to relieve dryness of mouth. Frequent mouth washes, use of chewing gum, applying glycerine on the lips are also helpful.

A high-fiber diet, increased fluid intake and laxatives if needed, help to reduce constipation.

Advise the patient to get up from the bed or chair very slowly. Patient should sit on the edge of the bed for one full minute dangling his feet, before standing up. Check BP before and after medication is given. This is an important measure to prevent falls and other complications resulting from orthostatic hypotension.

Differentiate between akathisia and agitation and inform the physician. A change of drug may be necessary if side-effects are severe. Administer antiparkinsonian drugs as prescribed.

Observe the patient regularly for abnormal movements.

Take all seizure precautions.

Patient should be warned about driving a car or operating machinery when first treated with antipsychotics. Giving the entire dose at bedtime usually eliminates any problem from sedation.

Advise the patient to use sunscreen measures (use of full sleeves, dark glasses etc) for photosensitive reactions.

Teach the importance of drug compliance, side-effects of drugs and reporting if too severe, regular follow-ups. Give reassurance and reduce unfounded fears and anxieties.

A patient receiving clozapine is at risk for developing agranulocytosis. Monitor TC, DC essentially in the first few weeks of treatment. Stop the drug if the WBC count drops to less than 3000/mm^3 of blood. The patient should also be told to report if sore throat or fever develops, which might indicate infection.

Seizure precautions should also be taken as clozapine reduces seizure threshold. The dose should be regulated carefully and the patient may also be put on anticonvulsants such as eptoin.

3.2.1.2 **Antidepressants**

Antidepressants are those drugs, which are used for the treatment of depressive illness. These are also called mood elevators or thymoleptics.

Indications

Depression

- Depressive episode
- Dysthymia
- Reactive depression
- Secondary depression
- Abnormal grief reaction

Childhood psychiatric disorders

- Enuresis
- Separation anxiety disorder
- Somnambulism
- School phobia
- Night terrors

Other psychiatric disorders

- Panic attacks
- Generalized anxiety disorder

Agolaphobia, social phobia
OCD with or without depression
Eating disorder
Borderline personality disorder
Post-traumatic stress disorder
Depersonalization syndrome

Medical disorders

Chronic pain
Migraine
Peptic ulcer disease

Pharmacokinetics

Antidepressants are highly lipophilic and protein-bound. The half-life is long and usually more than 24 hours. It is predominantly metabolized in the liver.

Mechanism of Action

The exact mechanism is unknown. The predominant action is by increasing catecholamine levels in the brain.

TCAs are also called monoamine reuptake inhibitors (MARIs). The main mode of action is by blocking the reuptake of norepinephrine (NE) and/or serotonin (5-HT) at the nerve terminals, thus increasing the NE and 5-HT levels at the receptor site.

MAOIs instead act on MAO (monoamine oxidase), which is responsible for the degradation of catecholamines after re-uptake. The final effect is the same, a functional increase in the NE and 5-HT levels at the receptor site. The increase in brain amine levels is probably responsible for the antidepressants action. It takes about 5 to 10 days for MAOIs and 2 to 3 weeks for TCAs to bring down depressive symptoms.

SSRIs act by inhibiting the re-uptake of serotonin and increasing its levels at the receptor site.

Side Effects

1. Autonomic side effects: Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence, impaired ejaculation, delirium, and aggravation of glaucoma.

2. CNS effects: Sedation, tremor and other extra-pyramidal symptoms, withdrawal syndrome, seizures, jitteriness syndrome, precipitation of mania.
3. Cardiac side effects: Tachycardia, ECG changes, arrhythmias, direct myocardial depression, quinidine-like action (decreased conduction time).
4. Allergic side-effect: Agranulocytosis, cholestatic jaundice, skin rashes, systemic vasculities.
5. Metabolic and endocrine side-effects: Weight gain.
6. Special effects of MAOI drugs: Hypertensive crisis, severe hepatic necrosis, hyperpyrexia.

Community Health Practitioner's Responsibility for a Patient Receiving Antidepressants

Most of the nurse's responsibilities for a patient on antidepressants are the same as for a patient receiving antipsychotics. In addition:

Patients on MAOIs should be warned against the danger of ingesting tyramine-rich foods which can result in hypertensive crisis. Some of these foods are beef liver, chicken liver, fermented sausages, dried fish, overriped fruits, chocolate and beverages like wine, beer and coffee.

Report promptly if occipital headache, nausea, vomiting, chest pain or other unusual symptoms occur; these can herald the onset of hypertensive crisis.

Instruct the patient not to take any medication without prescription.

Caution the patient to change his position slowly to minimize orthostatic hypotension.

Strict monitoring of vitals, especially blood pressure is essential.

3.2.1.3 **Lithium and other mood stabilizing drugs**

Mood stabilizers are used for the treatment of bipolar affective disorders. Some commonly used mood stabilizers are:

Lithium

Carbamazepine

Sodium valproate

Lithium

Lithium is an element with atomic number 3 and atomic weight 7. it was discovered by FJ Cade in 1949 and is a most effective and commonly used drug in the treatment of mania.

Indications

Acute mania

Prophylaxis for bipolar and unipolar mood disorder.

Schizoaffective disorder

Cyclothymia

Impulsivity and aggression

Other disorders

- premenstrual dysphoric disorder
- bulimia nervosa
- borderline personality disorder
- episodes of binge drinking
- trichotillomania
- cluster headaches

Pharmacokinetics

Lithium is readily absorbed with peak plasma levels occurring 2-4 hours after a single oral dose of lithium carbonate. Lithium is distributed rapidly in liver and kidney and more slowly in muscle, brain and bone. Steady state levels are achieved in about 7 days. Elimination is predominantly via kidneys. Lithium is reabsorbed in the proximal tubules and is influenced by sodium balance. Depletion of sodium can precipitate lithium toxicity.

Mechanism of Action

The probable mechanisms of action can be:

It accelerates presynaptic re-uptake and destruction of catecholamines like norepinephrine

It inhibits the release of catecholamines at the synapse.

It decreases postsynaptic serotonin receptor sensitivity.

Also these actions result in decreased catecholamine activity, thus ameliorating mania.

Dosage

Lithium is available in the market in the form of the following preparations:

Lithium carbonate: 300mg tablets (e.g. Licab); 400mg sustained release tablets (e.g. Lithosun-SR)

Lithium citrate: 300mg/5ml liquid.

The usual range of dose per day in acute mania is 900-2100mg given in 2-3 divided doses. The treatment is started after serial lithium estimation is done after a loading dose of 600mg or 900mg of lithium to determine the pharmacokinetics.

Blood Lithium Levels

Therapeutic levels = 0.8 – 1.2 mEq/L (for treatment of acute mania)

Prophylactic levels = 0.6 – 1.2 mEq/L (for prevention of relapse in bipolar disorder)

Toxic lithium levels > 2.0 mEq/L

Side Effects

1. Neurological: Tremors, motor hyperactivity, muscular weakness, cogwheel rigidity, seizures, neurotoxicity (delirium, abnormal involuntary movements, seizures, coma).
2. Renal: Polydipsia, polyuria, tubular enlargement, nephrotic syndeome.
3. Cardiovascular: T-wave depression
4. Gastrointestinal: Nausea, vomiting, diarrhoea, abdominal pain and metallic taste.
5. Endocrine: Abnormal thyroid function, goiter and weight gain.
6. Dermatological: Acneiform eruptions, popular eruptions and exacerbation of psoriasis.
7. Side-effects during pregnancy and lactation: Teratogenic possibility, increased incidence of Ebstein's anomaly (distortion and downward displacement of tricuspid valve in right ventricle) when taken in first trimester. Secreted in milk and can cause toxicity in infant.
8. Signs and symptoms of lithium toxicity (serum lithim level > 2.0 mEq/L):

   ataxia

   course tremor (hand)

   nausea and vomiting

   impaired memory

   impaired concentration

nephrotoxicity
muscle weaknesss
convulsions
muscle twitching
dysarthria
lethargy
confusion
coma
hyperreflexia
nystagmus

Management of Lithium Toxicity

Discontinue the drug immediately

For significant short-term ingestions, residual gastric content should be removed by induction of emesis, gastric lavage and adsorption with activated charcoal.

If possible instruct the patient to ingest fluids

Assess serum lithium levels, serum electrolytes, renal functions, ECG as soon as possible.

Maintenance of fluid and electrolyte balance

In a patient with serious manifestations of lithium toxicity, hemodialysis should be initiated.

Contraindications of Lithium Use

Cardiac, renal, thyroid or neurological dysfunctions

Presence of blood dyscrasias

During first trimester of pregnancy and lactation

Severe dehydration

Hypothyroidism

History of seizures

Community Health Practitioner's Responsibility for a Patient Receiving Lithium

The pre-lithium work up: A complete physical history, ECG, blood studies (TC, DC, FBS, BUN, creatinine, electrolysis) urine examination (routine and microscopic) must be carried out. It is important to assess renal function as renal side effects are common and the drug can be dangerous in

an individual with compromised kidney function. Thyroid functions should also be assessed as the drug is known to depress the thyroid gland.

To achieve therapeutic effect and prevent lithium toxicity, the following precautions should be taken:

Lithium must be taken on a regular basis, preferably at the same time daily (for example, a client taking lithium on TID schedule, who forgets a dose should wait until the next scheduled time to take lithium and not take twice the amount at one time because lithium toxicity can occur).

When lithium therapy is initiated, mild side effects such as fine hand tremors, increased thirst and urination, nausea, anorexia etc may develop. Most of them are transient and do not represent lithium toxicity.

Serious side-effects of lithium that necessitate its discontinuance include vomiting, extreme hand tremors, sedation, muscle weakness and vertigo. The psychiatrist should be notified immediately if any of these effects occur.

Since polyuria can lead to dehydration with the risk of lithium intoxication, patients should be advised to drink enough water to compensate for the fluid loss.

Various situations can require an adjustment in the amount of lithium administered to a client, such as the addition of a new medicine to the client's drug regimen, a new diet or an illness with fever or excessive sweating. In this connection, people involved in heavy outdoor labour are prone to excessive sodium loss through sweating. They must be advised to consume large quantities of water with salt, to prevent lithium toxicity due to decreased sodium levels. If severe vomiting or gastroenteritis develops, the patient should be told to report immediately to the doctor. These are the conditions that have a high potential for causing lithium toxicity by lowering serum sodium levels.

Frequent serum lithium level evaluation is important. Blood for determination of lithium levels should be drawn in the morning approximately 12-14 hours after the last dose was taken.

The patient should be told about the importance of regular follow-up. In every six months, blood sample should be taken for estimation of electrolytes, urea, creatinine, a full blood count and thyroid function test.

Carbamazepine

It is available in the market under different trade names like Tegretol, Mazetol, Zeptol and Zen Retard.

Indications

Seizures-complex partial seizures, GTCS, seizures due to alcohol withdrawal

Psychiatric disorders: rapid cycling bipolar disorder, acute depression, impulse control disorder, aggression, psychosis with epilepsy, schizoaffective disorders, borderline personality disorder, cocaine withdrawal syndrome.

Paroxysmal pain syndrome – trigeminal neuralgia and phantom limb pain.

Dosage

The average daily dose is 600-800mg orally, in divided doses. The therapeutic blood levels are 6-12µg/ml. Toxic blood levels are reached at more than 15µg/ml.

Mechanism of Action

Its mood stabilizing mechanism is not clearly established. Its anticonvulsant action may however be by decreasing synaptic transmission in the CNS.

Side Effects

Drowsiness, confusion, headache, ataxia, hypertension, arrhythmias, skin rashes, Steven-Johnson syndrome, nausea, vomiting, diarrhoea, dry mouth, abdominal pain, jaundice, hepatitis, oliguria, leucopenia, thrombocytopenia, bone marrow depression leading to aplastic anaemia.

Community Health Practitioner's Responsibilities

Since the drug may cause dizziness and drowsiness advise him to avoid driving and other activities requiring alertness.

Advise patient not to consume alcohol when he is on the drug.

Emphasize the importance of regular follow-up visits and periodic examination of blood count and monitoring of cardiac, renal, hepatic and bone marrow functions.

Sodium Valproate (Encorate chrono, valparin, Epilex, Epival)

Indications

Acute mania, prophylactic treatment of bipolar I disorder, rapid cycling bipolar disorder.

Schizoaffective disorder.

Seizures

Other disorders like bulimia nervosa, obsessive-compulsive disorder, agitation and PTSD

Mechanism of Action

The drug acts of gamma-aminobutyric acid (GABA) an inhibitory amino acid neurotransmitter. GABA receptor activation serves to reduce neuronal excitability.

Dosage

The usual dose is 15mg/kg/day with a maximum of 60mg/kg/day orally.

Side effects

Nausea, vomiting, diarrhoea, sedation, ataxia, dysarthria, tremor, weight gain, loss of hair, thrombocytopenia, platelet dysfunction.

Community Health Practitioner's Responsibilities

Explain to the patient to take the drug immediately after food to reduce GT irritation

Advise to come for regular follow-up and periodic examination of blood count, hepatic function and thyroid function. Therapeutic serum level of valproic acid is 50-100 micrograms/ml.

3.1.2.4 Anxiolytics (Anti-anxiety drugs) and Hypnosedatives

These are also called minor tranquillizers. Most of them belong to the benzodiazepine group of drugs.

Classification

1. Barbiturates: Example, Phenobarbital, pentobarbital, secobarbital and thiopentone.
2. Non-barbiturates non-benzodiazepine anti-anxiety agents: Example, Meprobamate glutethimide, ethanol, diphenhydramine and methaqualon.

3. Benzodiazepines: Presently benzodiazepines are the drugs of first choice in the treatment of anxiety and for the treatment of insomnia.
   Very short-acting: Example, Triazolam, Midazolam.
   Short-acting: Example, Oxazepam (Serepax), Lorazepam (Ativan, Trapex, Larpose), Alprazolam (Restyl, Trika, Alzolam, Quiet, Anxit).
   Long-acting: Example, Chlordiazepoxide (Librium), Diazepam (Valium, Calmpose), Clonazepam (Lonazep), Flurazepam (Nindral), Nitrazepam (Dormin).

Indications for Benzodiazepines

Anxiety disorders
Insomnia
Depression
Panic disorder and social phobia
Obsessive-compulsive disorder
Post-traumatic stress disorder
Bipolar I disorder
Other psychiatric indications include alcohol withdrawal, substance-induced and psychotic agitation

Dosage (mg/day) Alprazolam:
0.5-6 PO Oxazepam: 15-120 PO
Lorazepam: 2-6 PO/IV/IM
Diazepam: 2-10 PO/IM/slow IV
Clonazepam: 0.5-20 PO/IM
Chlordiazepoxide: 15-100 PO; 50-100 slow IV
Nitrazepam: 5-20 PO

Mechanism of Action

Benzodiazepines bind to specific sites on the GABA receptors and increase GABA level. Since GABA is an inhibitory neurotransmitter, it has a calming effect on the central nervous system, thus reducing anxiety.

Side Effects

Nausea, vomiting, weakness, vertigo, blurring of vision, body aches, epigastric pain, diarrhoea, impotence, sedation, increased reaction time, ataxia, dry mouth, retrograde amnesia, impairment of driving skills,

dependence and withdrawal symptoms (the drug should be withdrawn slowly, as a result).

Community Health Practitioner's Responsibility in the Administration of Benzodiazepines

Administer with food to minimize gastric irritation.

Advise the patient to take medication exactly as directed. Abrupt withdrawal may cause insomnia, irritability and sometimes even seizures.

Explain about adverse effects and advise him to avoid activities that require alertness.

Caution the patient to avoid alcohol or any other CNS depressants along with benzodiazepines; also instruct him not to take any over-the-counter (OTC) medications.

If IM administration is preferred give deep IM.

For IV administration do not mix with any other drug. Give slow IV as respiratory or cardiac arrest can occur; monitor vital signs during IV administration. Prevent extravasations since it can cause phlebitis and venous thrombosis.

3.1.2.5 **Antiparkinsoninan agents**

In clinical practice anticholinergic drugs, amantadine and the antihistamines have their primary use as treatments for medication-induced movement disorders, particularly neuroleptic-induced parkinsonism, acute dystonia and medication-induced tremor.

Anticholinergics

Trihexyphenidyl

Benztropine

Biperiden

Dopaminergic Agents

Bromocriptine

Carbidopa/Levodopa

Monoamine Oxidase Type B Inhibitors

Selegiline

Trihexyphenidyl (Artane, Trihexane, Trihexy, Pacitane)

Indications

Drug-induced parkinsonism

Adjunct in the management of parkinsonism

Mechanism of Action

It acts by increasing the release of dopamine from presynaptic vesicles, blocking the re-uptake of dopamine into presynaptic nerve terminals or by exerting an agonist effect on postsynaptic dopamine receptors.

Trihexyphenidyl reaches peak plasma concentrations in 2-3 hours after oral administration and has a duration of action of up to 12 hours.

Dosage

1-2mg per day orally initially. Maximum dose up to 15 mg/day in divided doses.

Side Effects

Dizziness, nervousness, drowsiness, weakness, headache, confusion, blurred vision, mydriasis, tachycardia, orthostatic hypotension, dry mouth, nausea, constipation, vomiting, urinary retention and decreased sweating.

Community Health Practitioner's Responsibilities

Assess parkinsonian and extrapyramidal symptoms. Medication should be tapered gradually.

Caution patient to make position changes slowly to minimize orthostatic hypotension.

Instruct the patient about frequent rinsing of mouth and good oral hygiene.

Caution patient that this medication decreases perspiration, and over-heating may occur during hot weather.

3.1.2.6 **Antabase drugs**

Disulfiram is an important drug in this class and is used to ensure abstinence in the treatment of alcohol dependence. Its main effect is to produce a rapid and violently unpleasant reaction in a person who ingests even a small amount of alcohol while taking disulfiram.

3.2.1.7 **Clonidine**

Indications

Control of withdrawal symptoms from opioids

Tourette's disorder

Control of aggressive or hyperactive behaviour in children

Autism

Mechanism of Action

Alpha 2- adrenergic receptor agonist.

The agonist effects of clonidine on presynaptic alpha 2- adrenergic receptors result in a decrease in the amount of neurotransmitter released from the presynaptic nerve terminals. This decrease serves generally to reset the sympathetic tone at a lower level and to decrease arousal.

Dosage

Usual starting dosage is 0.1mg orally twice a day; the dosage can be raised by 0.3mg a day to an appropriate level.

Side Effects

Dry mouth, dryness of eyes, fatigue, irritability, sedation, dizziness, nausea, vomiting, hypotension and constipation.

Community Health Practitioner's Responsibility

Monitor BP, the drug should be withheld if the patient becomes hypotensive.

Advice frequent mouth rinses and good oral hygiene for dry mouth.

Methylphenidate (Ritalin)

Methylphenidate, dextroamphetamine and pemoline are sympathomimetics.

Indications

Attention-deficit hyperactivity disorder

Narcolepsy

Depressive disorders

Obesity

Mechanism of Action

Sympathomimetics cause the stimulation of alpha and beta-adrenergic receptors directly, as agonists and indirectly by stimulating the release of dopamine and norepinephrine from presynaptic terminals. Dextroamphetamine and methyphenidate are also inhibitors of catecholamine reuptake, especially dopamine re-uptake and inhibitors of monoamino oxidase. The net result of these activities is believed to be the stimulation of several brain regions.

Dosage

Starting dose is 5-10mg per day orally, maximum daily dose is 80 mg/day.

Side Effects

Anorexia or dyspepsia, weight loss, slowed growth, dizziness, insomnia or nightmares, dysphoric mood, tics and psychosis.

Community Health Practitioner's Responsibilities

Assess mental status for change in mood, level of activity, degree of stimulation and aggressiveness.

Ensure that patient is protected from injury.

Keep stimuli low and environment as quiet as possible to discourage over stimulation.

To decrease anorexia, the medication may be administered immediately after meals. The patient should be weighed regularly (at least weekly) during hospitalization and at home while on therapy with CNS stimulants, due to the potential for anorexia/weight loss and temporary interruptions of growth and development.

To prevent insomnia administer last dose at least 6 hours before bedtime.

In children with behavioural disorders a drug 'holiday' should be attempted periodically under the direction of the physician to determine effectiveness of the medication and the need for continuation.

Ensure that parents are aware of the delayed effects of Ritalin. Therapeutic response may not be seen for 2-4 weeks; the drug should not be discontinued for lack of immediate results.

Inform parents that OTC (over-the-counter) medications should be avoided while the child is on stimulant medication. Some OTC

medications, particularly cold and hay fever preparations contain certain sympathomimetic agents that could compound the effects of the stimulated and create drug interactions that may be toxic to the child.

Ensure that parents are aware that the drug should not be withdrawn abruptly. Withdrawal should be gradual and under the direction of the physician.

3.2.1.8 **Electroconvulsive therapy**

Electroconvulsive therapy is a type of somatic treatment first introduced by Bini and Cerletti in April 1938. From 1980 onwards ECT is being considered as a unique psychiatric treatment.

Electroconvulsive therapy is the artificial induction of a grandmal seizure through the application of electrical current to the brain. The stimulus is applied through electrodes that are placed either bilaterally in the fronto-temporal region, or unilaterally on the non-dominant side (right side of head in a right-handed individual).

Parameters of Electrical Current Applied

Standard dose according to American Psychiatric Association, 1978:

Voltage – 70-120 volts

Duration – 0.7-1.5 seconds

Type of Seizure Produced

grandmal seizure – tonic phase lasting for 10-15 seconds

clonic phase lasting for 30-60 seconds

Mechanism of Action

The exact mechanism of action is not known. One hypothesis states that ECT possibly affects the catecholamine pathways between diencephalons (from where seizure generalization occurs) and limbic system (which may be responsible for mood disorders), also involving the hypothalamus.

Types of ECT

Direct ECT: In this, ECT is given in the absence of anaesthesia and muscular relaxation. This is not a commonly used method now.

Modified ECT: Here ECT is modified by drug-induced muscular relaxation and general anaesthesia.
Frequency and Total Number of ECT
Frequency: Three times per week or as indicated.
Total number: 6 to 10; up to 25 may be preferred as indicated.
Application of Electrodes

Bilateral ECT: Each electrode is placed 2.5-4cm above the midpoint, on a line joining the tragus of the ear and the lateral canthus of the eye.

Unilateral ECT: Electrodes are placed only on one side of head, usually non-dominant side (right side of head in a right-handed individual).

Unilateral ECT is safer, with much fewer side effects particularly those of memory impairment.

Indications

a. Major depression: With suicidal risk; with stupor; with poor intake of food and fluids; melancholia with psychotic features with unsatisfactory response to drugs or where drugs are contraindicated or have serious side-effects.
b. Severe catatonia (functional): With stupor; with poor intake of food and fluids; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
c. Severe psychosis (schizophrenia or mania): With risk of suicide, homicide or danger of physical assault; with depressive features; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
d. Organic mental disorders:
   organic mood disorders
   organic psychosis
e. Other indications: ECT is preferred to antidepressants therapy in some cases, such as for clients with cardiac disease; when tricyclics are contraindicated because of the potential for dysrhythmia and congestive heart failure; and for pregnant women, in whom antidepressants place the foetus at risk for congenital defects.

Contraindications

A. Absolute:
   Raised ICP (intracranial pressure)

B. Relative:

cerebral aneurysm
cerebral hemorrhage
brain tumour
acute myocardial infarction
congestive heart failure
pneumonia or aortic aneurysm
retinal detachment

Complications of ECT

Life-threatening complications of ECT are rare. ECT does not cause any brain damage.

Fractures can sometimes occur in elderly patients with osteoporosis. In patients with a history of heart disease, dysrhythmias and respiratory arrest may occur.

Side effects of ECT

Memory impairment
Drowsiness, confusion and restlessness
Poor concentration, anxiety
Headache, weakness/fatigue, backache, muscle aches
Dryness of mouth, palpitations, nausea, vomiting
Unsteady gait
Tongue bite and incontinence.

ECT Team

Psychiatrist, anaesthesiologist, trained nurses and aides should be involved in the administration of ECT

Treatment Facilities

There should be a suite of three rooms:

1. A pleasant, comfortable waiting room (pre-ECT room).
2. ECT room, which should be equipped with ECT machine and accessories, an anaesthetic appliance, suction apparatus, face masks, oxygen cylinders with adjustable flow valves, curved tongue depressors, mouth gags, resuscitation apparatus and emergency drugs. There should be immediate access to a defibrillator.
3. A well equipped recovery room.

Role of the Community Health Practitioners

a. Pre-treatment evaluation

Detailed medical and psychiatric history, including history of allergies.

Assessment of patient's and family's knowledge of indicators, side-effects, therapeutic effects and risks associated with ECT.

An informed consent should be taken. Allay any unfounded fears and anxieties regarding the procedure.

Assess baseline vital signs.

Patient should be on empty stomach for 4-6 hours prior to ECT.

Withhold night doses of drugs, which increase seizure threshold like diazepam, barbiturates and anticonvulsants.

Withhold oral medications in the morning.

Head shampooing in the morning since oil causes impedance of passage of electricity to brain

Any jewellery, prosthesis, dentures, contact lens, metallic objects and tight clothing should be removed from the patient's body.

Empty bladder and bowel just before ECT.

Administration of 0.6mg atropine IM or SC 30 minutes before ECT, or IV just before ECT.

b. Intra-procedure care

Place the patient comfortably on the ECT table in supine position.

Stay with the patient to allay anxiety or fear.

Assist in administering the anaesthetic agent (thiopental sodium 3-5mg/kg body weight) and muscle relaxant (1mg/kg body weight of succynylcholine).

Since the muscle relaxant paralyzes all muscles including respiratory muscles, patent airway should be ensured and ventilatory support should be started.

Mouth gag should be inserted to prevent possible tongue bit.

The place(s) of electrode placement should be cleaned with normal saline or 25 percent bicarbonate solution, or a conducting gel applied.

Monitor voltage, intensity and duration of electrical stimulus given.

Monitor seizure activity using cuff method.

100 percent oxygen should be provided.

During seizure monitor vital signs, ECG, oxygen saturation, EEG etc.

Record the findings and medicines given in the patient's chart.

c. Post-procedure care.

Monitor vital signs

Continue oxygenation till spontaneous respiration starts.

Assess for post-ictal confusion and restlessness.

Take safety precautions to prevent injury (side-lying position and suctioning to prevent aspiration of secretions, use of side rails to prevent falls).

If there is severe post-ictal confusion and restlessness, I.V. diazepam may be administered.

Reorient the patient after recovery and stay with him until fully oriented.

Document any findings as relevant in the patient's record.

3.2.1.9 **Psychosurgery**

Psychosurgery is defined by APA's Task Force as "a surgical intervention, to sever fibres connecting one part of the brain with another, or to remove, destroy, or stimulate brain tissue, with the intent of modifying behaviour, thought or mood disturbances, for which there is no underlying organic pathology".

Indications

Severe psychiatric illness.

Chronic duration of illness of about 10 years.

Persistent emotional disorders.

Failure to respond to all other therapies.

High risk of suicide.

Major Surgical Procedures

Stereotactic subcaudate tractotomy.

Stereotactic limbic leucotomy.

Stereotactic bilateral amygdalotomy

Nursing care for a patient undergoing psychosurgery is the same as for any neurosurgical procedure.

4.0 **Conclusion**

The essence of this unit is to expose the learners to different pharmacological treatment of psychiatric patients. You must have gone through some therapeutic modalities in this unit. Electroconvulsive therapy was also discussed in the unit, the mechanism of action, indications,

contraindications, complications, side-effects and the role of the nurse in the management of a patient undergoing ECT.

5.0 Summary

You have acquired knowledge on therapeutic modalities in psychiatry with particular reference to somatic therapies and I hope your exposure has enriched you greatly.

6.0 Tutor Marked Assignment

(1) Explain the meaning of Electroconvulsive therapy.

(2) Describe your role as a nurse in the management of a patient undergoing ECT.

7.0 References / Further Readings

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Staurt, W. G. and Sundeen, J. S. 1995. Principles and Practice of Psychiatric Nursing. 5th Ed. London: C. V. Mosby Company.

Staurt, W. G. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Ahuja, N. A. 1999. Short Text Book of Psychiatry 3rd Ed. New Delhi: Jaypee Brothers.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 9: Therapeautic Modalities in Psychiatry II (Psychological therapy)

Contents

1.0 Introduction

This unit being a continuation of Unit 8 which was on somatic therapies while this unit is on psychological therapies as part of the therapeutic modalities in psychiatry. The psychological therapies that shall be discussed in this unit include psychoanalytic, behaviour, cognitive therapies, hypnosis, abreaction, relaxation, individual, supportive, group, family and marital therapies.

2.0 Objectives

At the end of this unit, you should be able to:

- describe psychoanalytic therapy
- explain behavioural therapy
- describe cognitive therapy
- discuss relaxation therapies
- differentiate between individual, group, family and marital therapies

3.0 **Main content**

PSYCHOLOGICAL THERAPIES

There are several kinds of psychological therapies:

- Psychoanalytic therapy
- Behaviour therapy
- Cognitive therapy
- Hypnosis
- Abreaction therapy
- Relaxation therapies
- Individual therapy
- Supportive therapy
- Group therapy
- Family and marital therapy

3.1 **Psychoanalytic therapy**

Psychoanalysis was first developed by Sigmund Freud at the end of the 19th century. The most important indication for psychoanalytical therapy is the presence of long-standing mental conflicts, which may be unconscious but produce symptoms. The aim of therapy is to bring all repressed material to conscious awareness so that the patient can work towards a healthy resolution of his problems, which are causing the symptoms.

Psychoanalysis makes use of free association and dream analysis to affect reconstruction of personality. Free association refers to the verbalization of thoughts as they occur, without any conscious screening. The psychoanalyst searches for patterns in the material that is verbalized and in the areas that are unconsciously avoided (such areas are identified as resistances).

Analysis of the patient's dreams helps to gain additional insight into his problems and the resistances. Thus dreams symbolically communicate areas of intrapsychic conflict.

The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation.

The process is complicated by the occurrence of transference reactions. This refers to the patient's development of strong positive or negative feelings towards the analyst and they represent the patient's past response to a significant other, usually a parent. The therapist's reciprocal response to the patient is called

countertransference. Such reactions must be handled appropriately before progress can be made.

The roles of the patient and psychoanalyst are explicitly defined by Freud. The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. He is frequently in a recumbent position on a couch during therapy to induce relaxation, which facilitates free association. The psychoanalyst is a shadow-person. He reveals nothing personal, nor does he give any directions to the patient. His verbal responses are for the most part brief and noncommittal, so as not to interfere with the associative flow. He departs from this style of communication when an interpretation of behaviour is made to the patient.

By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is also able to relate to others uninhibited by neurotic conflicts.

Psychoanalytical therapy is a long-term proposition. The patient is seen frequently, usually five times a week. It is therefore time consuming and expensive.

3.2 **Behaviour therapy**

It is a form of treatment for problems in which a trained person deliberately establishes a professional relationship with the client, with the objective of removing or modifying existing symptoms and promoting positive personality, growth and development.

Behaviour therapy involves identifying maladaptive behaviours and seeking to correct these by applying the principles of learning derived from the following theories:

Classical conditioning model by Ivan Pavlov (1936)

Operant conditioning model by BF Skinner (1953)

Major Assumptions of Behaviour Therapy

Based on the above-mentioned theories, the following are the assumptions of behaviour therapy:

All behaviour is learned (adaptive and maladaptive).

Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced.

Maladaptive behaviour can be unlearned and replaced by adaptive behaviour if the person receives exposure to specific stimuli and reinforcement for the desired adaptive behaviour.

Behavioural assessment is focused more on the current behaviour rather than on historical antecedents.

Treatment strategies are individually tailored. Behaviour therapy is a short duration therapy.

Behaviour therapy is a short duration therapy, therapists are easy to train and it is cost-effective. The total duration of therapy is usually 6-8 weeks. Initial sessions are given daily but the later sessions are spaced out. Unlike psychoanalysis where the therapist is a shadow person, in behaviour therapy both the patient and therapist are equal participants. There is no attempt to unearth an underlying conflict and the patient is not encouraged to explore his past.

Behaviour Techniques

(A) Systematic desensitization: It was developed by Joseph Wolpe, based on the behavioural principle of counter conditioning. In this patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response. The negative reaction of anxiety is inhibited by the relaxed state, a process called reciprocal inhibition.

It consists of three main steps:

1. Relaxation training
2. Hierarchy construction
3. Desensitization of the stimulus.

1. Relaxation training: there are many methods which can be used to induce relaxation, some of them are:

Jacobson's progressive muscle relaxation

Hypnosis

Meditation or yoga

Mental imagery

Biofeedback

2. Hierarchy construction: Here the patient is asked to list all the conditions which provoke anxiety. Then he is asked to list them in a descending order of anxiety provocation.

3. Desensitization of the stimulus: This can be done either through imaginary or in reality. At first, the lowest item in hierarchy is confronted. The patient is advised to signal whenever anxiety is produced. With each signal he is asked to relax. After a few trials, patient is able to control his anxiety gradually.

Indications:

Phobias
Obsessions
Compulsions
Certain sexual disorders

(B) Flooding: The patient is directly exposed to the phobic stimulus, but escape is made impossible. By prolonged contact with the phobic stimulus, the therapist's guidance and encouragement and his modeling behaviour reduce anxiety.
Indication: Specific phobias

(C) Aversion therapy: Pairing of the pleasant stimulus with an unpleasant response, so that even in absence of the unpleasant response the pleasant stimulus becomes unpleasant by association. Punishment is presented immediately after a specific behavioural response and the response is eventually inhibited.

Unpleasant response is produced by electric stimulus, drugs, social disapproval or even fantasy.
Indications:

Alcohol abuse
Paraphilias
Homosexuality
Transvestism

(D) Operant conditioning procedures for increasing adaptive behaviour

1. Positive reinforcement: When a behavioural response is followed by a generally rewarding event such as food, praise or gifts, it tends to be strengthened and to occur more frequently than before the reward. This technique is used to increase desired behaviour.
2. Token economy: This programme involves giving token rewards for appropriate or desired target behaviours performed by the patient. The token can be later exchanged for other rewards. For example, on

inpatient hospital wards, patients receive a reward for performing desired behaviour, such as tokens which they may use to purchase luxury items or certain privileges.

(E) Operant conditioning procedures to teach new behaviour

1. Modeling: Modeling is a method of teaching by demonstration, wherein the therapist shows how a specific behaviour is to be performed. In modeling the patient observes other patients indulging in target behaviours and getting rewards for those behaviours. This will make the patient to repeat the same behaviour and earn rewards in the same manner.

2. Shaping: In shaping the components of a particular skill, the behaviour is reinforced step by step. The therapist starts shaping by reinforcing the existing behaviour. Once it is established he reinforces the responses which are closest to the desired behaviour and ignores the other responses.

   For example, to establish eye-to-eye contact, the therapist sits opposite the patient and reinforces him even if he moves his upper body towards him. Once this is established, he reinforces the person's head movement in his direction and this procedure continues till eye-to-eye contact is established.

3. Chaining: Chaining is used when a person fails to perform a complex task. The complete task is broken into a number of small steps and each step is taught to the patient. In forward chaining one starts with the first step, goes on to the second step, then to the third and so on. In backward chaining, one starts with the last step and goes on to the next step in a backward fashion. Backward chaining is found to be more effective in training the mentally disabled.

(F) Operant conditioning procedures for decreasing maladaptive behaviour

1. Extinction/Ignoring: Extinction means removal of attention rewards permanently, following a problem behaviour. This includes actions like not looking at the patient, not talking to the patient, or having no physical contact with the patient etc., following the problem behaviour.

   This is commonly used when patient exhibits odd behaviour.

2. Punishment: Aversive stimulus (punishment) is presented contingent upon the undesirable response. The punishment procedure should be administered immediately and consistently following the undesirable behaviour with clear explanation.

   Differential reinforcement of an adaptive or desirable behaviour should always be added when a punishment is being used for decreasing an undesirable behaviour. Otherwise the problem behaviours tend to get maintained because of the lack of adaptive behaviours and skill defect.

3. Timeout: Timeout method includes removing the patient from the reward or the reward from the patient for a particular period of time following a problem behaviour. This is often used in the treatment of childhood disorders. For example, the child is not allowed to go out of the ward to play if he fails to complete the given work.

4. Restitution (Over-correction): Restitution means restoring the disturbed situation to a state that is much better than what it was before the occurrence of the problem behaviour.

   For example, if a patient passes urine in the ward he would be required to not only clean the dirty area but also mop the entire/largest area of the floor in the ward.

5. Response cost: This procedure is used with individuals who are on token programmes for teaching adaptive behaviour. When undesirable behaviour occurs, a fixed number of tokens or points are deducted from what the individual has already earned.

(G) Assertiveness and social skill training: Assertive training is a behaviour therapy technique in which the patient is given training to bring about change in emotional and other behavioural pattern by being assertive. Client is encouraged not to be afraid of showing an appropriate response, negative or positive, to an idea or suggestion. Assertive behaviour training is given by the therapist, first by role playing and then by practice in a real life situation. Attention is focused on more effective interpersonal skills.

Social skills training helps to improve social manners like encouraging eye contact, speaking appropriately, observing simple etiquette and relating to people.

3.3 **Cognitive therapy**

Cognitive therapy is a psychotherapeutic approach based on the idea that behaviour is secondary to thinking. Our moods and feelings are influenced by our thoughts. Self-defeating and self-depreciating patterns of thinking result in depressed mood. The therapist helps the patient by correcting this distorted way of thinking, feelings and behaviour.

The cognitive model of depression includes the cognitive triad:

1. A negative view about self
2. A negative view about the environment and
3. A negative view about the future

These negative thoughts are modified to improve the depressive mood. Cognitive therapy is used for the treatment of depression, anxiety disorder, panic disorder, phobic disorder and eating disorders.

3.4 **Hypnosis therapy**

The word 'hypnotism' was first used by James Briad in the 19^{th} century. Hypnosis is an artificially induced state in which the person is relaxed and unusually suggestible. Hypnosis can be induced in many ways, such as by using a fixed point for attention, rhythmic monotonous instructions etc.

Changes that occur during Hypnosis

The person becomes highly suggestible to the commands of the hypnotist.

There is an ability to produce or remove symptoms or perceptions.

Dissociation of a part of body or emotions.

Amnesia for the events that occurred during the hypnotic state.

Techniques

Patient is either made to lie down on a bed or sit in a chair. He is asked to gaze fixedly on a spot. Therapist makes monotonous suggestions of relaxation and sleep. The patient however is not asleep and can hear what is being said, answer questions and obey instructions.

This therapy is useful in:
Abreaction of past experiences.
Psychosomatic disorders.
Conversion and dissociative disorders.
Eating disorders.
Habit disorders and anxiety disorders.

3.5 **Abreaction therapy**

Abreaction is a process by which repressed material, particularly a painful experience or conflict, is brought back to consciousness. The person not only recalls but also relives the material, which is accompanied by the appropriate emotional response. It is most useful in acute neurotic conditions caused by exreme stress (Post-traumatic stress disorder, hysteria etc).

Although abreaction is an integral part of psychoanalysis and hypnosis, it can also be used independently.

Method

Abreaction can be brought about be strong encouragement to relieve the stressful events. The procedure is begun with neutral topics at first, and gradually approaches areas of conflict. Although abreaction can be done with or without the use of medication, the procedure can be facilitated by giving a sedative drug intravenously. A safe method is the use of thiopentone sodium i.e. 500mg dissolved in 10 c.c. of normal saline. It is infused at a rate no faster than 1 cc/minute to prevent sleep as well as respiratory depression.

3.6 **Ralaxation therapy**

Relaxation produces physiological effects opposite those of anxiety: slowed heart rate, increased peripheral blood flow and neuromuscular stability.

There are many methods which can be used to induce relaxation.
Jacobson’s Progressive Muscle Relaxation

Patients relax major muscle groups in fixed order, beginning with the small muscle groups of the feet and working cephalad or vice versa.
Mental Imagery

It is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant relaxed memories. Such images allow patients to enter a relaxed state or experience a feeling of calmness and tranquility.

Use of Tape-recorded Exercises or Instructions

Which allows patients to practice relaxation on their own.

Meditation or Yoga

It is concentrating on the spirit by using certain postures to prepare the body to sit motionless, remain alert and focus on one particular point.

Yoga is highly useful in reducing stress and treating anxiety.

Bio-feedback

Bio-feedback is based on the idea that the autonomic nervous system can come under voluntary control through operant conditioning. Thus it helps people to control usually involuntary physiological functions so as to change them, for instance, by relaxing. People learn to control these functions by hearing or seeing signals from instruments that produce information about various measures such as muscle tension, blood pressure, etc. This feedback helps the patient to control such responses.

Uses of bio-feedback include treatment of enuresis, and treatment of a host of ailments brought on by stress such as migraine headaches, tension headaches, idiopathic hypertension, cardiac problems etc.

3.7 Individual therapy

Psychotherapy can be defined as the treatment of problems of an emotional nature, in which a trained person deliberately establishes a professional relationship with the patient to remove, modify or retard existing symptoms, mediate disturbed patterns of behaviour and promote positive personality growth and development.

Individual psychotherapy is conducted on a one-to-one basis, i.e. The therapist treats one client at a time. The patient is encouraged to discover for himself the reasons for his behaviour. The therapist listens to the patient and offers explanation and advice when necessary. By this he helps the patient to come to a greater understanding of himself and to find a way of dealing with his problems.

Indications: Stress-related disorders, alcohol and drug dependence, sexual disorders and marital disharmony.

3.8 **Supportive therapy**

In this, the therapist helps the patient to relieve emotional distress and symptoms without probing into the past and changing the personality. He uses various techniques such as:

Ventilation: It is a free expression of feelings or emotions. Patient is encouraged to talk freely whatever comes to his mind.

Environmental modification/manipulation: Improving the well-being of mental patients by changing their living condition.

Persuasion: Here the therapist attempts to modify the patient's behaviour by reasoning.

Re-education: Education to the patient regarding his problems, ways of coping etc.

Reassurance

3.9 **Group therapy**

Group psychotherapy is a treatment in which carefully selected people who are emotionally ill meet in a group guided by a trained therapist, and help one another effect personality change.

Selection

Homogeneous groups.

Adolescents and patients with personality disorders.

Families and couples where the system needs change.

Advantages

Group therapy gives an opportunity for immediate feedback from a patient's peers and a chance for both patient and therapist to observe the patient's psychological, emotional and behavioural responses towards a variety of people.

Contraindications

Antisocial patients.

Actively suicidal or severely depressed patients.

Patients who are delusional and who may incorporate the group into their delusional system.

Size

Optimal size for group therapy is 8 to 10 members.

Frequency and Length of Sessions

Most group psychotherapists conduct group sessions once a week. Length of session is 45 minute/hour.

Approaches to Group Therapy

The therapist role is primary facilitator, he should provide a safe, comfortable atmosphere for self-disclosure.

Focus on the "here and now".

Use any transference situations to develop insight into their problems.

Protect members from verbal abuse or from scapegoating.

Whenever appropriate provide positive reinforcement, this gives ego support and encourages future growth.

Handle circumstantial patients, hallucinating and delusional patients in a manner that protects the self-esteem of the individual and also sets limits on the behaviours to protect the other group members.

Develop ability to recognize when a group member is "fragile"; he should be approached in a gentle, supportive and non-threatening manner.

Use silence effectively to encourage introspection and facilitate insight.

Laughter and a moderate amount of joking can act as a safety valve, and at times can contribute to group cohesiveness.

Role playing may help a member develop insight into the ways in which he relates to others.

Some Techniques Useful in Group Therapy

Reflecting or rewording comments of group members.

Asking for group reaction to one member's statement.

Asking for individual reaction to one member's statement.

Pointing out any shared feelings within group.

Summarizing various points at the end of the session.

Psychodrama is a method of group psychotherapy in which personality makeup, interpersonal relationships, conflicts and emotional

problems are explored by means of special dramatic methods. Psychodrama may focus on any special area of functioning (a dream, a family or a community situation), a symbolic role, an unconscious attitude or an imagined future situation.

3.10 **Family and marital therapy**

In family and marital therapy the focus of intervention is not on the individual but on the family unit. The family therapist works towards improving group interactions and helping each member to function better.

Indications

Family therapy is indicated whenever there are relational problems within a family or marital unit, which can occur in almost all types of psychiatric problems including the psychoses, reactive depression, anxiety disorders, psychosomatic disorders, substance abuse and various childhood psychiatric problems.

Components of Therapy

Assessment of family structure, roles, boundaries, resources, communication patterns and problem solving skills.

Teaching communication skills.

Teaching problem solving skills.

Writing a behavioural marital contract.

Homework assignments.

4.0 **Conclusion**

Management of psychiatric patients is multidimensional, so this unit has looked into psychological therapies in the care of disorders of mental health individuals.

5.0 **Summary**

This unit has taken the learners through various psychological therapies like psychoanalytic therapy, behaviour therapy, cognitive, relaxation, individual therapies to mention but a few. The knowledge acquired in this unit will assist you in the management of psychiatric patients in your day to day professional activities.

6.0 **Tutor Marked Assignment**

(1) List five ways of psychological therapies

(2) Discuss any two of the five psychological therapies mentioned above.

7.0 References / Further Readings

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Staurt, W. G. and Sundeen, J. S. 1995. Principles and Practice of Psychiatric Nursing. 5th Ed. London: C. V. Mosby Company.

Staurt, W. G. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Ahuja, N. A. 1999. Short Text Book of Psychiatry 3rd Ed. New Delhi: Jaypee Brothers.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 10: Therapeautic Modalities in Psychiatry III

Contents

1.0 Introduction

Units eight and nine were on therapeutic modalities in psychiatry basically on somatic and psychological therapies. In continuation of the therapeutic modalities, this unit will look into therapeutic mileu, therapeutic community and activity therapy in the management of mentally ill individuals. Therapeutic mileu is an environment that is structured and maintained as an ideal, dynamic setting in which to work with clients.

2.0 Objectives

At the end of this unit, the learners should be able to:

- describe mileu therapy.
- explain how to maintain a mileu therapy
- state the components of a mileu therapy
- list the aims of activity therapy
- enumerate the components of activity therapy
- describe the implications of activity therapies.

3.0 Main content

3.1 Mileu therapy

The therapeutic milieu is an environment that is structured and maintained as an ideal, dynamic setting in which to work with clients. This milieu includes safe physical surroundings, all the treatment team members, and other clients. It is supported by clear and consistently maintained limits and behavioural expectations.

A therapeutic setting should minimize environmental stress such as noise and confusion, and physical stress. It provides a chance for rest and

nurturance of self, a time to focus on the development of strengths, and an opportunity to learn to identify alternatives or solutions to problems and to learn about the psychodynamics of those problems.

A therapeutic milieu is a "safe space", a non-punitive atmosphere in which caring is a basic factor. In this environment, confrontation may be a positive therapeutic tool that can be tolerated by the client. Nurses and treatment team members should be aware of their own roles in this environment, maintaining stability and safety, but minimizing authoritarian behaviour. Clients are expected to assume responsibility for themselves within the structure of the milieu as much as possible. Feedback from other clients and the sharing of tasks or duties within the treatment programme facilitate the client's growth.

The various components of the therapeutic Milieu include:

Maintaining Safe Environment

The medical staff should follow the facility's policies with regard to prevention of routine safety hazards and supplement these policies as necessary. For example:

Dispose of all needles safely and out of reach of clients.

Restrict or monitor the use of matches and lighters.

Do not allow smoking.

Remove mouthwash, aftershave lotions and so forth, if substance abuse is suspected.

Listed below are the most restrictive measures to be used on a unit on which clients who are exhibiting behaviour directly threatening or harmful to themselves or others may be present. These measures may be modified based on the assessment of the client's behaviour:

- immediately on the client's admission, search the client and all of the client's belongings and remove potentially dangerous items, such as wire, clothes hangers, ropes, belts, safety pins, scissors and other sharp objects, weapons, and medications; keep these belongings in a designated place inaccessible to the client.
- be sure mirrors, if glass, are securely fastened and not easily broken.
- keep sharp objects (e.g scissors, pocket knives, knitting needles) out of reach of clients and allow their use only with

supervisors; use electric shavers when possible (disposable razors are easily broken to access blades).

- identify potential weapons (e.g. mop handles, hammers) and dangerous equipment (e.g. electrical cords, scalpels), and keep them out of the client's reach.
- do not leave cleaning fluids, bleach, mops and tools, unattended in client care areas.
- do not leave medicines unattended or unlocked.
- keep keys (to unit door, medicines) on your person at all times.
- be aware of items that are harmful if ingested, for example, mercury in manometers.
- search packages brought in by visitors, explain the reason for such rules briefly and do not make any exceptions.

The Trust Relationship

One of the keys to a therapeutic environment is the establishment of trust. Both the client and the nurse must trust that treatment is desirable and productive. Trust is the foundation of a therapeutic relationship, and limit-setting and consistency are its building blocks.

Building Self-esteem

Strategies to help build or enhance self-esteem must be individualized and built on honesty and on the client's strengths. Some general suggestions are:

Set and maintain limits Accept

the client as a person Be non-

judgmental at all times

Structure the client's time and activities

Have realistic expectations of the client and make them clear to the client

Initially provide the client with tasks, responsibilities and activities that can be easily accomplished; advance the client to more difficult tasks as he progresses

Praise the client for his accomplishments, however small, giving sincere appropriate feedback for meeting expectations, completing tasks, fulfilling responsibilities and so on.

Never flatter the client

Use confrontation judiciously and in a supportive manner; use it only when the client can tolerate it.

Allow the client to make his own decisions whenever possible. If the client is pleased with the outcome of his decision, point out that he was responsible for the decision and give positive feedback.

If the client is not pleased with the outcome, point out that the client, like everyone, can make and survive mistakes, then help the client identify alternative approaches to the problem; give positive feedback for the client's taking responsibility for problem solving and for his efforts.

Limit-setting

Setting and maintaining limits are integral to a trust relationship and to a therapeutic milieu. Before starting a limit explain the reasons for limit-setting. Some basic guidelines for effectively using limits are:

State the expectations or the limit as clearly, directly and simple as possible.

The consequence that will follow the client's exceeding the limit also must be clearly stated at the outset.

The consequences should immediately follow the client's exceeding the limit and must be consistent, both over time (each time the limit is exceeded) and among staff (each staff member must enforce the limit).

Consequences are essential to setting and maintaining limits, they are not an opportunity to be punitive to a client.

In conclusion, the nurse works with other health professionals in an interdisciplinary team; the interdisciplinary team works within a milieu that is constructed as a therapeutic environment, with the aim of developing a holistic view of the client and providing effective treatment.

3.2 Therapeutic community

The concept of therapeutic community was first developed by Maxwell Jones in 1953. He wrote a book entitled "Social Psychiatry" which was first published in England. Later on when it was published in the United States, its title was changed to "Therapeutic Community".

Definition

Stuart and Sundeen defined therapeutic community as "a therapy in which patient's social environment would be used to provide a therapeutic

experience for the patient by involving him as an active participant in his own care and the daily problems of his community.

Objectives

To use the patient's social environment to provide a therapeutic experience for him.

To enable the patient to be an active participant in his own care and become involved in daily activities of his community.

To help patients to solve problems, plan activities and to develop the necessary rules and regulations for the community.

To increase their independence and gain control over many of their own personal activities.

To enable the patients to become aware of how their behaviour affects others.

Elements of Therapeutic Community

Free communication.

Shared responsibilities.

Active participation.

Involvement in decision making.

Understanding of roles, responsibilities, limitations and authorities.

Components of Therapeutic Community

Daily Community Meetings

These meetings are composed of 60-90 patients. All levels of unit staff are involved, including administrative personnel. Acute patients are not involved in the meetings.

Meetings should be held regularly for 60 minutes

Discussion should focus mainly on day-to-day life in the unit.

During discussions patients' feelings and behaviours are examined by other members.

Frank discussions are encouraged, these may take place with much outpouring of emotions and anger.

Patient Government or Ward Council

The purpose of patient government is to deal with practical unit details such as house-keeping functions, activity planning and privileges.

A group of 5-6 patients will have specific responsibilities, such as house keeping, physical exercise, personal hygiene, meal distribution, a group to observe suicidal patients etc. Staff members should be available always.

All decisions should be feedback to the community through the community meetings.

Staff Meetings or Review

A staff meeting should be held following each community meeting (Patients are excluded and only staff are present). In this meeting the staff would examine their own responses, expectations and prejudices.

Living and Learning Opportunities

Learning opportunities are to be provided within the social milieu, which should provide realistic learning experiences for the patients.

Advantages of Therapeutic Community

Patients develop harmonious relationships with other members of the community.

Gains self-confidence.

Develops leadership skills.

Learns to understand and solve problems of self and others.

Becomes socio-centric.

Learns to live and think collectively with the members of the community.

Lasting therapeutic community provides opportunities to participate in the formulation of hospital rules and regulations that affect patient's personal liberties like bedtime, meal time, weekend permission, control of radio or T.V., social activities, late night privileges.

Disadvantages of Therapeutic Community

Role blurring between staff and patient

Group responsibility can easily become nobody's responsibility.

Individual needs and concerns may not be met.

Patient may find the transition to community difficult.

Role of the community health practitioner

Providing and maintaining a safe and conflict free environment through role modeling and group leadership.

Sharing of responsibilities with patients.
Encouraging the patient to participate in decision-making functions.
Assisting patients to assume leadership roles.
Giving feedback.
Carrying out supervisory functions.
In conclusion, therapeutic community is an approach which is:
Democratic as opposed to hierarchial.
Rehabilitative rather than custodial.
Permissive instead of limited and controlled.

3.3 **Activity therapy**

Activity therapies include occupational therapy, recreational therapy, educational therapy, play therapy, music therapy, dance therapy, and art therapy.

Aims

To assist the client in making the transition from the sick role to becoming a contributing member of society.
To assist in diagnostic and personality evaluation.
To enhance psychotherapy and other psychotherapeutic measures (the activity prescribed for the client often provides a nonverbal means for the client to express and resolve his feelings).

3.3.1 **Occupational therapy**

Occupational therapy is the application of goal-oriented, purposeful activity in the assessment and treatment of individuals with psychological, physical or developmental disabilities.

Goal

The main goal is to enable the patient to achieve a healthy balance of occupations through the development of skills that will allow him to function at a level satisfactory to himself and others.

Settings

Occupational therapy is provided to children, adolescents, adults and elderly parents. These programmes are offered in psychiatric hospitals, nursing homes, rehabilitation centres, special schools, community group homes, community mental health centres, daycare centres, half-way homes and deaddiction centres.

Advantages

Helps to develop social skills and provide an outlet for self expressions.

Strengthens ego defenses.

Develops a more realistic view of the self in relation to others.

Points to be kept in mind

The client should be involved as much as possible in selecting the activity.

Select an activity that interests or has the potential to interest him.

The activity should utilize the client's strengths and abilities.

The activity should be of short duration to foster a feeling of accomplishment.

If possible, the selected activity should provide some new experience for the client.

Process of Intervention

It consists of six stages:

1. Initial evolution of what patient can do and cannot do in a variety of situations over a period of time.
2. Development of immediate and long-term goals by the patient and therapist together. Goals should be concrete and measurable so that it is easy to see when they have been attained.
3. Development of therapy plan with planned intervention.
4. Implementation of the plan and monitoring the progress. The plan is followed until the first evaluation. If satisfactory, it is continued, or altered if not.
5. Review meetings with patient and all the staff involved in treatment.
6. Setting further goals when immediate goals have been achieved; modifying the treatment programme as relevant.

Types of Activities

Diversional activities: These activities are used to divert one's thoughts from life stresses or to fill time.

For example, organized games.

Therapeutic activities: These activities are used to attain a specific care plan or goal.

For example, basket making, carpentry etc.

Suggested Occupational Activities for Psychiatric Disorders

Anxiety disorder: Simple concrete tasks with no more than 3 or 4 steps that can be learnt quickly. E.g. kitchen tasks, washing, sweeping, mopping, mowing lawns and weeding gardens.

Depressive disorder: Simple concrete tasks which are achievable; it is important for the client to experience success. Provide positive reinforcement after each achievement.

For example, crafts, mowing lawns and weeding gardens.

Manic disorder: Non-competitive activities that allow the use of energy and expression of feelings. Activities should be limited and changed frequently. Client needs to work in an area away from distractions.

For example, raking grass, sweeping etc.

Schizophrenia (paranoid): Non-competitive, solitary, meaningful tasks that require some degree of concentration so that less time is available to focus on delusions.

For example, puzzles, scrabble.

Schizophrenia (catatonic): Simple concrete tasks in which client is actively involved. Client needs continuous supervision and at first works best on a one-to-one basis.

For example, metal work, moulding clay.

Antisocial personality: Activities that enhance self-esteem and are expressive and creative, but not too complicated. Client needs supervision to make sure each task is completed.

Dementia: Group activities to increase feelings of belonging and self-worth provide those activities which promotes familial individual hobbies. Activities need to be structured, requiring little time for completion and not too much concentration. Explain and demonstrate each task, then have client repeat the demonstration.

Substance Abuse: Group activities in which clients uses his talents. For example, involving client in planning social activities, encouraging interaction with others etc.

Childhood and adolescent disorders:
Children: Playing, story telling, painting, poetry, music etc. Adolescents: Creative activities such as leather work, drawing, painting. Mental retardation: Repetitive work assignments are ideal; provide positive reinforcement after each achievement.

For example, cover making, candle making, packaging goods.

3.3.2 Recreational Therapy

Recreation is a form of activity therapy used in most psychiatric settings. It is planned therapeutic activity that enables people with limitations to engage in recreational experiences.

Aims

To encourage social interaction.
To decrease withdrawal tendencies.
To provide outlet for feelings.
To promote socially acceptable behaviour.
To develop skills, talents and abilities.
To increase physical confidence and a feeling of self-worth.

Points to be kept in mind

Provide a non-threatening and non-demanding environment.
Provide activities that are relaxing and without rigid guidelines and time-frames.
Provide activities that are enjoyable and self-satisfying.

Types of Recreational Activities
Motor forms: These can be further divided into fundamental and accessory; among the fundamental forms are such games as hockey and football, while the accessory forms are exemplified by play activity and dancing.

Sensory forms: These can be either visual e.g. looking at motion pictures, play etc., or auditory such as listening to a concert.
Intellectual forms: These include reading, debating and so on.
Suggested Recreational Activities for Psychiatric Disorders

Anxiety disorder: Aerobic activities like walking, jogging etc.

Depressive disorder: Non-competitive sports, which provide outlet for anger, like jogging, walking, running etc.

Manic disorder: One-to-one basis individual games like chess, puzzles.
Schizophrenia (paranoid): Concentrative activities like chess, puzzles.
Schizophrenia (catatonic): Social activities to give client contact with reality, like dancing, athletics.

Dementia: Concrete, repetitious crafts and projects breed familiarization and comfort.

Childhood and adolescent disorders: It is better to work with the child on a one-to-one basis and give him a feeling of importance. Some activities include playing, story telling and painting.

Adolescents fare better in groups; provide gross motor activities like sports and games to use up excess energy.

Mental retardation: Activities should be according to the client's level of functioning such as walking, dancing, swimming, ball playing etc.

3.3.3 **Educational Therapy**

Educational therapy is used when the client has problems which result from a great deal of misconception. The educational therapist provides reading and learning experiences that can do a great deal to eliminate his misconceptions and anxiety.

3.3.4 **Biblio Therapy**

It is described as the prescription of reading materials that will help to develop emotional maturity and sustain mental health.

Some emotionally disturbed individuals are able to relate therapeutically to the experiences of others when they read about them, rather than experiencing them directly. It also provides a medium for discussions with others.

3.3.5 **Play Therapy**

Play is a natural mode of growth and development in children. Through play a child learns to express his emotions and it serves as a tool in the development of the child.

Curative functions

It releases tension and pent-up emotions.

It allows compensation for loss and failures.

It improves emotional growth through his relationship with other children.

It provides opportunity to the child to act out his fantasies and conflicts, to get rid of aggression and to learn positive qualities from the other children.

Diagnostic functions

Play therapy gives the therapist a chance to explore the family relationships of the child and discover what difficulties are contributing to the child's problems.

Play therapy allows to study hidden aspects of the child's personality.

It is possible to obtain a good idea of the intelligence level of the child.

Through play inter-sibling relationships can be adequately studied.

Types of Play Therapy

Individual vs group play therapy: In individual therapy, the child is allowed to play by himself and the therapist's attention is focused on this one child alone.

In group play therapy other children are involved.

Free play vs controlled play therapy: In free play the child is given freedom in deciding with what toys he wants to play.

In controlled play therapy, the child is introduced into a scene where the situation or setting is already established.

Structured vs unstructured play therapy: Structured play therapy involves organizing the situation in such a way so as to obtain more information.

In unstructured play therapy no situation is set and no plans are followed.

Directive vs non-directive play therapy: In directive play therapy, the therapist totally sets the directions, whereas in non-directive play therapy, the child receives no directions.

Play therapy is generally conducted in a play room. The play room should be suitably stocked with adequate play material depending upon the problem of the child.

3.3.6 **Music Therapy**

Music therapy is the functional application of music towards the attainment of specific therapeutic goals.

Advantages

Facilitates emotional expressions.

Improves cognitive skills like learning, listening and attention span.

Exercise through body movement maintains good circulation and muscle tone.

Social interaction is stimulated.

3.3.7 **Dance Therapy**

It is a psychotherapeutic use of movements, which furthers the emotional and physical integration of the individual.

Advantages

Helps to develop body awareness.

Facilitates expression of feelings.

Improves interaction and communication.

Fosters integration of physical, emotional and social experiences that result in a sense of increased self-confidence and contentment.

3.3.8 **Art Therapy**

The goal of art therapy is to help the patient express his thoughts, emotions and feelings through his drawings.

Importance of art therapy

It is used as a diagnostic and therapeutic tool.

It provides socially acceptable outlets for fantasy and wish fulfillment.

It helps the patient to gain relief from anxiety by graphically representing conflicts and aggressive and traumatic material without guilt.

3.3.9 **Implications of Activity Therapies.**

The health practitioner has an important role in enhancing the therapeutic effects of activity therapies. Some points to be kept in mind are:

Close coordination between the nursing staff and the activity therapy department is essential.

By engaging in these activities, the health practitioner not only has an opportunity to support the therapeutic efforts of the recreational therapist, but also has an invaluable opportunity to observe the client in different settings.

Through her observations of the client's behaviour during these activities, the nurse will gain valuable information that she can subsequently utilize to therapeutic advantage in the working phase of the health practitioner -client relationship.

4.0 **Conclusion**

The needs of mentally ill individual are numerous as the illness may affect both the body and the mind of the patient, so meeting the needs can be approached from somatic, psychological and activities point of the view, so this unit dealt with the use of milieu therapy, therapeutic community and activity in meeting the needs of psychiatric patients in our communities.

5.0 **Summary**

This unit looked into the use of environment in meeting the needs of individuals with disorders of mental health. I hope the knowledge gained from the unit can now assist you to answer the following tutor marked assignments.

6.0 Tutor Marked Assignments

(1) Discuss how a milieu therapy can be attained by you as a nurse to meet the needs of your clients.

(2) List four activity therapies and discuss ANY TWO of the four mentioned.

7.0 References / Further Readings

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Staurt, W. G. and Sundeen, J. S. 1995. Principles and Practice of Psychiatric Nursing. 5th Ed. London: C. V. Mosby Company.

Staurt, W. G. and Lavaia, M. T. 2001. Principles and Practice of Psychiatric Nursing. 7th Ed. Missouri: Mosby. Inc.

Ahuja, N. A. 1999. Short Text Book of Psychiatry 3rd Ed. New Delhi: Jaypee Brothers.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 11: Crisis Intervention

Contents

1.0 Introduction

Mental health clients may be labeled with one or more psychiatric diagnosis, but all have one thing in common i.e. unsuccessful coping behaviours. The very nature of mental illness is characterized by actions that are not in keeping with society's definitions of appropriate behaviours. Mental health caregivers provide clients with education about and opportunities to engage in more effective behaviours. When experiencing stress, people use their resources to decrease the discomfort. These efforts called coping mechanisms used as the tools that help us work through the ups and downs of daily living. A crisis is an upset in the homeostasis of an individual. A crisis has several characteristics that separate it from other stressful situations. For example, a crisis occurs when an individual's usual coping mechanisms are ineffective so the crisis demands new solutions with new coping strategies. Crisis is self-hinting because human beings can not endure high levels of continued stress, crisis are usually resolved within a short time and because a crisis usually affects more than one person, for everyone within the person's support system is affected by the crisis.

2.0 Objectives

At the end of this unit, the learners should be able to:

- define what crisis is
- define grief crisis is
- list the characteristics of individuals prone to crisis
- enumerate the types of crisis
- describe the resolution of crisis
- describe the stages of grief

- explain how grief is resolved

3.0 **Main content**

3.1 **Crisis**

Crisis can be viewed as an integral component of everyday life situations. A crisis may influence people's lives in different ways. As a consequence of a crisis experience, the individual may go down to a lower or less healthy level of functioning than what was before the crisis, or he may resume the same level of functioning by repressing the crisis and the related emotions. On the other hand, he may function at a healthier level than prior to the crisis, because the challenge of a crisis can bring out new strengths, skills and coping mechanisms.

Intervention at a crisis is extremely important to prevent mental illness, because long-standing problems make the person totally incapable of handling the situation. If proper guidance is provided at the correct time, the victim will come out of it better equipped to handle future problems in life.

3.1.1 **Definition**

Crisis is a state of disequilibrium resulting from the interaction of an event with the individual's or family's coping mechanisms, which are inadequate to meet the demands of the situation, combined with the individual's or family's perception of the meaning of the event (Taylor 1982)

3.1.2 **Crisis Proneness**

Hendricks (1985) suggests that certain individuals are more prone to crisis than others. The following are characteristics often found in individuals who are regarded as being more susceptible to crisis:

Dissatisfaction with employment or lack of employment.
History of unresolved crisis.
History of substance abuse.
Poor self-esteem, unworthiness. Superficial
relationships with others. Difficulty in coping
with everyday situations.
Under utilization of resources and support systems.
Aloofness and lack of caring.

It is important to note that individual personality traits must also be considered in conjunction with these characteristics. Crisis is defined by the individual; what is a crisis for one is merely an occurrence for another. This factor is a critical component that must be evaluated in relation to crisis prone characteristics as well as personality traits.

3.1.3 **Types of Crisis**

Maturational Crisis

Maturational crisis can be defined as the predicable processes of growth and development that evolve over a period of time, the ultimate goal of these processes is maturity.

The transition points where individuals move into successive stage often generate disequilibrium. Individuals are required to make cognitive and behavioural changes and to integrate those physical changes that accompany development.

The extent to which individuals experience success in the mastery of these tasks depends on previous successes, availability of support systems, influence of role models and acceptability of the new role by others.

The transitional periods or events that are most commonly identified as having increased crisis potential are adolescence, marriage, parenthood, midlife and retirement.

Situational Crisis

A situational crisis is one that is precipitated by an unanticipated stressful event that creates disequilibrium by threatening one's sense of biological, social or psychological integrity.

Examples of events that can precipitate situational crises are premature birth, status and role changes, death of a loved one, physical or mental illness, divorce, change in geographic location and poor performance in school.

Social Crisis

Social crisis is accidental, uncommon and unanticipated and results in multiple losses and radical environmental changes. Social crisis include natural disasters like flood, earthquakes, violence, nuclear accidents, mass

killings, contamination of large areas by toxic wastes, wars etc. This type of crisis is unlike maturational and situational crisis because it does not occur in the lives of all people.

Because of the severity of the effects of social crisis coping strategies may not be effective. Individuals confronted with social crisis usually do not have previous experience from which to draw expertise. Support systems may be unavailable because they may also be involved in similar situations. Mental health professionals are called upon to act quickly and provide services to large numbers of people and in some cases, the whole community.

3.1.4 **Phases of Crisis**

Caplan (1964) has described four phases of crisis as described below:

Phase I

Perceived threat acts as a precipitant that generates increased anxiety. Normal coping strategies are activated, and if unsuccessful, the individual moves into Phase II.

Phase II

The ineffectiveness of the Phase I coping mechanisms leads to further disorganization. The individual experiences a sense of vulnerability. The individual may attempt to cope with the situation in a random fashion. If the anxiety continues and there is reduction, the individual enters Phase III.

Phase III

Redefinition of the crisis is attempted and the individual is most amenable to assistance in this phase. New problem solving measures may also affect a solution. Return to pre-crisis level of functioning may occur. If problem solving is unsuccessful, further disorganization occurs and the individual is said to have entered Phase IV.

Phase IV

Severe to panic levels of anxiety with profound, cognitive, emotional and physiological changes may occur. Referral to further treatment resources is necessary.

3.1.5 Signs and Symptoms of Crisis

The major feeling in a crisis situation is anxiety. The individual experiences a heavy burden of free-floating anxiety.

The anxiety may be manifested through depression, anger and guilt. The victim will attempt to get rid of the anxiety using various coping mechanisms, healthy or unhealthy.

The individual may become incapable of even taking care of his daily needs and may neglect his responsibilities.

The individual may become irrational and blame others for what has happened to him.

3.1.6 Resolution of Crisis

Healthy resolution of a crisis depends upon the following three factors:

1. Realistic appraisal of the precipitating event, i.e. recognition of the relationship between the event and feelings of anxiety id necessary for effective problem-solving to occur.
2. Availability of support systems.
3. Availability of coping measures over a life-time: A person develops a repertoire of successful coping strategies that enable him to identify and resolve stressful situations.

There are three ways by which the individual may resolve the crisis:

Pseudo-resolution

In this, the individual uses repression and pushes out of consciousness the incident and the intense emotions associated with it, so there will not be any change in the level of functioning of the individual. But in future, if and when a crisis occurs, the repressed feelings may come to surface and influence the feelings aroused by the new crisis. In such a situation, the particular crisis may be more difficult to resolve because the feelings associated with the earlier crisis are neither expressed nor handled at that time.

Unsuccessful Resolution

In this, the victim uses pathological adaptation at any phase of crisis, resulting in a lower level of functioning. The victim, rather than accepting the loss and reorganizing his life, keeps ruminating over the loss. An example is prolonged grief reaction, which results in depression.

Successful Resolution

In this, the victim may go through the various phases of crisis, but reaches Phase III where various coping measures are utilized to resolve the crisis situation. The individual develops better skills and problem solving ability, which can be and will be used in various situations in future.

3.1.7 **Crisis Intervention**

Crisis intervention is a technique used to help an individual or family to understand and cope with the intense feelings that are typical of a crisis. Community health practitioners function as part of the interdisciplinary team in the use of crisis intervention as a therapeutic modality. Community health practitioner may employ crisis techniques in their work with high-risk groups such as clients with chronic diseases, new parents and bereaved persons.

Community health practitioner may also use crisis intervention in dealing with intra-group staff issues and client management issues.

Aims of Crisis Intervention Technique

To improve a correct cognitive perception of the situation.

To assist the individual in managing the intense and overwhelming feelings associated with the crisis.

Intervention

A. Steps to provide a correct cognitive perception

Assessment of the situation

This may be achieved by direct questioning with the purpose of identification of the problem and the people involved.

It is necessary to identify the support systems available and to know the depth in which the individual's feelings are affected.

Assessment should also be done to identify the strengths and limitation of the victim.

Defining the event

The victim at times may not be able to identify the precipitating even because of possible denial, or due to reluctance to talk about it.

It may be necessary for the therapist to review the details of the incidents in the past 2 to 4 weeks in order to identify the event that precipitated the crisis. Such a review will also help to bring the precipitating even to the awareness of the victim.

Develop a plan of action

The victim and the people closely associated with him should have actual involvement in developing the plan of action.

The therapist must be aware that the victim may not be in a condition mentally to comprehend complicated information due to the overwhelming anxiety experienced by him. The instructions given by the therapist must be simple and clear, and too much information should not be given at a time. The instructions may have to be written down, as the victim may not be able to retain all the information.

B. Steps to assist the victim in managing the intense feelings

Helping the individual to be aware of the feelings

The victim needs help in identifying his own feelings, which is the first step in handling them.

The therapist should use appropriate communication technique so that the victim will feel comfortable to express his feelings without the fear of being judged or criticized.

The therapist also should be efficient in observing the non-verbal and verbal behaviour of the victim, so that he will be able to make a careful assessment of his feelings.

Helping the individual to attain mastery over the feelings

The individual should be given adequate support and guidance through the therapeutic process in order to handle the feelings associated with the crisis but special care should be taken not to give any false reassurance.

He should not in any way be encouraged to blame others, as this will only let him escape from taking any responsibility.

Care must be taken that the individual may not develop too much dependency on the therapist, which is unhealthy.

After the victim and the support groups make the plan of action under the guidance of the therapist, this should be discussed with the victim and the concerned others, so that they will have a clear understanding of the methods of implementation of the plan.

To improve coping with the situation necessary environmental manipulation must be done in physical or interpersonal areas.

It is advisable to have another appointment for the victim to visit the therapist within a week, in order to assess how the plan is working out, and if needed, to revise and modify the plan.

3.2 **Grief**

Grief is a subjective state of emotional, physical and social responses to the loss of a valued entity. The loss may be real, in which case, it can be substantiated by others (e.g. death of a loved one) or perceived by the individual alone, in which case, it can not be perceived or shared by others (e.g. loss of feeling of femininity following mastectomy).

3.2.1 **Stages of Grief**

Kubler-Ross (1969) having done extensive research with terminally ill patients identified five stages of feelings and behaviours that individuals experience in response to a real, perceived or anticipated loss:

Stage I-Denial: This is a stage of shock and disbelief. The response may be one of "No, it can't be true!" Denial is a protective mechanism that allows the individual to cope within an immediate time-frame while organizing more effective defense strategies.

Stage II-Anger: "Why me?" and "It is not fair!" are comments often expressed during the anger stage. Anger may be directed at self or displaced on loved ones, caregivers and even God. There may be a preoccupation with an idealized image of the lost entity.

Stage III-Bargaining: "If God will help me through this, I promise I will go to church every Sunday and volunteer my time to help others". During this stage, which is generally not visible or evident to others, a bargain is made with God in an attempt to reverse or postpone the loss.

Stage IV-Depression: During this stage, the full impact of the loss is experienced. This is a time of quiet desperation and disengagement from all associations with the lost entity.

Stage V-Acceptance: The final stage brings a feeling of peace regarding the loss that has occurred. Focus is on the reality of the loss and its meaning for the individuals affected by it.

All individuals do not experience each of these stages in response to a loss, nor do they necessarily experience them in this order. some individuals grieving behaviour may fluctuate and even overlap between stages.

3.2.2 **Resolution of Grief**

Resolution of the process of mourning is thought to have occurred when an individual can look back on the relationship with the lost entity and accept both the pleasure and the disappointments (both the positive and negative aspects) of the association. Pre-occupation with the lost entity is replaced with energy and desire to pursue new situations and relationships.

The length of the grief process may be prolonged by a number of factors:

If the relationship with the lost entity had been marked with ambivalence, reaction to the loss may be burdened with guilt, which lengthens the grief reaction.

In anticipatory grief where a loss is anticipated, individuals often begin the work of grieving before the actual loss occurs. Most people experience the grieving behaviour once the actual loss occurs, but having this time to prepare for the loss can facilitate the process of mourning, actually decreasing the length and intensity of the response.

The number of recent losses experienced by an individual also affects the length of the grieving process and whether he is able to complete one grieving process before another loss occurs.

3.2.3 **Maladaptive Grief Responses**

Maladaptive grief responses to loss occur when an individual is not able to satisfactorily progress through the stages of grieving to achieve resolution. Several types of grief responses have been identified as pathological [Lindemann (1944), Parkes (1972)].

These are prolonged, delayed/inhibited and distorted responses.

Prolonged Response

It is characterized by an intense preoccupation with memories of the lost entity for many years after the loss has occurred.

Delayed or Inhibited Response

The individual becomes fixed in the denial stage of the grieving process. The emotional pain associated with loss is not experienced, but there may be evidence of anxiety disorders or sleeping disorders. The

individual may remain in denial for many years until the grief response is triggered by a remainder of the loss or even by another unrelated loss.

Distorted Response

The individual who experiences a distorted response is fixed in the anger stage of grieving. The normal behaviours associated with grieving, such as helplessness, hopelessness, sadness, anger and guilt are exaggerated out of proportion to the situation. The individual turns the anger inward on the self and is unable to function in normal activities of daily living. Pathological depression is a distorted grief response.

3.2.4 Treatment

Normal grief does not require any treatment while complicated grief requires medication depending on the prevailing behaviour responses.

3.2.5 Health Care Intervention

Provide an open accepting environment.

Encourage ventilation of feelings and listen actively.

Provide various diversional activities.

Provide teaching about common symptoms of grief.

Reinforce of goal-directed activities.

Bring together similar aggrieved persons, to encourage communication, share experiences of the loss and to offer companionship, social and emotional support.

4.0 Conclusion

Griefs and crises can be successfully managed with adequate adaptation, social support from significant individuals in the society as unresolved griefs and crises may result in major health and psychological problems. Emotional support and referral to various community resources should be offered promptly.

5.0 Summary

You have gone through this unit on griefs and crises management, the knowledge is to assist you as learners for better adaptation and for you to assist you clients.

6.0 Tutor Marked Assignments

Describe how you will assist a teenager that drops out of school as a result of loss of her parents in air crash that recently happened.

7.0 References / Further Readings

Morrison-Valfre, M. 2005. Foundations of Mental Health Care, Missouri: Mosby Inc.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 12: Community Mental Health Care

Contents

1.0 Introduction

This unit will introduce the learners to community mental health care. Community mental health has developed a response to the realization that much of the effort expended in the past as treatment for mentally ill individuals encouraged chronicity rather than a return to a productive life. Thus, the current trend is to treat the individual immediately in the community, no matter how disturbed his behaviours may be. In this way, it is hoped that the development of chronic symptomatology and the rupturing of community ties through institutionalization can be avoided.

2.0 Objectives

At the end of this unit, the learner should be able to:

- describe the aims of community mental health care
- list the methods used in practicing community psychiatry
- discuss the roles of community psychiatric practitioner.

3.0 Main content

3.1 Introduction

The term community can be defined either as a political (geographic) unit or as a functional unit. People qualify as members of a geographic or political unit by holding rights of citizenship within the boundaries of specified territory or merely by living there.

Community Psychiatry is a new speciality- though a widely embracing one-within the field of psychiatry. It consists of the acceptance of responsibility by one or more Psychiatrists and others working with them for the prevention, early detection, and short-terms and long-term (including rehabilitative) treatment of metal disorders in a circumscribed population.

Community care consists of medical and social services provided by four main groups, namely, department of Health and Social Security Area Health Authorities, Local Authorities and Voluntary Organisations.

Community mental health is essentially a synonym for community psychiatry. The aim is to provide care for patients at centres located near their homes as at a stage when their disorder have not yet becomes severe or chronic , so that disruption of their lives id minimized. In most cases these are patients these prognosis is good. Both rehabilitative and primary preventive efforts are also emphasised; the latter through education and consultation.

Thus, the Community Mental Health was a revolutionary idea when it was introduced in the early 1960's. Its overall goal was helping people in their own community or neighbourhood to reach and maintain more satisfactory levels of functioning.

Another aims of community care is to use the support of patient's relatives (family) and friends where possible and to put them in touch with the psychiatric services which exist for guidance and treatment of such patients.

The family is the principal "medium" by which the Community's "message" is transmitted. While acknowledging the importance of biological and others influences, the Community Psychiatrist place special emphasis on the fact that the emotional health of the individual and families depends on the healthy development and functioning of human communities.

Since the patient receives treatment within his own environment, the possibility of "lengthy rehabilitation" as in the case of patient admitted in a comprehensive psychiatric setting (Psychiatric Hospital) is reduced.

Community Mental care prevents unnecessary boredom often experienced by hospitalised patients. It is also worth mentioning that the

social stigma attached to people with mental disorders is considerably reduced.

3.2 Community Mental Health- Practitioner Attributes

Awareness of self, personal and cultural values

Non-judgmental attitude

Problem solving skills

Ability to cross service system (e.g. to work with school, other health care providers, employers, etc).

Knowledge of community resources

Willingness to work with the family or significant other identified by the client as support people.

Understanding of the social, cultural and political issues that affect mental health and illness

Knowledge of political activism

3.3 Goals of Community Mental Health Nursing

To provide prevention activities to populations for the purpose of promoting mental health.

To provide interventions as early as possible.

To provide corrective learning experiences for client-groups who have deficits and disabilities in the basic competencies needed to cope in society, and to help individuals develops a sense of self-worth and independence.

To anticipate when populations become at risk for particular emotional problems and to identify and change social and physiological factors that diversely affect people's interaction with their environments.

To develop innovative approaches to primary prevention activities.

To assist in providing mental health education to populations about mental health and illness and to teach people how to assess their mental health.

Community Mental Health Care Process

The key aspects of the assistance include:

Impairments directly due to psychiatric disorder such as persistent hallucinations, negatively symptoms, social withdrawal, under-activity and slowness.

Secondary social disadvantages such as unemployment, poverty and homelessness, as well as the stigma attached to psychiatric illness.

Personal reactions to illness and social disadvantage such as low self-esteem and hopelessness, poor motivation and capacity for self-management and performance of social roles.

Unpredictable behaviour, risk of harm to self and others, and liability to relapse.

Financial circumstance of the client.

Availability of community resources.

Social circumstances to which the patient is likely to return.

The expected outcome of the assessment is a detailed outline of the person's present functioning highest level of functioning, highest level functioning and the needed services.

Intervention

Community health practitioner must approach innervations with inflexibility and resourcefulness to need the broad range of needs of the patients with continued mental deficits. Interventions cannot be direct only towards discrete psychiatric symptoms, but must also facilitate client's access to various community resources providing for basic needs such as housing nutrition, etc.

Since people suffering from mental illness often remain in or return to the community following treatment, nurses mist be able to the assess the presence of continued mental health problems and plan and implementation interventions within the confines of the resources available in the community.

Roles Of Health Practitioner In Community Mental Health

Consultative roles: This means giving advice to other professionals in the community about the type and level of care required for a given client group.

Clinician role: Providing direct care to the patient in the community.

Therapeutic role: Employing psychotherapeutic and behavioural methods for management of patients.

Assessor/researcher role: The health practitioner assess the care given to the client group, and may also assess the outcome ongoing care programs.

Educator: Creating awareness in the community about mental health and metal illness with special focus on vulnerable groups.

Trainer/Manpower facilitators: Training of paraprofessionals, community leaders, school-teachers and other care-giving professionals in the community.

Manager/Administrator: Management or resources, planning and coordination.

Domiciliary care: Services are provided to the client by visiting their homes. Services like administration of medications, assessment of the level of functioning and improvement of patient, monitoring of side-effects of drug, counselling of patients and family members are offered at the client's home setting.

Liaison role: Community health practitioner working in the community help the clients and the family members by bridging the gap between the client and the hospital, client and the employers and also by networking in the community for resources development.

Preventive roles: These preventive roles are under primary, secondary, and tertiary levels.

Other areas of community health psychiatric care

Social skills training
Assertive management and relaxation
Bereavement counselling
Group meetings
Community out-reach work services
Child care services
Adult care and elderly care services

Some Tips to be Kept in Mind when Working in the Community

1. Identification of Patient in the Community: Talk to important people like, village panchayat members, local leader, teachers, and educated

youth members of services agencies like angawadi mahila mandals, etc. and request them to tell you about individuals:

Who talk nonsense and act ion manner considered stranger or abnormal.

Who have becomes very quit and do not talk or ix with other people

Who claim to heat voice or see things that others cannot hear or see.

Who are suspicious and claim that others are trying to harm them.

Who have become unusually cheerful, crack jokes and say that they are very wealthy and superior to others when it is not really so.

Who have become very sad lately and cry without reason.

Who talk about suicide or have made an attempt at suicide.

Who get processed by god or spirit or who are said to be the victims of black magic or evil power

Who are dull, mentally not grown up like other of their age and slow since birth.

When you visit homes, enquire about members suffering form mental illness. Ask the above mentioned questions tactful without offending them and obtain information about the existence of a patient in them in that family, neighbourhood or among their relatives.

When you go to school, enquire from teachers and students about children who suffer from fits, behavioural and learning problems.

2. Refer the immediately in the following conditions

The patients is severely ill, violent or unmanageable at home

History of recent head injury

Repeated convulsions (continuous or more than 3 times a day)

Distributed behaviour after delivery

The client has attempted suicide or is threatening commit suicide

Distributed behaviour in people with known diabetes or hypertensions

People who show abnormal behaviour after taking alcohol or nay other intoxicating substance.

3. Follow-up care with special emphasis on medication regimen, improvement made, and side effects, patient's occupational function

4. Be prepared to answer certain common questions asked regarding mental illness.

Is mental illness hereditary?
Is mental illness contagious?
Do ghosts, black magic, curse cause mental-illness?
Is mental illness treatable?
Can patients take up responsibilities after recovery?
Can marriage cure mental illness?

5 Remember

Do not give false assurance or make false promises, just tell them you will do your best to help them.
Do not make any decisions for the family.
Do not criticise or blame
See that they develop confidence in their abilities.
Do not make them dependent on you
Avoid half-heated attempts; hard work yields good results.

3.4 **Psychiatric Services In Community Psychiatry**

Various ways (methods) are used in practising community psychiatry:

(a) Psychiatric service in General Hospital: They furnish strategic application of community psychiatry. Here, the hospital serves as the community psychiatry. In this setting, psychiatric staff members can interact closely with their medical and paramedical colleges. People turn more readily to non-Psychiatrist physicians for help with their physiologic difference than to anyone else. Furthermore, any illness is psychologically stressful both to the patient and to his family; and many physical illness are provoked at least in part by emotional tension. The psychiatrist in the general hospital can help his colleagues learns ways of responding hospital instead, feelings of shame and stigma are minimised and the intensive care that can be given shortens the hospital stay. As in other psychiatric treatment setting, continuity of care can be maintained as people are transferred form outpatient to impatient to artificial hospitalization (night or day hospital) and then back to outpatient

(b) Day Hospital (in the Hospital or on separate premises): Day hospital may be provided within the community. They are either attached to an hospital or stand on their own. Patients are brought by their relations to receive psychiatric treatment, depending on patient's condition,

how stays in the say hospitals for example morning till evening with relatives.

Patient may even be admitted for a short-term treatment with the relative in attendance.

(c) The field of child and family psychiatry serve as models for much of what takes place in community psychiatry. The therapist treating an emotionally disturbed child recognises that other members of the family play a part in his patient's disturbance. Parents may be urged to obtain individuals therapy, or they may be regarded essentially as consultees. The child's problems are then discussed with the parents in such a way as to ease the parent's tensions and enlist them as colleagues in treating the child.

(d) Psychiatric Social workers form the hospital do follow-up of patients in assessing situations in the environment, treating and advising the community on health grounds.

(e) Day centres are also established for care of the elderly, for chronic Schizophrenia, for the mentally handicapped.

(f) Child Guidance Clinics are established in the community to take care of physical, emotional and psychological cares of children. The psychiatrist pay visit to the institutions.

(g) Social clubs in the Community aid treatment and prevention of psychiatric conditions. The alcoholics for example form themselves into clubs, they sheer opinions and receive advice form medical team.

(h) Village system care-neighbouring villages are used in some cases. Patients and relatives say there and receive treatment in the hospital.

3.5 Role of The Community Psychiatric Health Practitioner

1. In community Mental Health today, Psychiatric health officer with a generalist background are prepared to attempt to meet the needs of "total patient". Their flexibility enhances the developmental nature of this growing speciality. Community mental nurses are action oriented. As in all Community health, the focus is one primary prevention. The community health practitioner does not wait for the patient to become

"ill" first, rather, the emphasis on prevention. Problems are dealt with in the setting where they began; an attempt is made not to remove the person from the community.

2. Among other things, the community health practitioner who is a clinical specialist in Psychiatric care serves as an individual and group therapist and consultation and liaison person to community agencies and hospital units.
3. The community Psychiatric health officer makes home visits and serves as a resources person, educator, administrator and researchers.
4. The community Psychiatric health officer communicates clearly with other health members to maintain their significant professional contributions.
5. She assists the relatives in the management of the patient by helping them to prepare for the patient's return to the community, - providing support for the family, noting signs of stress within the family and taking appropriate remedial action.
6. She is also concerned with giving health education within the community
7. She plays a role in running groups/social clubs which provide support after patient's discharged home.
8. The community Psychiatric health practitioner is also concerned with provision of community of hospital in-patient or outpatient treatment.
9. At times she runs a "supportive", and works with outpatient.

3.6 **Levels Of Prevention**

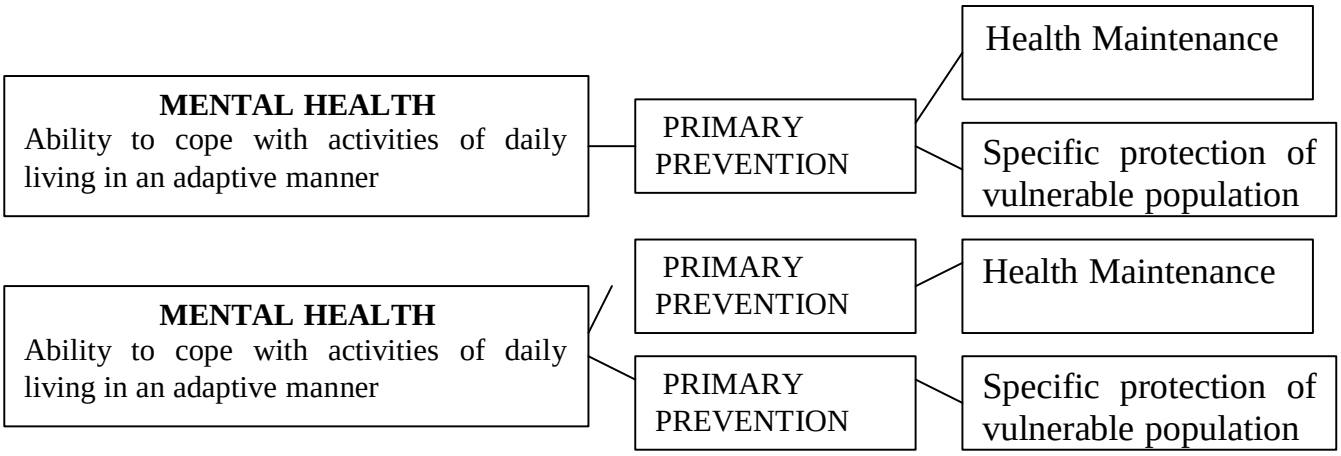
In the 1960s, psychiatric Gerald Caplan described levels of prevention specific to psychiatry. He defined *primary prevention* as an effort directed towards reducing the incidence of mental disorders in a community. Secondary prevention refers to decreasing the duration of disorder while tertiary prevention refers to reducing the levels of impairment.

Primary Prevention

Primary prevention seeks to prevent the occurrence of mental disorders by strengthening individual, family and groups coping abilities.

Role of a nurse in primary prevention

Community mental health officer are in a key position to identify individual, family and group needs, conflicts and stressors. Thus, they play a level of prevention



(This paradigm was developed by Bloom, 1979)

Major role in identifying high-risk groups and preventing the occurrence of mental illness in them. Some interventions include:

Antenatal care to the mother an educating her regarding the adverse effects of irradiation, certain drugs and prematurely.

Ensuring timely and efficient obstetrical assistance to guard against the ill effects of anoxia an injury to the newborn at birth.

Dietary corrections of those infants suffering from metabolic disorders.

Fostering bonding behaviours

Teaching growth the and development to parents and teachers.

Correction of endocrinal disorders.

Consulting with parents about appropriate disciplinary measures

Promoting open health communication in families.

Rendering crisis counselling to the parents of physically and mentally handicapped children.

Identifying the problems of scholastics performance and emotional disturbances among school children and going timely intervention. School teachers can be taught to recognize the beginning symptoms of problems.

Ensuring harmonious relationship among the members of the family and teaching healthy adaptive techniques at the time of stress-producing events.

Extending mental health education services at Child Guidance Clinics about child rearing practice; at parent-teachers association regarding the triad relationship between teacher, child and parent;

and at various extramural health agencies regarding integration of mental health into general health practice.

Strengthening social support for the frustrated ages and helping them to retain their usefulness.

Secondary Prevention

Secondary prevention targets people who show early symptoms of mental health disruption but regain premorbid level of functioning through aggressive treatment.

Role of a Community Health Practitioner in Secondary Prevention

Case finding through screening and periodic examination of population at risk, monitoring of client etc. thus in clinics, schools, home health care and the work place community mental health officer detect early sign of increase level of anxiety, decreased ability to cope with stress and failure to perceive self, the environment and/or reality accurately and provide direct service appropriate

Consultation and referral services.

Early and effective treatment for patient, and if necessary, to family members as relevant; providing counselling services to caregivers of mentally ill patients.

Tertiary Prevention

Tertiary Prevention targets those with metal illness and helps to reduce the severity, discomfort and disability associated with their illness. In these terms community mental health nurses play a vital role in monitoring the progress of discharged patients in halfway homes, houses, etc., especially with regard to their medication regimen, coordination of care, and so on.

Roles of a Community Health Practitioner in tertiary prevention

There are wide range of service that need to be provided to patient as part of the tertiary prevention program. Community health practitioner need to be familiar with the agencies in the community that provide these services. Collaborative relationship between mental health care providers and community agencies are absolutely essentially if rehabilitation is to succeed.

An important intervention in the maintenance of patient in their own homes in the community is the Training in Community Living (TCL) program, designed by 'Stein' and 'Test'. In this model when a person is referred for a hospital admission the staff goes to the community with him rather than his going to the hospital to be with the staff. This real world experience with the patent enables the health practitioner to assess accurately the skills that the person breeds to learn and to mutually agree on realistic goals.

Another aspect of community life that is more difficult to assess accurately and deal with effectively, is the stigma attached to mental illness. Many patient and their families try to avoid stigma by keeping the nature of the person's illness secret. The need for secrecy place additional stress on the family system because there us always the fear that the truth will be revealed. Health practitioner in the community are in a key position to monitor community attitudes and help in fostering a realistic attitude towards the mentally ill.

For some patents, the emotional climate of the family to which they return can have a significant effect on their adjustment, and eventually, recovery from the debilitating effects off chronic metal illness. Families sometimes view mental illness as a weakness of character that can be overcome by exertion of moral effort. This type of familial attitude may result in guilt on the part of the patient who believe that he has disappointed his significant other. Guilt leads to increase anxiety and decrease self-esteem. These are the conditions that interface with a high level of functioning. Therefore community health practitioner working with families need to foster health attitudes towards the mentally ill member.

4.0 **Conclusion**

Community mental heath-psychiatric care which is the application of specialized knowledge to populations and communities to promote and maintain mental health, and to rehabilitate populations at risk that continues to have residual effects of mental illness. Psychiatric care in the community setting differs markedly from its hospital counterparts. The community setting requires that the psychiatric health officer posses knowledge about a broad array of community resources and be flexible in approaching

problems related to individual psychiatric symptoms, family and support systems and basic livings needs such as housing and financial support.

5.0 Summary

You will agree with me that the method of treating mental illness have changed dramatically in the past century thus bringing about the shift in mental health care from the institution to the community and heralding the era of deinstitutionalization. This unit has taken you through these changes which makes you more relevant in the management of mental disorders as a professional nurse.

6.0 Tutor Marked Assignments

Differentiate between institutionalized and deinstitutionalized management of mental health nursing in Nigeria

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing. Ile-Ife: Basag (Nig) Enterprises.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 13: Legal Aspects of Mental Health Care

Contents

1.0 Introduction

In one of your previous courses, you studied health care ethics and jurisprudence, the course reflected on legal aspects of nursing profession. In this unit, you will also be taken through the legal aspects of psychiatry and psychiatric health care, so the need to reflect and go back to the previous course on health care ethics and jurisprudence.

The practice of psychiatric health care is influenced by the law particularly in concern for rights of patients and the quality of care they are receiving. The relationship between psychiatric and law reflects on tension between individual rights and social needs, and the two areas have many similarities. Both psychiatric and law deals with human behaviours, the interrelationships between people and the responsibilities people assume based on these relationships. Both also have a role in society's desire for control of undesirable behaviours. Together, they mutually analyse when psychiatric treatment is therapeautic, custodial or incarceration.

2.0 Objectives

At the end of this unit, the learners should be able to:

- state the similarities and dissimilarities between psychiatry and law
- explain the essence of law in psychiatry
- explain when and why the patient must be compulsorily admitted to hospital, detention for care and discharge
- state the legal and criminal responsibilities of mentally ill in Nigeria
- explain the concept of criminal responsibility

- discuss the concept of diminished responsibility
- state the role of psychiatrist and the law
- enumerate the rights of patients

3.0 **Main content**

3.1 **Trends in Patients' Care and the Law**

Mental (psychiatric) hospitals have ceased to be generally regarded merely as places of care and custody and their ability to treat and cure patients has been widely recognised. Unlocking of doors, removal of railings and reduction of other restrictions on personal liberty have become the common practice, and in this the mental hospitals have met with public support.

An increasing number of general hospitals provide accommodation for psychiatric patients for it is now recognised that they do not always need to be treated in special hospitals. This change of attitude to the mentally ill, which came about concurrently with rapid advances in treatment and new methods of hospital administration called for revision of outworn laws and statutory regulations.

In Britain, the repeal of section 315 of the lunacy Act made possible the admission of patients to mental hospitals without any formalities as 'informal' patients. The new Act removed the magistrate form any part in the legal detention of patients. Furthermore, it decreed that a patients suffering from a mental disorder, even if detained against his will, could be treated in a general hospital and do not only in a mental hospital as was previously the case.

Formerly, even a voluntary patient could not be admitted to a psychiatric hospital unless he was suffering from a 'psychiatric illness', although the latter term was not clearly defined in the regulations. There is now complete freedom to admit patients to any kind of hospital according to their clinical needs and the facilities available. There is no legal bar to a psychiatric hospital reserving wards for, say, maternity or general surgical cases, in the same way as there is no bar to a general hospital reserving wards or beds for psychiatric patients.

Of course this legal freedom is not likely to cause any great change in the function of hospitals, other than to bring more psychiatric patients into general hospitals. Patients with different kinds of psychiatric illness will

continue to be treated in different clinics or hospitals, because those with mental illness need different treatment from those with mental subnormality.

3.2 **Essence of Law in Psychiatry**

It seems rather convenient to start by explaining why the law is so necessarily important in psychiatric. The answer lies partly in the nature of psychiatric illness itself, partly in the concept of responsibility and accountability, and partly in the acceptance of the principle of the fundamental human right of freedom of movement of the individual.

Firstly, psychiatric illness, unlike physician illness, is not always referable to a deviation from biological norms. Rather it may manifest in a behavioural pattern that constitute a deviation is so gross and so bizarre that there is no difficulty among all and sundry in saying that the person involved must be mentally ill. In others, it requires the opinion of experts before any pronouncement of illness can be made.

Secondly, an individual with the types of behaviour specified above, attribute to illness, cannot be expected to be accountable for his own actions. Yet any attempt to restrict his movement might one old event that may be of help in illustrating the above analysis was reported on the back of the *Nigeria Sunday Sketch* newspaper of December 12, 1976. An Alhaji who had just returned from holy pilgrimage in Mecca 'had just seen off some guests' and whilst returning to his house 'he became the target of lunatic roaming the streets in the area'. He was gripped from behind by the mentally disordered man and "frightened by the unexpected assault, the Alhaji struggled and freed himself from the clutches of the lunatic. In a desperate bid to escape he took to his heels and ended up under a moving vehicle".

In order to avoid incidents of this type, there should exist in each society laws to provide for the hospitalization (compulsory if necessary) of mentally disordered persons, and to ensure that they are not allowed to roam at large in the community. This is not to say that every mentally disordered persons, and to ensure that they are not allowed to roam at large in the community. This is not to say that every mentally disordered person must be hospitalized. The types of person that are of particular concern here are those who are unable to recognise or accept that they are ill and in need of treatment, those unable to look after themselves and at the same time do not have anybody to take responsibility for their welfare those with overt or potential destructiveness either to themselves or to others, or to property, and

those with inability to control their behaviour especially when such behaviour is of a destructive.

An acceptable law must make provisions for the hospitalisation of the types of persons described above whilst at the same time taking into account the principle of the fundamental human right of freedom of movement. In addition, the law must ensure that, though certain personal and civil right of persons suffering from some types of illness may have to be curtailed, other rights are not unduly restricted. And it must make allowance for the effects of mental illness on a person's sense of responsibilities and accountability especially with respect to criminal behaviour. From these points of view, the law may be divisible into two groups. The first group, describe as "humanitarian" would consist of rules intended to protect the mentally ill person himself; whilst the second group, intended to protect the public, may be described as 'self-preservatory'.

3.2.1 **Humanitarian**

Thus the humanitarian rules would be concerned with:

1. Care or treatment of the individual:
   a. Getting him, if necessary against his will to a place where he can be looked after and keeping him there until he is well enough to be released.
   b. Protecting those who have to carry out (a) above; so that they are not deemed to be violating his fundamental human rights.
   c. Ensuring that he is not deprived of his liberty for an unnecessarily long time.
2. Protection from undue criminal conviction.
3. Protection of his property and affairs whilst ill.

3.2.2 **Self-Preservatory Rules**

These rules would be concerned with the protection of the public form:

1. Mentally disordered persons who may find themselves in position of power in the governmental machinery. For example:
   a. Kings, Emperors, Presidents, Prime Ministers, Ministers and/or state Secretary (ies):
   b. Judges and Magistrates
   c. Other High government officials.

2. Mentally disordered persons who are not in crucial positions in the government but by virtue of their being loose in the society, are capable of inflicting harm on other people either by:
   a. direct/indirect assault on person;
   b. damage to property; or
   c. entering into marriage contract with unsuspecting persons.

3.3 **The Law and The Mentally Ill in Nigeria (Compulsory Admission To Hospital, Detention For Care And Discharge)**

The law which provided for the custody and removal of the mentally ill in Nigeria used to be called the Lunacy Ordinance.

(1) This law, which was first commenced on 21st December 1916, was a transcription of the English law, which was over 100years old and which was repealed and replaced by an Act of Parliament known as the Mental Act of 1959.

(2) At about this time, with the creation of self-governing regions in Nigeria, the Lunacy Ordinance was revised and incorporated into the Laws of each region as the Lunacy Law.

(3) And in Eastern and Northern Nigeria in 1963, (4,5) The Law. In all three regions are similarly worded except in a few minor details. The description which follows therefore, applies to all of them although the Lunacy Law of Western Nigeria is used as an example.

The sections of the Lunacy Law which are of relevance for discussion here are sections 10-18. only these will be discussed.

Section 10 of the Lunacy Law in Western Nigeria States that, "whenever a Medical Officer has cause to suspect that any person is a lunatic and considers it expedient that such person should be placed forthwith under observation in an asylum, he may grant a certificate of emergency, and shall cause such a person to be taken to an asylum and it shall be lawful for such a person to the asylum specified, and for the superintended of the asylum to receive and detain such a person in the asylum:

‘Provided that no such person shall be detained in an asylum under any such certificate for a longer period than (7) seven days except with the authority of a magistrate’

Section 11-16 require that an information be given on oath to a magistrate who may then examine the person suspected to be mentally disordered, and hold an inquiry as to this person’s state of mind. There are regulations governing the conduct of such an inquiry. The magistrate may issue a warrant of arrest of the suspected persons. He should appoint a qualified medical practitioner to examine the patient, and complete a statutory certificate. Depending on the opinion of the magistrate may then complete another certificate authorising the compulsory admission of the patient. Where there is no qualified medical practitioner within the magisterial district the magistrate must be complete a warrant in term of form F (see Appendix) to a magistrate in a district where there is a qualified medical practitioner.

The latter magistrate must then go through the procedure of conducting an inquiry into the state of mind of the suspected person all over again. But he will be required to complete a different compulsory admission of the patient into the asylum.

The Discharge Procedure under the Lunacy Law (Sections 17 and 18) provides for only two people who may order the discharge of only two people who may order the discharge of a compulsorily admitted patient. These are magistrate and the governor of the state. But the magistrate can only order the discharge of a patient ‘has been granted by the superintendent of the asylum in which the person is detained, or by any two qualified medical practitioners of whom one at least shall be a Medical Officer’.

The governor, on the other hand, ‘may order the discharge from any asylum of any person detained therein under this law whether recovered or not and may allow any lunatic to be absent on trial for such period as he thinks fit, and may at any time grant an extension of such period’. And ‘In respect of any lunatic absence on trial, the governor may order the payment out of the revenue of any sum not exceeding the sum of two pounds per month (or about ₦ 300.00) to the person taking charge of such lunatic’.

3.3.1 **Observations**

In spite of its revision in 1959, the Lunacy Law remains couched in a language which reminiscent of Pre-Renaissance concepts of mental disorders and which must militate against the willingness of mental health personnel in this country to apply the law. It is therefore not surprising that it is difficult to find any psychiatric establishment in this country where the law is put into practice.

While the majority of patients can be treated informally, there will always be a group of patients whose illness makes them a potential source of danger to themselves or to others but who are so lacking in insight that they will not voluntarily seek the care, protection and treatment they require. This group includes, among others, the severely mentally disordered persons who live on and roam the streets, the streets of our towns and cities i.e. vagrant psychoses. For this category of patients the law must evolve a system that will facilitate a smooth and speedy admission procedure so that the treatment which these patients' need may be promptly instituted. That the personal liberty of the individual is not unduly jeopardized is safeguarded in the fundamental human right of Freedom of Movement in the constitution of the Federal Republic of Nigeria (6). Section 21 (i.e.) provides that no person shall be deprived of his personal liberty save in certain circumstances which involve persons suffering from infectious diseases, persons of unsound mind, persons addicted to drugs or alcohol or vagrants. And in these cases, deprivation of personal liberty must be for the purpose of their care or treatment or the protection of the community.

In terms of smoothness of practice for mental health personnel, the early institution of badly needed treatment and the convenience of the mentally disordered patient, section 10 (cited above) is about the only satisfactory provision available in this law. In order to detain a patient for longer than seven days, one must go through a legal procedure (Sections 11-16) which, in the light of Nigeria judicial system, may be very cumbersome and discouraging.

Perhaps such a cumbersome procedure as is demanded by Sections 11-16 above may help to safeguard the personal liberty of the suspected patient as envisaged by the provisions of the constitution of the federation by ensuring that he may never be compulsorily admitted until a detailed inquiry has been conducted to confirm a disordered mental state. It is, however,

obvious that the advantages associated with such a procedure far outweigh any advantage it may possess.

3.3.2 **Suggested Modifications**

Modification of the Law, both in terms of its language and the procedure laid down for the compulsory admission of the psychiatric patient seems long overdue. The need for change is buttressed by the fact that a considerable advancement in psychiatric knowledge has taken place, and progress made in the provision of mental health care in Nigeria since the Lunacy Ordinance was introduced in 1916.

Firstly, there is a need for an overhaul of the terminology. The terms "lunacy", "lunatic", "asylum", "insanity" should be replaced. These words not only reflect an antiquated notion of the nature of mental illnesses, they also carry with them negative social values. A considerable proportion of the unfavourable attitudes the public manifests towards the mentally ill originate from fears of mental illness as a terrible and shameful social condition.

The procedure stipulated in Sections 11-16 which necessitates in the issue of warrant for the arrest of the patient the holding of a summary trial involving his exposure to public spectacle detention in prison pending decision on his state of mind is distastefully stigmatizing to the patient as well as to his family. These sections of the law need to be abolished and be replaced by more enlightened and humanitarian ones. The 1957 Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which sat under the chairmanship of Lord Percy of Newcastle stated *inter alia*, 'mental disorders of all kinds must be viewed primarily as a matter of protecting society'. In other words, it is largely a medical rather than a legal concern. The English Mental Health Act 1959 is based on this commission's report.

Dr. Issac Ray, an American Psychiatrist who lived in the 19th century, has enumerated the essential and basic components of enlightened and humanitarian laws governing the involuntary hospitalization of the mentally ill (7). He stated these components as follows:

"In the first place" – the law should put no hindrance in the way of prompt use of those instrumentalities which are regarded as most effectual in promoting the comfort and restoration of the patient".

Secondly, it should avoid all unnecessary exposure of private trouble, and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment. It would be objective enough to any legal provision that it failed to secure these objectives in the completest possible manner.

3.4 **The Law and the mentally ill in Nigeria II**

3.4.1 **Introduction**

When a mentally ill individual first manifests an act that will later be perceived as psychiatric symptom, the act is not always recognized as a symptom of illness but rather as a deviation from social norms. (1) This is particularly so with major mental illnesses. It follows, therefore that in order to avoid imposing punishment for an offence committed by a mentally disordered person, the society must formulate laws to guide those who administer justice in our law courts.

The Nigerian Criminal Code Ordinance

The law which provides for the determination of legal and criminal responsibility of the mentally ill in Nigeria is embodied in the Nigerian Criminal Code Ordinance. (2) which is based on a Criminal Code drafted by the renowned English criminal lawyer, Sir Fitzjames Stephens, in 1878 it was proposed to replace the Common Law in England but was never enacted by the British Parliament. It was instead introduced into Queensland in Australia in 1899 and into Nigeria in 1916 following the unification of the north and south. (3) With the creation of self-governing regions around 1959, the Criminal Code Ordinance was revised and incorporated into the laws of the Western and Eastern Regions as "Criminal Code Law". In Northern Nigeria, due to the prevailing Moslem religion there, the Criminal Code Ordinance redrafted and brought into operation in September, 1960 as the Penal Code Law. (4) According to Richardson (5); the Northern Nigeria Penal Codes were based on the equivalent Sudan Codes which were in turn modelled upon the Indian Penal Codes.

The sections of the Nigerian Criminal Code Ordinance which are of relevance to the theme of this discussion here are Sections 27, 28 and 327.

'**Section 27**

Every person is presumed to be of sound mind and to have been of sound mind at any time which comes in question until the contrary is proved.

‘Section 28

A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to control his actions, or capacity to know that he ought not to do the act or make the omission.

A person whose mind, at the time of his doing or omitting to do an act is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.

‘**Section 327**

Any person who attempts to kill himself is guilty of a misdemeanour and is liable to imprisonment for one year.

Despite its intention to avoid conflict with the Holy Qu’ran and Sunna, the Northern Nigerian Penal Code has retained a number of offences contained in the Nigerian Criminal Code Ordinance so that nothing which is an offence under the Criminal Code ceases to be an offence in Northern Nigeria. Thus, Section 231, which deals with ‘attempting to commit suicide’ is essentially the same as Section 327 of the Nigerian Criminal Code. Similarly, Section 51 in the Penal Code, which gives the legal definition of insanity, contains almost all the elements of Section 28 of the Nigerian Criminal Code.

3.4.2 **Observations**

The above Laws are of concern to the medical profession from certain points of view:

(a) The desire of the physician to ensure that his mentally abnormal patient is not unjustly convicted for an offence of which he is accused.

(b) The compatibility of the Laws with the modern trend in psychiatric knowledge.

In order to examine the Law from these points of view it would be fruitful, at this stage, to examine the meaning of ‘criminal responsibility’.

3.4.3 **The Concept of Criminal Responsibility**

According to Jacobs (1971), 'a person is responsible for something if he can be called upon to answer questions about it'. Thus responsibility, either in law or morals, constitutes an instrument of social control. In criminal law, the general rule is that liability requires "mens rea", lawyers Latin for a guilty mind, and "actus reus" – wrongful intention. The interpretation of these requirements usually involves a subjective inquiry into the actual state of mind of the accused at the time of offence committed. Since the criminal law seeks to punish the offender for the offence committed. It is absolutely important that the law lays down criteria for distinguishing, on ground of supposed mental abnormality, between those who are, and those who are not, responsible for their actions.

3.4.4 **Mental Illness and Criminal Responsibility in the Nigerian Criminal Code**

Section 28 of the Nigerian Criminal Code gives the legal definition of insanity but it places the onus of proof of mental abnormality on the accused, through Section 27. Such a proof is based on informed advice from the medical profession by the production of medical evidence and/or cross-examination of a medical witness. The onus however, is not as great as that placed on the prosecution to prove its case beyond all reasonable doubts. Sometimes a positive family history of mental abnormality may constitute sufficient admission. For example, in the case of Rex. vs Edem Ugo Inyang the judges ruled that, "Evidence of insanity of ancestors or blood relations is admissible. Medical evidence is not essential".

Section 28 of the law emphasizes that the mental abnormalities should have existed at the material time when the offence was committed. It does not matter if such abnormality was temporarily or permanently although the former may be difficult to establish. For example, in Rex. vs Edem Ugo Inyang the high court judge had ruled that the accused as sane at the time he committed the offence. At the Appeal Court, J.I.C Taylor, in arguing on behalf of the appellant, distinguished between 'partial insanity' and 'total insanity'. By 'partial insanity', he meant that the appellant was subject to periods of insanity, during one of which he killed the deceases. 'Total insanity' meant permanent insanity. But the Appeal Judges in disagreeing with Taylor's submission, stated: "It is clear that the learned Judges' summing up of the appellant when he struck the deceased, no matter whether that state of mind was a temporary or permanent one".

The principle followed in most English speaking countries was laid down in 1843 in the McNaughten Rules Walker (1968). McNaughten was a paranoid who attempted to assassinate the British Prime Minister, Sir Robert Peel, being under the delusion that only by shooting the Prime Minister could he escape from the persecution, which had been dogging him for many years. He shot and killed the Prime Minister's Private Secretary, apparently mistaking him for Peel. The argument of McNaughten's lawyer, Cockburn, sought to rely on lack of control and the jury had no hesitation in acquiring his client. The public reaction to the case led the House of Lords to pose five questions to the judges in Britain on the question of insanity. The judges' answer to the third and fourth questions embody the McNaughten Rule as follows:

"The jurors ought to be told in all cases that every man is to presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction and that to establish a defence on the grounds of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong".

Thus the McNaughten Rules take into consideration only the cognitive aspects of the individual's behaviour and ignores the emotional and volitional aspects. The accused person must be suffering from a defect of reason… so as to know… if he did not know that he was doing what was wrong. If it were strictly applied, it would be almost impossible to find anyone to whom the Rules would apply. The Nigerian Criminal Code whilst incorporating the McNaughten Rules in its Sections 27 and 28, has gone far further in taking cognizance of the individual's volitional state. Thus, the capacity to control his actions… which is in Section 28, is not found in the McNaughten's Rules.

There has been one instance in Nigerian medicolegal history in which the Nigerian Criminal Code (Section 28) was compared with the McNaughten Rules. This was in the case of Rex. vs Omoni which is regarded as the standard case on our law of insanity. This comparison shows that the Nigerian Legislature had not only departed from the phraseology of the English Judges 1845 but had also introduced two entirely new factors: "natural mental infirmity" and "capacity to control his actions". In trying to

elicit the exact menaing of the phrase "natural mental infirmity", the West African Court of Appeal (WACA) Judges Rex. vs Omoni stated, "We must ascribe to them (i.e. the words "natural mental infirmity" an intention to distinguish between 'mental disease' and 'natural mental infirmity', for otherwise the last words would be redundant. The words 'natural mental infirmity' mean, therefore, in one's opinion, 'a defect in mental power neither produced by own default nor the result of disease of the mind'.

The only category of mental abnormality which falls into this class is that group known as mental subnormality or mental retardation. Thus, it would seem that a mentally retarded person cannot be held to be criminally responsible for his offences. In Britain, on the other hand, a mental defective would still be found guilty although, under the Mental Deficency Acts of 1913 and 1927, the courts would be empowered to place him under guardianship or to send him to an institution for mental defectives instead of passing sentence on him.

Let us examine the phrase 'to deprive him of capacity to control his actions'. The W.A.C.A. Judges observed that these words not only departed from the Rules in McNaughten's case, but were in direct conflict with the line of English decisions subsequent thereto, in which the Judges of England have declined to accept the defence of irresistible impulse' which these words appear to have introduced into the laws of Nigeria. The Judges further observed, 'As to the wisdom of introducing or maintaining this departure from English Law, it is one for the legislature to judge; this court can only apply this law as one finds it'. They went on to quote Hewart in the case of Rex. vs Kopach, where the learned Lord Chief Justice said, 'The complaint against the Judge is that he did not tell the jury that something was the law which was not the law. It is the fantastic theory of uncontrollable impulse which if it were to become part of our criminal law, would be merely subversive. It is not yet part of the Criminal Law and it is to be hoped that the time is far distant when it will be made so.

Obviously these judges were averse to the concept of "uncontrollable impulse". It is notable that in this respect the Nigerian Law has been ahead of the British Law which places emphasis on the cognitive aspects of the individual's behaviours only, and refuses explicitly to recognize the importance of volitional factors. Thus the Nigerian Criminal Code, by virtue of the clause 'incapacity to control his actions', seem to exonerate persons suffering from disorders like kleptomania states of epilepsy associated with

automatism or certain abnormal metabolic states in which the individual may behave in an uncontrollable manner e.g. hypoglycaemic states.

It appears however that the judges in Nigerian Courts have been reluctant to give recognition to the full meaning of this phrase. Although a plea of 'uncontrollable impulse' may be made, it is not considered as sufficient proof of insanity. In the case of Rex. vs Ashigifuwo (11), the judges ruled that 'mere absence of any evidence of motive for a crime is not a sufficient ground upon which to infer mania'. In Rex. vs Inyang (1) they stated 'where there was sufficient evidence indicative of insanity rather than the opposite, the absence of any evidence of motive may become relevant to the point at issue and material to it'.

The inclusion of the second part of Section 28 may represent a setback in the Nigerian Law. The interpretation of this paragraph seems to be that the mere presence, per se, of delusion in the accused person is sufficient ground to absolve him from the offence charged. Aguda (1965) has attempted to clarify this paragraph by giving the following example as an illustration:

A sees Z and Z's wife in his house and A, under the insane delusion that the woman was his wife and that Z was committing adultery with her, kills Z. The rule says that A's criminal responsibility should be considered on the basis of the fact as he supposed them to be. If the facts would have amounted to a killing as a result of provocation, then he will be convicted of manslaughter.

Although it is arguable whether A, in the above example, would be said to be suffering from a delusion or an illusion, we could agree for the purposes of this discussion that he was in fact suffering from a delusion. The argument that A would be liable to conviction for manslaughter seems to indicate that the law makers have definitely failed to be guided by informed psychiatric knowledge on this issue. According to Jaspers (1959), 'since time immemorial, delusion has been taken as the basic characteristic of madness'. To be mad was to be deluded. Delusion manifests itself in judgements; delusions can only arise in the process of thinking and judging. To this extent, pathologically falsified arguments are termed delusions, it is, therefore, apparent that the person who is deluded (whether 'on some specific matter or matters') cannot but be entitled to the benefit of the first paragraph of Section 28. fortunately, the practical application of this part of

Section 28 is strictly limited. Aguda (1965) pointed out that most cases could be disposed off under the first part of this section. The inclusion of the second paragraph is thus unnecessary.

3.4.5 **The Concept of 'Diminished Responsibility'**

The Nigerian Law does not recognize the concept of 'diminished responsibility', which became incorporated in the English Law in the Homicide Act of 1957 (14). This concept dates back to 835 Walker (1968). In the case of William Braid who pleaded guilty to some unrecorded offence, Dr. Trail was examined, after the accused's mind had diminished his responsibility, although it did not take it away entirely. "It seems to have been based on the concept of 'partial insanity' put forward in Scotland by Sir George Mackenzie who lived between 1636-91 Walker (1968). He argued that since the law granted total immunity to those who were shown to suffer from total insanity, it should by rule of proportions, moderate the punishment if those with partial insanity. Although partial insanity was not usually recognized as a defence, it was taken into account after conviction, by the practice of allowing, or advising, the jury to recommend a pardon. One wonders if this was what Taylor was trying to achieve when he tried to distinguish between 'partial insanity' and 'total insanity' in the appeal of this client (Rex. vs Inyang suprs).

Regular use of the concept of 'diminished responsibilities' did not, occur until 1867 in Aberdeen, when Lord Dees tried Dingwall, a 45-year-old chronic alcoholic, who stabbed his wife to death after a drinking bout. Lord Dees, in directing the jury, ask the jury to consider, among other factors that the prisoner appeared to have been peculiar in his mental constitution and to have had his mind weakened by successive attacks of disease (he had had repeated attacks of delirium tremens). Lord Dees was of the opinion that the weakness of his mind was not inadmissible in deciding whether the offence should be classed as murder or culpable homicide. The state of mind of a prisoner, he thought, might be an extenuating circumstance, although not such as to warrant an acquittal on grounds of insanity. The result was the substitution of a lesser penalty than death. Lord Dees and his fellow judges in Scotland continued to steer juries into similar verdicts and by 1909, the phrase 'diminished responsibility' was actually being used by judges.

It is arguable that the development of the concept of 'diminished responsibility' in Scottish Courts was the result of accident of history. The McNaughten Rules which were in force in England at that time were not

applicable to Scotland. Thus the boundary between murder and culpable homicide was less clearly defined in Scotland. However, the advantages of this concept are obvious:

1. A greater number and types or degrees of mental abnormality could be taken into account.
2. Whereas English Law allowed only two possibilities that the prisoner was or was not so insane as not to be accountable for his act or omission, Scots law allowed a third; that he was sufficiently disordered to deserve mitigation of the usual punishment though not complete exemption. That is, he was not in complete control of his own mind.
3. The effect enabled the judge to pronounce either a sentence of life-imprisonment, imprisonment for a specified term, a fine, a probation order, or an absolute or conditional discharge.

In Nigeria, where the death penalty is still in force, the inclusion of 'diminished responsibility' would no doubt prevent the execution of a sizeable number of convicted persons who could only be classified as 'partially insane' thus not qualifying for acquittal under Section 28, for example, Lambo (1962) made a study of persons convicted for criminal offences which included murder or multiple murders by members of the prescribed Odozi Obodo and Leopard Men societies. He found that the criminal behaviour by such persons could be regarded as one of the components of a psychiatric syndrome which he termed "Malignant Anxiety".

Aguda (1965), thinks that the defence of irresistible impulse covers 'diminished responsibility' and even more. This is doubtful. He argues that whereas the defence of diminished responsibility is restricted to cases of homicide the defence of irresistible impulse under the Nigerian Criminal Code is applicable to all offences. It is true that for example, the kleptomanic in Nigeria may be able to obtain an acquittal with a defence of irresistible impulse, but this does not necessarily mean that all or majority of mentally ill persons accused of a criminal offence suffer from irresistible impulse. There is still a considerable class of persons who commit homicide while suffering from some form of mental illness which is significant in the commitment of the offence but the nature of which does not entitle them to total acquittal under Section 28 of the Criminal Code. The provision of a

defence of diminished responsibility would enable such persons to be given a lesser penalty than death.

The Northern Nigeria Penal Code does not recognize the defence of irresistible impulse, nor that of diminished responsibility.

3.4.5.2 Attempting to Commit Suicide

Section 327 of the Criminal Code which deals with attempted suicide is overdue for abrogation. Persons who commit suicide or attempt suicide are usually mentally ill, some of them severely so. In a study of 38 patients with self-poisoning and self-injury admitted to University College Hospital, Ibadan, only 21 percent were found to have no evidence of psychiatric illness (Ebie, 1972). If a person succeeds in committing suicide the law cannot reach him to try him. But if he fails to die, then he may be sent to jail for one year. It is thus arguable whether such a person is being tried because he failed or because he ever attempted suicide in the first place. Section 327 is that it seems to be imposing a moral judgment on the individual. Suicide used to be a crime in England but this is no longer so since the passing of the Suicide Act of 1961.

It cannot be argued that the imposition of a penalty for attempted suicide is based on the rationale that it would help to deter people from committing this act. There is evidence to suggest that Nigeria has one of the lowest suicide rates in the world. Asuni (1961) found an incidence of less than 1 in every 100,000 in Western Region Nigeria (now Ondo, Ekiti, Osun, Oyo, Ogun, Edo and Delta states). This was lower than the lowest figure recorded anywhere else in the world. There are reasons to believe that this rate is due, not to the punitive intent of Section 327, but to other factors. Imposition of a penalty is more likely to make people conceal the fact of an attempted suicide or increase their determination to ensure that they successfully carry out the act. Hence people in need of care would be reluctant to come forward for the help they badly need.

3.4.5.3 The Role of Psychiatrists and the Law

In the course of all these, I have often wondered whether a psychiatrist is the most qualified person to deal with this sort of subject or whether it does not actually belong in the territory of legal practitioners. The law is, fundamentally a complete artefact – a collection of man made rules enacted by legislators or rulers of a country with or without taking into account the predominant current social feelings at the time each rule

becomes enacted. The people who administer the law (lawyers, police, magistrates, judges) are therefore interested in medical aspects only to enable them ensure that justice (as in implicit in the Law) is done. Thus they are more interested in say for example, the time of death in the case of a murder, the state of mind of the accused at the time of offence alleged etc. There is little interest in etiological factors or pathogenesis or the phenomenology of the illness or disease in question. And they tend to expect accurate, unambiguous answers from medical witnesses. Unfortunately in the area of psychiatry, such clear cut answer cannot always be offered. This is a situation that has tended to make the law courts cautious with psychiatric testimonies.

This subject of law and psychiatry is an interdisciplinary one in which both psychiatry and law overlap and should ideally involve the corroborative effort of both the lawyer and the psychiatrist. Otherwise a person seeking to tackle such a subject single-handedly should, ideally be both a lawyer and a psychiatrist rolled into one person.

Doctors, on the other hand tend to be interested in the Law, only when they find themselves confronted with certain problems in medical practice. For example, the legal definition of death, or performing a life saving surgical procedure on a patient or his relatives. And the interest ceases once the problem has been solved.

It is my view that the role of the medical should extend beyond these limits. Although it is not the function of the medical profession to formulate laws for the society, the medical profession as a body, has a duty in educating the community and advising the lawmakers on these aspects of the Law relating to health. And there is a need for the lawmakers to acknowledge this. In playing these educational and advisory roles, objectives and scientific facts based on research should be placed above the personal beliefs of the doctor so that a Roman Catholic doctor faced with say, a move to liberate the law on abortion does not allow his religious beliefs to becloud his objectivity and scientific attitude.

3.4.5.4 **Rights of Patients**

Patient's Rights, generally include:

1. Right to keep personal effects (not harmful).
2. Right to independent psychiatric examinations.

3. Right to get his consent (or be informed) pre-procedure or any operation.
4. Right to treatment – to refuse or accept – Consider his mental state.
5. Right to marry and divorce.
6. Right to be employed, if possible.
7. Right to education.
8. Right to fair hearing in the court.
9. Right to periodic review.
10. Right to referral or discharge.
11. Right to compensation.
12. Right to contractual relationship.
13. Right to freedom from mechanical restraints or seclusion.
14. Right to request (and sign) for discharge – if he's not too psychotic.

4.0 **Conclusion**

It should be noted that despite the similarities in psychiatry and law, there existed some dissimilarities which include, that psychiatry is concerned with the meaning of behaviour and personal life satisfaction, law addresses the outcome of behaviour and has developed a system of rules and regulations to facilitate orderly social functioning. These differences are not the same in terminology when it is recognized that insane and legal-commitments are predominantly legal, not psychiatric terms.

5.0 **Summary**

You will agree with me that sound understanding of this unit will assist you in your professional services to humanity wherever you service is needed. Now you can attempt the following tutor marked assignments.

6.0 **Tutor Marked Assignment**

(1) Account for the similarities and dissimilarities between psychiatry and the law.

(2) What is the relevance of this unit to the development of nursing profession in Nigeria?

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing. Ile-Ife: Basag (Nig) Enterprises.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Fish, F. J. 1967. An outline of Psychiatry, Bristol: John Wright & Sons Ltd.

Henderson, D. and Gillespie, R. D. A. 1950. A textbook in Psychiatry. 7th Ed. New York: Oxford University Press.

Unit 14: Methods of Assessment in Psychiatry

Contents

1.0 Introduction

Psychiatric diagnosis rest upon the established principle of a thorough history and examination of patients. All of the forces contributing to the individual's life situation must be identified and this can only be done if the examination includes the history, mental status, medical conditions, and pertinent social, cultural and environmental factors impinging on the individual patient. This unit covers history taking, mental status examination, physical investigations and psychological assessment.

2.0 Objectives

At the end of this unit, you should be able to:

- explain how history taking of psychiatric patients is carried out
- discuss the process of mental status examination
- describe the physical investigations carried out on psychiatric patients
- list the psychological assessment that may be done of psychiatric patients

3.0 Main content

3.1 History Taking

1. Identification Data

Name	Age	Sex
Father/spouse		
Address		
Education	Occupation	Income
Marital status	Religion	

2. Information
3. Presenting Chief Complaint (with duration in chronological order)
4. History of Present Illness
   Duration (weeks/months/years):
   Mode of outset: Abrupt/acute/sub-acute/insidious (<48hrs)/<1wk/(1-2 wks) Course:
   Continuous/episodic/fluctuating/deteriorating/improving/unclear
   Precipitating factors:
   Description of present illness (chronological description of abnormal behaviour, associated problems like suicide, homicide, disruptive behaviour; thought content, speech, mood states, abnormal perception, biological functioning, social functioning, occupational functioning, changes in ADLs).

5. Treatment History
   Drugs (name of the drug, dose, route, side-effects, if any)
   ECT
   Psychotherapy
   Family therapy
   Rehabilitation

6. Past Psychiatric and History
   Hospitalization (psychiatric):
   Substance use:
   Surgical procedures/accidents/head injury/convulsions/unconsciousness/DM/HTN/CAD/venereal disease/HIV positive/any other

7. Family History
   Genogram (family of origin)
   Description (describe each family member briefly: age, education occupation, health status, relationship with the patient, age at death, mode of death)

8. Personal History
   A. Perinatal history
      Antenatal period: uneventful/eventful (specify)
      Birth: Full-term/premature/post mature
      Delivery: Normal/instrumental

Birth cry: Immediate/delayed
Birth defects:
Postnatal complications: Cyanosis/convulsions/jaundice
Any other:

B. Childhood history
Primary caregiver:
Feeding: breastfed/artificial mode of feeding
Age at weaning:
Developmental milestones: normal/delayed
Behaviour and emotional problems: thumb sucking/temper tatrums/stuttering head-banging/body rocking/nail biting enuresis/morbid fears/night terrors/somnambulism

C. Educational history
Age at beginning of formal education:
Academic performance:
Academic and extracurricular achievements, if any:
Relationships with peers and teachers:
School phobia: yes/no
Truancy: yes/no
Reason for termination of studies:

D. Play history
Games played (at what stage and with whom):
Relationships with playmates:

E. Emotional problems during adolescence
Running away from home/delinquency
Smoking/drug-taking/any other (specify).

F. Puberty
Age at appearance of secondary sexual characteristics:
Anxiety R/T puberty changes:
Age at menarche:
Regularity of cycles, duration of flow:
Abnormalities, if any (menorrhagia, dysmenorrhea etc):

G. Obstetrical history
Age at starting work:

Jobs held in chronological order:
Reasons for changes:
Current fob satisfaction:
(including relationships with authorities, colleagues, subordinates)
Whether job is appropriate to client's background:

I. Sexual and marital history Genogram
(family of procreation): Type of
marriage: self-choice/arranged
Duration of marriage:
Interpersonal and sexual relations: satisfactory/unsatisfactory

J. Premorbid personality
a. Interpersonal relationships:
Extrovert/introvert
Family and social relationships:
b. Use of leisure time:
c. Predominant mood:
Optimistic/pessimistic; stable/fluctuating;
cheerful/despondent
Usually reaction to stressful events
d. Attitude to self and others:
Self-appraisal of abilities, achievements and failures
General attitude towards others
e. Attitude to work and responsibility:
f. Religious beliefs and moral attitudes:
g. Fantasy life:
Daydreams - frequency and content
h. Habits:
Eating pattern: regular/irregular
Elimination: regular/irregular
Sleep: regular/irregular
Use of drugs, tobacco, alcohol:

3.2 **Mental Status Examination**

A. General Appearance and Behaviour
Appearance: looking one's age/older/younger
Level of grooming: normal/shabbily dressed
Level of cleanliness: adequate/inadequate/overtly clean

Level of consciousness and alert/drowsy/stuporous/comatosed
Mode of entry: came willingly/persuaded/brought using physician force.

Cooperativeness: normal/ more than so/less than so
Eye-to-eye contact: maintained/difficult/not maintained
Psychomotor activity: normal/increased/decreased
Rapport: spontaneous/difficult/not established
Gesturing: normal/exaggerated/odd
Posturing: normal posture/catatonic posture
Other movements: stereotypes/tremors/Extrapyramidal Symptoms (EPS)/Abnormal Involuntary Movements (AIMS)
Other catatonic phenomena: automatic obedience/negativism/excessive cooperation/waxy flexibility/echopraxia/echlalia
Conversion and dissociative signs:
Compulsive acts or rituals:
Hallucinatory behaviour: (Smiling and talking to self, odd gesturing)

B. Speech
Initiation: spontaneous/speaks when spoken to/minimal/mute
Reaction time: normal/delayed/shortened/difficult to assess
Rate: normal/slow/rapid
Productivity: monosyllabic/elaborate replies/pressured
Volume: normal/increased/decreased
Tone: normal variation/monotonous
Relevance: fully relevant/sometimes off target/irrelevant
Stream: normal/circumstantial/tangential
Coherence: fully coherent/loosening of associations
Others: rhyming/punning/echolalia/preserveration/neologism
Sample of speech (in response to open-ended questions):

C. Mood
Subjective:
Objective:
(predominant mood state appropriate/inappropriate/irritable/blunted/flattened)

D. Thought

Stream: normal/racy thoughts (pressure of thought)/retarded thinking (poverty of thought)/thought block/muddled or unclear thinking/ flight of ideas

Form: normal/formal thought disorder (specify with a sample of speech)

Content:

a. Ideas/delusions of: worthlessness/helplessness/hopelessness/guilt/hypochondriacal/poverty/nihilistic/death wishes/ suicidal/grandiose/reference/control persecution/bizarre.
b. Thought alienation phenomena: thought insertion/thought withdrawal/thought broadcasting.
c. Obsessional/compulsive phenomena: thoughts/images/ruminations/doubts impulsive rituals.

E. Perception

Hallucinations: Auditory
Visual
Olfactory
Gustatory
Tactile

Somatic passivity:

Déjà vu/jamais vu:

F. Cognitive Functions (neuropsychiatric assessment)

Consciousness

Conscious/cloudy/comatosed

Orientation

Time: appropriate time/date/day/month/year

Place: kind of place/area/city

Person: self/close associates/hospital staff

Attention

- Normal aroused/aroused with difficulty
- Digit forward
- Digit backward

Concentration

- Normally sustained/sustained with difficulty/distractible
- 100-7
- 40-3

- 20-1
- Names of months (backwards)
- Names of weekdays (backwards)

Memory

a. Immediate (same test as for attention):
b. Recent: (recent happenings-last meal, visitors, etc)
   Verbal recall- 3 unrelated objects
   unrelated objects, or imaginary address of
   5 items
c. Remote:
   personal events
   impersonal events
   illness-related events

Intelligence

- General fund of information
- Arithmetic ability: mental arithmetic/written sums

Abstraction

- Normal/concrete
- Interpretation of proverbs
- Similarities between paired objects
- Dissimilarities between paired objects

G. Insight

- Awareness of abnormal behaviour/experience: yes/maybe/no
- Attribution to physical causes: yes/may be/no
- Recognition of personal responsibility: yes/may be/no
- Willingness to take treatment: yes/may be/no

H. Judgment

- Personal: intact/impaired
- Social: intact/impaired
- Test: intact/impaired

Diagnostic Formulation

3.3 **Physical Investigations**

A. Routine: general screening, e.g., heamogram, urinalysis (additional investigations may be ordered in special populations)

B. Routine: specific
   - Based on diagnosis, e.g., liver function tests in alcoholics
   - Based on treatment-e.g, pre-lithium, pre-ECT work-up investigations.
   - Based on ongoing management-e.g. blood counts in patients receiving clozapine.

C. Non-routine: Based on need and index of suspicion, e.g., thyroid function tests in suspected hypothyroidism during lithium therapy; pregnancy tests in amenorrhea during treatment with a potential teratogen.

D.

E. Common neuropsychiatry investigations:
   - Electroencephalogram (EEG)
   - Computed tomographic (CT) scanning
   - The sleep EEG (polysomnogram)

3.4 **Psychological Assessment**

Psychological testing of patients is deadly conducted by a clinical psychologist who has been trained in the administration, scoring and interpretation of commonly used psychological tests.

1. To assist in diagnosis, e.g., rorscharch inkblot test.
2. To assist in the formulation of psychopathology and in the identification of areas of stress and conflict, e.g., Thermatic Appreception Test (TAT)
3. To determine the nature of the deficits that are present:
   - Cognitive neuropsychological assessments
4. To assess severity of psychopathology and response to treatment:
   - Hamilton Rating Scale for Depression
   - Brief Psychiatric Rating Scale
5. To assess general characteristics of the individual:
   - Assessment of intelligence
   - Assessment of personality

4.0 **Conclusion**

The manner in which the history is taken is important not only because it affects success in eliciting pertinent data but also because it may be of therapeautic value in itself. Your setting where history taking, mental status examination, physical investigations and psychological assessments are carried out should be quiet and the patients should be allowed a wide

degree of freedom and should not be structured. The format for this should be strictly followed so that no area is left out.

5.0 Summary

As you have gone through this unit, you are now knowledgeable in order to carry out rational and systematic history taking, physical investigations, mental status examination and psychological assessment on psychiatric patients.

6.0 Tutor Marked Assignment

Why is rational and systematic history taking crucial to effective management of psychiatric patients?

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing. Ile-Ife: Basag (Nig) Enterprises.

Morrison-Valfre, M. 2005. Foundations of Mental Health Care, Missouri: Mosby Inc.

Sreevani, R. 2004. A Guide to Mental Health and Psychiatric Nursing, New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.

Unit 15: Electro - Convulsive Therapy (E. C. T)

Contents

1.0 Introduction

Olatawura (2002) described ElectroConvulsive Therapy (E. C. T) as a mood normaliser. If a patient is too high, ElectroConvulsive Therapy brings him down, if he is too depressed, it lifts the patient up. This unit will take you through ElectroConvulsive Therapy such as indications, contraindications, preparation of patient for ElectroConvulsive Therapy pre and post operatively and complications that may result from its administration.

2.0 Objectives

At the end of this unit, the learners should be able to:

- describe ElectroConvulsive Therapy as a treatment measure of a psychiatric patient
- list the indications of ElectroConvulsive Therapy
- state the contraindications of ElectroConvulsive Therapy
- explain how patient is prepared for the therapy
- list the complications of ElectroConvulsive Therapy

3.0 **Main content**

3.1 **Introduction**

ELECTRO-CONVULSIVE THERAPY (E.C.T)

3.1 **Introduction**

Electro-convulsive therapy (ECT), also referred to as electro-shock therapy (EST) was first used in 1993 by Cerletti and Bini, Meduna Started by using chemically induced convulsions in 1935, while Certletti and Bini were the first to use electrical induced fits.

Of all physical treatments, E.C.T is apparently the most successful. It causes a central nervous system seizure (Peripheral Convulsion is not neccesary) by means of electric current. The key objective is to exceed the seizure threshold, which can be accomplished by a variety of means.

The mechanism of action is not known but it is thought to involve major neuro-transmitter responses at the cell membrane. Current insufficient to cause a seizure produce no therapeutic benefits and cause more postictal confusion.

Speculative theories of a neurophysiologic sort suggest that the convulsion alters the Conditionality of an intr9icate system or that in some way it alters the level of arousal of the central nervous system. Other theorists suggest that in some unknown way it alters the balance of a central mood regulating mechanism. These tend to represent the views of those favouring its use.

Those who are on the whole opposed to its use tend to suggest that it is a form of "shock" treatment which in a way 'shocks' the patient into altered behaviour as in the past patients were 'shocked' by sudden immersion or being whirled around in resolving chairs.

It has also been suggested that is the sudden loss of consciousness which affects the patient.

3.2 **Definition of E.C.T.**

Electroconvulsive Therapy (E.C.T) is a physical method of treatment in psychiatry, administered to the patient's body in order to produce changes in his behaviour.

It is (E.C.T) the most widely used of the physical therapies; with the exception of drug therapy originating with the mistaken impression that epilepsy and Schizopherenia never occurred in the same patient and the false conclusion that convulsions might eliminate the symptoms of the illness, efforts were made in the early 1930s to induce convulsions as a form of treatment.

Electro Convulsive therapy is the most effective (about 70%) treatment of severe depression, particularly with delusions and agitation commonly seen in the involutional period. It is also very effective in the manic disorders. It has not been shown to be helpful in chronic schizophrenic disorder.

Using the same E.C.T. apparatus, E.C.T can be given in two forms.

(i) With drug (known as *MODIFIED E.C.T*)
(ii) Without drugs (known as *STRAIGHT E.T.C*)

3.3 **Indications:**

E.C.T. is given in the following conditions.

1. All depressions (excepts neurotic depression)
2. Acute suicidal patients
3 Patients in a state of Manic or Catatonic excitement
4. Schizophrenia (especially Catatonic stupor)
5. Acute schizophrenia (that does not respond to use to phenothiazine-drugs)
6. Used for patient who are refractory to drugs.

3.4 **Contraindications:**

1. Brain Tumor
2. Severe Heart disease
3. Other Chest Complications (including- Bronchitis, Asthma Tuberculosis etc).
4. Fracture
5. Abnormal temperature, Pulse, and Respiration (including cough).
6. Increased intra-cranial pressure
7. Chronic Renal disease

3.5 **Preparation of Patient (Pre-operative care)**

1. Before E.C.T is given to any patient, history and physical examination should be performed, along with indicated laboratory test.
2. Permission form (CONSENT FORM) must be signed by patient's relatives or the patient himself (if he's of age and non-psychotic) prior to the administration of E.C.F
3. Inform patient or relatives about transient period of impaired memory for about a month after treatment.
4. One rare occasion X-ray of the spine is done to permit evaluation of complications and to avoid malpractices.

Then the following sequence of event is as follows:-

(a) Give nothing by month for at least 8 hours before treatment (to avoid complication of vomiting).

(b) Give 0.55-0.8mg of atropine sulphate subcutaneously or I/Muscularly 30minu6tes before treatment to decrease salivation and bronchial secretions

(c) Just before the shock is delivered, give an intravenous muscle relaxant such as succinlycholine chloride (Anectine), 10-30mg IV. (0.5mg-5mg per minutes) to prevent violent muscle contractions. 30-60mg I.V. will produce a flaccid paralysis.

(d) Remove Dentures- if patient has any

(e) Empty bladder – because of incontinence resulting form the seizures.

(f) Because the muscle relaxant paralyses the muscles of respiration, it is usually necessary to assist respiration mechanically and through the use of oxygen during a brief period of Post-Convulsant apnea.

AN ANAESTHETIST SHOULD BE IN ATTENDANCE SINCE PROLONG APNEA OR LARYNGEAL STRIDOR MAY OCCUR

The anaesthetist administers 100% oxygen form the onset of unconsciousness until spontaneous respiration resumes.

NOTE: The above points (b-f) under preparation of patient are applicable when giving MODIFIED E.C.T.

PROCEDURE: (Take note to trolley-setting in the ward).

The Nurse prepares the E.C.T. trolley with the necessary materials including- the E.C.T. apparatus. The Nurse checks all emergency equipments- including oxygen and suctions machines.

Either the patient's bed (Preferably with a hard mattress or a couch can be used). E.C.T. may be given in the operating room or in a specially equipped room in the inpatient or outpatient Psychiatric setting.

The E.C.T. machine is connected to MAINS (Electricity) and the electrodes to the "Output" section of the E.C.T. machine. Patients is given Pre-Operative injections if he's to be given MODIFIED ECT and an Anaesthetist should be in attendance with the oxygen apparatus or resuscitator.

Patient is allowed to lie on his back with the back (Pelvix) supported with a hard pillow; and the arms stretched on wither sides of patient. A bed sheet is spread to cover the patient leaving the patient's face and toes. The nursing staff hold the bedsheet tightly on either sides of the patient. A rubber MOUTH-GAG is put with in patient's movement most be properly controlled during the fit to prevent fractures.

Current of 70-130 volts is provided through 2 electrodes which are positioned on the patient's temples. The "shock" is given by the psychiatrist. An electric timer is provided to vary the duration of shock from 0.1-05 second. The optimal dosage is the lowest current for the shortest time that will produce a grandmal or generalised tonic and clonic convulsion. A seizures usually lasts 5-20 seconds, with a brief postictal state.

Placement of electrodes may be bitemporal, unilateral on the nondominant side. The latter is considered to produce less impairment of memory although it may be slightly less effective and required more that the usual 9-12 treatment. The electrodes are enclosed in lint pads in 30 per cent saline during each procedure.

After the convulsion, patient is turned to one side and a clear air-way is ensured.

3.6 **Post-Operative Care**

During the period immediately after E.C.T. the patient required close nursing observation in recovery area. Emergency equipment should be readily available.

Patient vital sign, especially the pulse is checked form time to time. Ensure clear air-way.

Ideally, a qualified staff remain with the patient who has harrd E.C.T. to monitor his condition until he recovers fully from treatment. If he is left unattended, he may roll form the recovery bed to the floor or stumble around the recovery room, during waking confusion. Assist patient to ambulate when vital signs are stable.

3.7 **Post-Operative Complications**

Post-operative complications after administrations of E.C.T. are common especially when 'straight' E.C.T. is given; and they include:

1. Headache
2. Loss of memory (which is temporary)
3. Backache
4. Dislocation (of the Jaw and Joint)
5. Fracture (of long bone, and thoracic vertebral compression).

a. E.C.T. remains a bulwark of modern psychiatry, - safe, easy and effective. It supercedes medication (or they can be given together in critical depressions or unresponsive agitations. It has no place in treatment of neurosis.

b. E.C.T. can now be given to patient or selected outpatients with a minimum of preparation. Small, portable E.C.T. apparatuses are available that operate on 110volts off alternating current and are equipped with a rheostat to deliver 70-130 volts.

It is customary to give 2-3 treatments a week until substantial improvement occurs and then 3 or 4 treatments to complete the course.

A minimum or 6 treatment, an average of 9 treatments, and maximum of 25 treatments are considered normal limits for a course of treatment. Patient's conditions (Physical and mental state) is a reviewed within the course of treatment.

(c) Since effective antidepressant drugs becomes available, most Psychiatrists have preferred to try a course of drug therapy before suong shock therapy unless there is an urgent reason why he must be returned as soon as possible to his role as family bread winners or other critical position.

(d) Antidepressant drugs do not become maximaly effective for 3 weeks or more after beginning therapy, whereas the patient is sometimes restored to nearly normal functions within 7-10 days after E.C.T.

(e) Because of the period of impaired memory associated with E.C.T. the patient receiving a course of treatment should be advised against making important business decision until fully recovered. Also, if he receiving treatments on an ambulatory or outpatient basis, he should be under someone's supervision while travelling back to his home after treatment.

(f) An insufficient voltage will produce momentary loss of consciousness (sub-shock) but no convulsion, while several sub-shocks may produce a cessation of breathing and collapse. Breathing can generally be restored by pressure on the thorax (or administration of oxygen by an anaesthetist). For elderly patients and those liable to marked cyanosis after the fit, 5 per cent CO_2 in oxygen given in B.L.B. mark is useful.

It has been observed that fits produced intellectual impairment and to induce fits unnecessarily to reduce the patient's level of intelligence without any advantages to him.

(g) Characters disorders, neurotic states and chronic Schizophrenia do not themselves respond to shock therapy, but an excited, depressed or suicidal phase may develop in the course of nay of these illnesses and may best treated with E.C.T.

With proper care, E.C.T. has a mortality rate of no more than one in 25,000 cases and is one of the safest treatments in medicine

4.0 **Conclusion**

ElectroConvulsive Therapy should be seen as being similar to a surgical operation. Thus, the patient must be adequately prepared to avoid and to reduce post treatment complications.

5.0 Summary

The learners have gone through the meaning of ElectroConvulsive Therapy, indications, contraindications of ElectroConvulsive Therapy, preparation of patient for ElectroConvulsive Therapy (pre and post), and complications of ElectroConvulsive Therapy in this unit, this will enhance your adequate preparation for greater task ahead of you as a nurse.

6.0 Tutor Marked Assignment

Discuss how post ElectroConvulsive Therapy complications can be prevented or reduced.

7.0 References / Further Readings

Adedotun, A. 2000. Basic Psychiatry and Psychiatric Nursing. Ile-Ife: Basag (Nig) Enterprises.

Altschul, A. and Davis, D. L. 1960. Aid to Psychiatric Nursing. London:Baillaire, Tindall and Cox

Greist, J. H., Jefferson, J. W. and Spitzer, R. C. 1982. Treatment of Mental Disorders, London: Oxford University Press.

Gunderson, J. and Mosher, L. 1975. Psychotherapy of Schizophrenia. Jason: Arouson.

Mereness, D. A. and Taylor, C. M. 1978. Essentials of Psychiatric Nursing, 10th Ed. New Delhi: Mosby Comp.

Unit 16: Rehabilitation

Contents

1.0 Introduction

Psychosocial rehabilitation is a way of assisting people with mental health problems to readjust and adapt to life in the community. In these settings, nurses are able to use their full range of skills without the focus being placed on illness or disability. Wellness, wholeness and the abilities of the individual are emphasized. Vocational, educational, residential, social, and personal adjustment services are offered. This unit will take the learners through the meaning of rehabilitation, team approach to rehabilitation, essence of rehabilitation, nurses' role and psychosocial aspects of rehabilitation.

2.0 Objectives

At the end of this unit, you should be able to:

- describe the concept of rehabilitation
- explain team approach to rehabilitation
- state the essence of rehabilitation
- list the nurses' role in rehabilitation
- discuss the psychosocial aspects of rehabilitation

3.0 **Main content**

3.1 **Introduction**

Definition:

1. Rehabilitation means restoring of the function of the mind or body, the maintenance of such health when once restored and the resettlement of the individual in the outside world in a job.

2. Rehabilitation may be defined as a process of assisting a physically disabled, chronically ill, or convalescent person to realize his particular goals in living and working to the utmost of his potential.

This process involves various aspects of the individual's social economic, mental and physical functioning, and it includes almost all those receiving health care.

The word "rehabilitation' itself means "retraining" or 'restoring" in contrast to the word "habilitation", which refers to the initial capacity for living. For example, when a baby first tries to learn to walk, the process is habilitation, but when an individual learns to walk again, it is rehabilitation.

Rehabilitation actually begins as soon as a patient place himself under medical care, and not when he has recovered and is awaiting discharge from hospital. Once the patient has begun to recover, the question of his work in the outside world must be considered. In many cases the patient has lost his job on entering hospital, whilst in others the job is unsuitable and for this reason it is often necessary to train the patient for a new job.

3.2 **Team approach to rehabilitation**

Rehabilitation usually comprises a number of special health services that may be made available to the individual patient on the basis of his particular need. Personal representing these special services include:-

- The physician
- The nurse It may include: Occupational Therapist Psychiatrist
  Speech therapist
  Social worker
  Psychologist.

Both the patient and patient's relatives (family) play active role in the rehabilitation process of the patient.

Because rehabilitation is a complex process involving patient and a number of professional personnel, a team relationship usually provide the structure through which each member can make his special knowledge and skills available for the greatest benefit to the patient. The team evaluates the patient's need for rehabiliattiona dn develops a plan whereby he may receive maximum assistance in achieving his rehabilitation goals. The success of the team depends on the patient who is also a key member of the team.

3.3 **Essence of Rehabilitation**

Rehabilitation is designed to reduce the severity of symptoms and possibly the number of deaths associated with illness and to restore the function lost through disease. In psychiatry, rehabilitation is important in patients with chronic mental disorder (e.g. dementia and schizophrenia). It has been shown that stressful life events exacerbate the course of schizophrenia, leading to acute relapses and accelerated decline in social functioning. Interviewing with patients and their families (e.g. with counseling or psychotherapy) following a stressful life even is both a form of secondary prevention of an acute relapse and tertiary prevention of further deterioration. In chronically institutionalized patients, the decline in social functioning associated with routinized behaviour and neglect in some long-term residential settings (called "chronic social breakdown" of institutionalism) can be reversed by active psychosocial rehabilitation in the form of stimulation, changes in routine, and activities therapy or occasionally, by release to less restrictive residential (Gruenberg, 1980). This form of tertiary prevention so encouraged the field of institutional psychiatry that it stimulated dramatic changes in the delivery of mental health services.

3.4 **Community Health Practitioner's role as a member of the rehabilitation team**

The community health practitioner can make a valuable contribution to the effectiveness of the rehabilitation team.

a. She may stimulate development of motivation through her attitude of respect for the patient and her confidence in his ability to return to the highest level of independence possible for him.

b. Through the community health practitioner, supportive relationship with the patient she observe, listens, and evaluates and so may be able to contribute pertinent information about the patient's condition and progress – that might not otherwise be available to the team.

c. The longer contact that community health practitioner has with be patient often provides the opportunity for her to act as a coordinator in planning the patient's day – thus enabling other team members to schedule their special rehabilitation service more effectively for the welfare of the patient.

d. The community health practitioner may be a helper to other team member. For example, the physical therapist may enlist the help of the community health practitioner in maintaining correct body alignment and in carrying out some of the frequently repeated exercises to achieve the best therapeutic results.

3.6 **Psychosocial aspects of rehabilitation**

a Motivation of the patient is one of the most different problems the community health practitioner will have to solve. The patient often stresses the abilities that he had lost rather than those which remain. In some instances, a disability means that the patient will have to recognize his entire life, whereas in others he may be able to return to his former routine, with some modifications. To be motivated, the patient must have hope. This hope must be of the realistic type, nei their the patient nor his family should set unrealistic goals. The patient should be encouraged to engage in some creative thinking of his own.

b. Unless the present abilities of the patient are stressed, he may develop a feeling of inferiority. His psychologic changes may be greater than the physical changes. The community health practitioner can help him gain faith in himself by encouraging him to do whatever he can.

c. Both the community health practitioner and family need to understand the emotional aspect of the patient's condition. Fear itself is a large factor. The patient often has fears of not being accepted by his family, his friends, or society and also has fears concerning his new limitations and of the future in general. A patient who is worried and afraid may express his feelings in a multitude of ways. However, he

may not be able to express these feelings as fears or anxiety. If they are not expressed as fear and worry they may appear as irritability frustration, hostility, depression, embarrassment or shame.

Application of the behavioural principle that the individual reacts to a situation as he perceives it, regardless of reality or of how others see the situation and is therefore susceptible to errors or distortions in his perceptions, will assist the nurse in trying to understand the patient's behaviour as she works with him.

d. An important point in health care for the patient undergoing rehabilitation is to encourage him to do all that he can for himself. Allowing sufficient time for his slow movements will avoid the impression that he's inadequate merely because he cannot do something quickly.

When the patient cannot perform acts for himself, he then should be allowed to make as many decisions as possible. He should be allowed to make as many decisions as possible. He should be encourage to start planning his care in such a way that the routine will be continued at home.

e. In order for the patient to make plans for the future, he may need to talk with the nurse to clarify his own ideas and to be reassured that his plans are realistic, that is, if they are realistic.

The family, too may need assistance in recognizing accepting and solving future problems.

It will be seen, therefore that not only is it the duty of those looking after a patient to effect his recovery in hospital but also to resettle him in the outside world in reasonable environmental conditions and to follow the patient up after leaving the hospital. In this way much can be done to prevent relapses and to produce a healthier atmosphere in the home in which the future generation is to be brought up.

4.0 **Conclusion**

Self-help is a fundamental concept of psychosocial rehabilitation. The belief that all people have the inherent capacity for change and the focus on what the client can do resulted in some remarkable successes. Community

health practitioner who practice within these settings truly work with persons in their environment to maximize wellness.

5.0 Summary

You have learnt greatly in this unit and now you can answer the tutor marked assignment here under.

6.0 Tutor Marked Questions

(1) List the members of the team rendering rehabilitation
(2) Describe the psychosocial aspects of rehabilitation

7.0 References / Further Readings

Morrison-Valfre, M. 2005. Foundations of Mental Health Care, Missouri: Mosby Inc.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.

Unit 17: Behavioural Syndromes

Contents

1.0 Introduction

Psychophysiological or psychosomatic disorders are organic dysfunctions in which emotional disturbances presumably play an important aetiologic or contributory role. The autonomic nervous system is most frequently involved. The organic symptoms are actually produced or aggravated by emotional disorders and not symbolic substitutes for them, as in the neuroses. The phenomenon "somatization" is a process whereby an individual's feelings, emotional needs, or conflicts are manifested through physical symptoms. This process inevitably occurs when the emotional state is intense and supports the widely accepted belief that the functions and reactions of the mind and body are inextricably related.

2.0 Objectives

At the end of this unit, you should be able to:

- describe the concept "psychophysiological" and neurotic disorders
- list common examples of "psychophysiological" disorders
- discuss eating disorders
- explain sleep disorders and their management

3.0 Main content

3.1 Psychophysiological / Psychosomatic Disorders

The word 'psychosomatic' means mind and body, Psychosomatic disorders are those disorders in which the psychic elements are significant

for initiating chemical, physiological or structural alterations, which in turn create the symptoms in the person.

The term ‘psychosomatic’ has now been replaced with ‘psychosomatic’.

There are three factors which must be present simultaneously for a person to develop a ‘psychosomatic’ disorder;

1. The individual must have “biological predisposition”.
2. The individual must have ‘psychosomatic vulnerability”
3. The individual must experience a significant psychosocial stress in his/her susceptible personality area.

3.1.1 Common Examples of psychophysiological disorders.
Franz Alexander, the father of psychosomatic medicine, described seven classical psychosomatic illnesses.

Cardiovascular disorders

Essential hypertension
Coronary artery disease
Post-cardiac surgery delirium
Migraine
Mitral valve prolapse syndrome

Endocrine disorders

Diabetes mellitus
Hyperthyroidism
Cushing’s syndrome
Pre-menopausal syndrome
Amenorrhea
Menorrhagia

Gastrointestinal disorders

Esophageal reflux
Pepticulcer
Ulcerative colitis
Crohn’s disease

Immune disorders

Autoimmune disorders, e.g. systemic lupus erythematosus
Allergic disorders, like bronchial asthma and hay fever.
Viral infections.

Musculoskeletal disorder

Rheumatoid arthritis

Respiratory disorders

Bronchial asthma
Hay fever
Rhinitis

Skin Disorder

Psoriasis
Pruritus
Urticaria
Acnevulgaris
Warts

3.1.2 **Treatment**

1. Relaxation techniques: This is one of the most important methods aimed at reducing anxiety or restlessness. They include:
* Jacobson's progressive relaxation technique.
* Yoga
* Auto hypnosis
* Meditation
* Bio-feedback
2. Behaviour modification techniques.
3. Individual therapy
4. Group therapy

3.1.3 **Management**

Assessment

Perform thorough physical assessment
Monitor laboratory valves, vital signs, intake and out put and other assessments necessary to maintain an accurate on going appraisal.
Assess patient's level of anxiety.

Assess patient's level of knowledge regarding effects of psychological problems on the body.

Diagnoses

Ineffective individual coping related to repressed anxiety and inadequate coping methods, evidenced by initiation or exacerbation of physical illness.

Knowledge deficit related to psychological factors affecting physical condition, evidenced by various physical problems.

Interventions

Encourage patient to discuss current life situations that the perceives as stressful, and the feelings associated with each.

Provide positive reinforcement for adaptive coping mechanisms identified or used. Suggest alterative coping strategies but allow patient to determine which can most appropriately be incorporated into his life style.

Help patient to identify a resource person within the community (friend or significant others) to use as a support system for the expression of feelings.

Have patient keep a diary of appearance, duration, and intensity of physical symptoms. A separate record of situations that the patient finds especially stressful should be kept.

Help patient identify needs that the being met through the sick role. Together, formulate more adaptive means for fulfilling these needs practice by role-playing.

Provide instruction in assertive techniques, especially the ability to recognize the differences among passive, assertive, and aggressive behaviours and the important of respecting the rights of others while protecting one's own basic rights.

Discuss adaptive methods of stress management, such as relaxation techniques, physical exercises, meditation and breathing exercises.

3.2 **Eating disorders**

The two most important eating disorder are;

Anorexia nervosa, and

Bulimia nervosa

3.2.1 **Anorexia Nervosa**

Anorexia nervosa is characterized by highly specific behavioural and psychopathological symptoms and significant somatic signs. Majority are females and the onset is during adolescence. The core psychopathological feature is the dread of fatness, weight phobia and a drive for thinness.

Etiology

b. Genetic causes: Among female siblings of patients with established anorexia nervosa, 6-10 percent suffer from the condition compared to the 1-2 percent found in the general population of the same age (Strober, 1995).
c. A disturbance in hypothalamic function.
d. Social factors: There is a high prevalence of anorexia nervosa among female students and in occupational groups particularly concerned with weight (for example, dancers). Influence of mass media, beauty contests are other important social causes.
e. Individual psychological factors; A disturbance of body image, a struggle for control and a sense of identify are important factors in the causation of anorexia nervosa. Traits of low self esteem and perfectionism are often found.
f. Causes within the family: Disturbance in family relationships, over protection, family members having an unusual interest in food and physical appearance.

Clinical features

There is an intense fear of becoming obese. This fear does not decrease even if the person loses weight grossly and becomes very thin.

The body weight is 15 percent below the standard weight.

There is a body image disturbance. The patient is unable to perceive the body size accurately.

The pursuit of thinness may take several forms. Patients generally eat little and set themselves daily calorie limits (often between 600 and 1000 calories). Some try to achieve weight loss by inducing vomiting excessive exercise, and misusing laxatives.

Other signs and symptoms are secondary to starvation and include sensitivity to cold, delayed gastric emptying, constipation, low blood pressure, bradycardia, hypothermia and amenorrhea in females.

Vomiting and abuse of laxatives may lead to a variety of electrolyte disturbances, the most serious being hypokalemia.
Hormonal abnormalities also may be seen.

Course and prognosis

Anorexia nervosa often runs a fluctuating course with periods of exacerbations and partial remissions. Outcome is very variable.

Treatment

Pharmacotherapy

Neuroleptics
Appetite stimulants
Antidepressants

Psychological therapies

Individual psychotherapy
Behaviouarl therapy
Cognitive behavior therapy
Family therapy.

Interventions

Short-term management is focused on ensuring weight gain and correcting nutritional deficiencies. Maintaining normal weight and preventing relapses long-term goals to be achieve.

Hospitalization is usually required and successful treatment depends on good care, with clear aims and understanding on the part of the patient as well as the nurse.

Eating must be supervised by the health practitioner and a balanced diet of at least 3000 calories should be provided in 24 hours

In the early stages of treatment, it is best for the patient to remain in bed in a single room while the health care practitioner maintains close observation. The goal should be to achieve a weight gain of 0.5 to 1 kg per week.

Weight should be checked regularly. Monitor serum electrolyte levels and signs and symptoms like amenorrhea, constipation, hypoglycemia, hypotension, etc.

Control vomiting by making the bathroom inaccessible for at least 2 hours after food.

In extreme cases when the patient refuses to eat and comply with the treatment, gavage feedings may need to be instituted.

3.2.2 **Bulimia Nervosa**

Bulimia Nervosa is described as repeated bouts of overeating and a preoccupation with control of weight that leads to self induced vomiting.

Clinical feature

An irresistible craving for food: there are episodes of overeating in which large amount of food are consumed within short-periods of time (eating binges)

Attempt to counteract the effects of overeating by self-induced vomiting.

There is usually no significant weight loss.

Treatment

Antidepressants, carnbomazepine and lithium for patients with co-morbid mood disorders.

Group therapy

Family therapy

Cognitive behaviour therapy.

3.3 **Sleep disorders**

Sleep can be regarded as a physiological reversible reduction of conscious awareness.

Sleep disorders are divided into subtypes:

3.3.1 **Dyssomnias**

* Insomnia
* Hypersomnia
* Disorders of sleep wake schedule

2. Parasomnias

* Stage IV disorder
* Other disorders

3.3.1 **Dyssomnias**

Insomnia

Insomnia is disorder of initiation and maintenance of sleep. This includes frequent awakening during the night and early morning awakening.

Causes

Medical illnesses

Any painful or uncomfortable illness
Heart disease
Respiratory diseases
Brain stem or hypothalamic lesions
Delirium
Rheumatic and other musculoskeletal disease
Periodic movements in sleep
Old age.

Alcohol and drug use

Delirium tremens
Amphetamines or other stimulants
Chronic alcoholism

Psychiatric disorder

Mania (due to decreased and for sleep)
Major depression (early morning awakening or late insomnia)
Dysthymia or neurotic depression (difficulty in initiating sleep or early insomnia)
Anxiety disorder (difficulty in initiating sleep due to worrying thoughts).

Social causes

Financial loss
Separation or divorce
Death of spouse or close relative
Retirement
Stressful life situations

Behavioral causes

Naps during the day
Irregular sleeping hours
Lack of physical exercise
Excessive intake of beverage in the evening, e.g. coffee.
Disturbing environment (heat, cold, noise).

Treatment

A thorough medical and psychiatric assessment, polysomnography may be needed in some cases.

Treatment of underlying physical or psychiatric disorder.

Withdrawal of current medications, if any.

Transient insomnia can be treated initially with hypnotics.

Non-drug treatment for insomnia

Progressive relaxation

Autosuggestion

Meditation, yoga.

Stimulus control therapy: do not use the bed for reading or chatting – go to bed for sleep only.

Sleep hygiene

Regular; daily physical exercise in the evening

Avoid fluid intake and heavy meals just before bedtime.

Avoid caffeine intake (e.g. tea, coffee cola drinks) before sleeping hours.

Avoid reading or watching television while in bed.

Back rubs, warm milk and relaxation exercises.

Sleep in a comfortable environment.

3.3.2 **Hypersomnia**

Hypersomnia is known as Disorder of Excessive Somnolence (DOES). It includes excessive daytime sleepiness, sleep attacks during daytime, sleep drunkenness (Person needs much more time to awaken, and during this period he is confused or disoriented).

Causes

Narcolepsy – excessive daytime sleepiness characterized by:

sleep attacks

Cataplexy – sudden decreased or loss of (sleep paralysis) muscle tone, often generalized and may lead on to sleep.

Sleep paralysis – it occurs either at awakening in morning or at sleep onset. The person is conscious but unable to move his body.

Hypnagogic hallucinations

3. Sleep apnea: Repeated episodes of apnea during sleep.
4. Kleine-Levin syndrome; periodic episodes of hypersomnia.

3.4 **Disorder of sleep-wake schedule**

The person with this disorder is not able to sleep when he wishes to, although at other time he is able to sleep adequately.

Causes

- Work shifts
- Unusual sleep phases

Parasomnias

In this the person frequently wakes during sleep

Stage IV sleep disorders

- Sleep walking (Somnambulism)
- Night terrors
- Sleep-related enuresis
- Bruxism (tooth-grinding)
- Sleep talking (somniloquy).

Other sleep disorders

- Nocturnal angina
- Nocturnal asthma
- Nocturnal seizures
- Sleep paralysis.

3.5 **General management of client with psychophysiological disorders**

A. Medical care
B. Medical treatment
A. Medical care

i. **Emotional care**

The community health practitioner must fully understand and accept the fact that this person is physically ill and that his symptoms may reach life-threatening proportions. This health practitioner must not indicate the attitude that patient will get over his problems if he merely exerts more control over his emotions. During the acute episodes of his illness, meeting the physical needs of the patient is of primary importance, even if in so doing the health practitioner is supporting dysfunctional emotional adaptation.

The basic emotional needs of patients with psychological disorders and physical disorder are the same. To differentiate between them would be artificial and unrealistic. Therefore understanding the fact that patient with psychosomatic disorder have both psychological and physical disorder, their problems should be well understood and adequate nursing care given. Relate positively with the patient. The community health practitioner must therefore support the patient emotionally making herself available at the needs or expectations of the patient.

The community health practitioner should develop a warm, accepting atmosphere in the ward – which is one of the major therapeutic contributions of the nurse. The community health practitioner cares for the physical and psychological problems.

ii. **Physical care**

Most physical illness, regardless of cause, present a potential threat to the person's perception of himself as an independent adult. In the case of persons with psychophysiogical disorder, there often are underlying conflicts between dependency and independency needs, and the imposed dependence that results from the illness may stimulate a high degree of anxiety in the patience.

In such instances the nurse can be helpful if she meets the patients needs for dependence in an indirect way while simultaneously acknowledging his status as a responsible adult. An example of such an intervention is the nurse who wisely addresses the client with a Peptic ulcer as Mr. Smith instead of Michael.

Good personal hygiene should be ensured. Give or encourage patient to bath, change bed linens when necessary and do oral toilet adequately. All these make patient clean and he is psychologically relieved and happy.

iii. **Communication**

Since patient's problem is both physical and psychological, there is no more important task for the community health practitioner than listening to the patient in a positive, dynamic emphatic way without at the same time giving advice, stating opinions or making suggestions. Thus, the nurse by listening to the patient is able to collect a lot of information related to patient's illness and this helps her approach to care of the patient.

The community health practitioner has many opportunities to engage in conversation with the hospitalized patient. She can be of emotional assistance to him if she encourages him to talk about his feelings. It must be understood, however, that many of the patient's feelings are acceptable to him and therefore acceptance of him and his feelings by the nurse is of primary importance. As in communicating with any client, the community health practitioner is most helpful when she is accepting and nonjudgmental.

iv. **Control of Anxiety**

The patient suffering from a psychophysiological disorder can be helped to feel in control of his situation by adequate explanations of what he can expect to experience during diagnostic and treatment procedures. Some patients however, become increasingly anxious if they are given too much information, and their dependence needs are best met by trusting in the judgment of their physician and nurse. Therefore the amount and nature of information offered to the patient should be primarily determined by an assessment of his anxiety level. Certainly the patient's questions would be answered, but the degree of elaboration necessary should be gauged by his response to the answer rather than by the health practitioner's need to engage in health teaching.

v. Diet

Patient's food should be attractively served. He should be encouraged to take his food; but where need be – to be helped by the nurse. Good food improves patient's condition physically and physiologically.

vi. **Provision of Activity**

As patient's condition improves, he should be encourage to engage in indoor and outdoor games. This relieves boredom, improves patients physical and mental capabilities, and ensures harmony, confidence and understanding between the staff and patient.

Such indoor games like – draft, "Ayo" 'Ludo' and outdoor games like footballing, Lawn-Tennis etc. are adequate for this purpose. Patient could also engage in occupational therapies.

B. **Medical Treatment**

1. Psychotherapy: Psychotherapy is still the customary way of treating these disorders. Irrespective of the therapist's philosophic orientation, the relationship with the therapist in individual therapy is

anxiety – reducing and effective when the therapy deals with the conflict producing the anxiety. The therapist who can help the patient delineate specific alternatives to unproductive or harmful ways of dealing with problems. In some cases psychoanalysis is helpful.

2. Drug: Other drugs – Antipsychotic agents and barbiturates have many side effects.
    i. Sedatives are effective in reducing anxiety.
    - Benzodiozepines are the sedatives of choice in most cases (e.g. Chlordiazepoxide = Librium, 5 – 30mg/d orally.
    ii. Tricycline and new cyclic antidepressants as well as monoamine oxidase inhibitors have been quite effective in the treatment of panic attacks (e.g. imipramnie, 75-150mg/dly. Orally) but less so in blocking phobic-avoidant behaviour.

3. Rehabilitation: Working with the patient's family is necessary to aid them in understanding the complexity of his illness and its treatment.

4.0 Conclusion

Treatment of psychosomatic disorders from the psychiatric view point is challenging. Organic disease, when psychogenically determined, constitutes one of the most rigid character defenses. Often, patients do not show demonstrable anxiety. When anxiety is present it is frequently associated in the patients' minds with concern about their physical condition.

5.0 Summary

I am sure found this unit very insightful like the previous ones. In this unit, we have gone through psychophysiological/psychosomatic disorders, eating disorders and sleep disorders.

6.0 Tutor Marked Assignment

Discuss seven classical psychosomatic illnesses.

7.0 References / Further Readings

Morrison-Valfre, M. 2005. Foundations of Mental Health Care, Missouri: Mosby Inc.

Olatawura, M. O. 2002. Psychology and Psychiatry Lecture Series from Ibadan, Ibadan: Spectrum Books Ltd.