

LECTURE NOTES

For Nursing Students

Psychiatric Nursing



**Ethiopia Public Health
Training Initiative**

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In collaboration with the Ethiopia Public Health Training Initiative, The Carter Center,
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PREFACE

In low-income countries where morbidity and mortality due to malnutrition and preventable infectious diseases are very common, mental disorders, which are not regarded as life-threatening problems, are considered to be insignificant and unworthy of attention. Since Ethiopia is one of the poorest countries in the world, providing high standard mental health services to the needy people is not an easy task and the situation reflects the lack of attention indicated above.

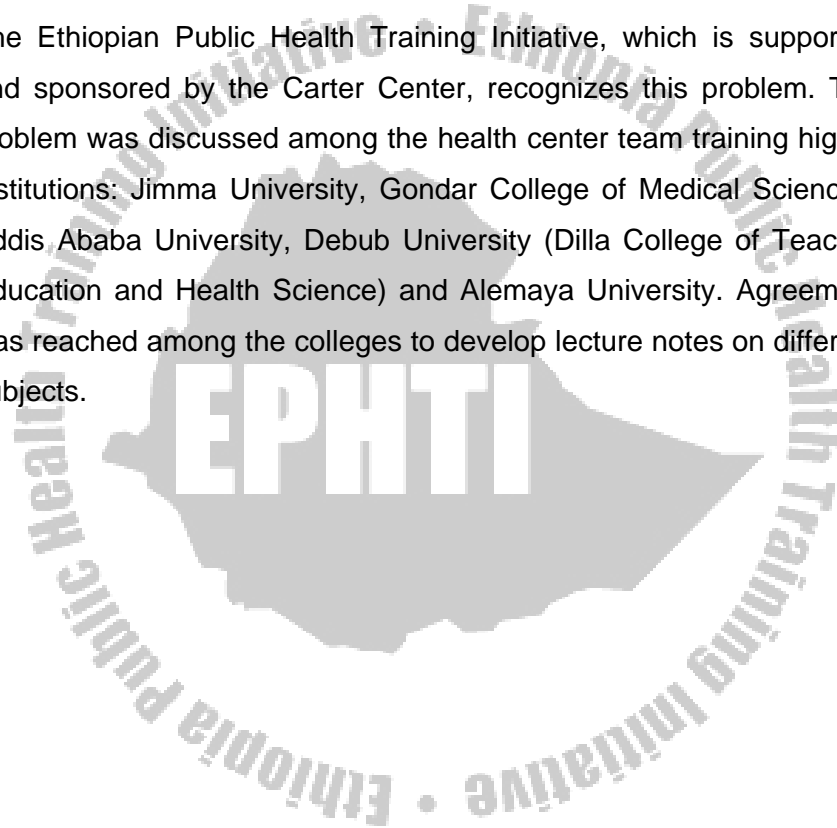
The training of psychiatric nurses who are well equipped in the profession is the priority issue for the higher teaching institutions and service giving organizations, in order to respond to the country mental health need.

To fulfill this need, a need based training program, which is target oriented and task based as well as community based training has been established to tackle the major mental health problems of the nation.

However, majority of Ethiopia's higher learning institutions that are training public health nurses in diploma programs experience a critical shortage of teaching staff trained in psychiatric nursing and equipped to teach health center teams and of teaching learning materials appropriate to the needs of students and scope of their studies. Most classroom lectures are based on western textbooks, which lack relevance to the developing world context in many aspects. The

practice outlined and the general focus of the books are not appropriate to developing countries and leave the students and instructors in a difficult situation in relation to practice with in Ethiopia. It is recognized that this type of dependence has many disadvantages.

The Ethiopian Public Health Training Initiative, which is supported and sponsored by the Carter Center, recognizes this problem. The problem was discussed among the health center team training higher institutions: Jimma University, Gondar College of Medical Sciences, Addis Ababa University, Debu University (Dilla College of Teacher Education and Health Science) and Alemaya University. Agreement was reached among the colleges to develop lecture notes on different subjects.



ACKNOWLEDGMENTS

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I would like to express my great gratitude to my wife W/ro Selamawit Tekaligne for her support and tolerance during my absence from home during weekends and journeys far from home to work while developing this material.

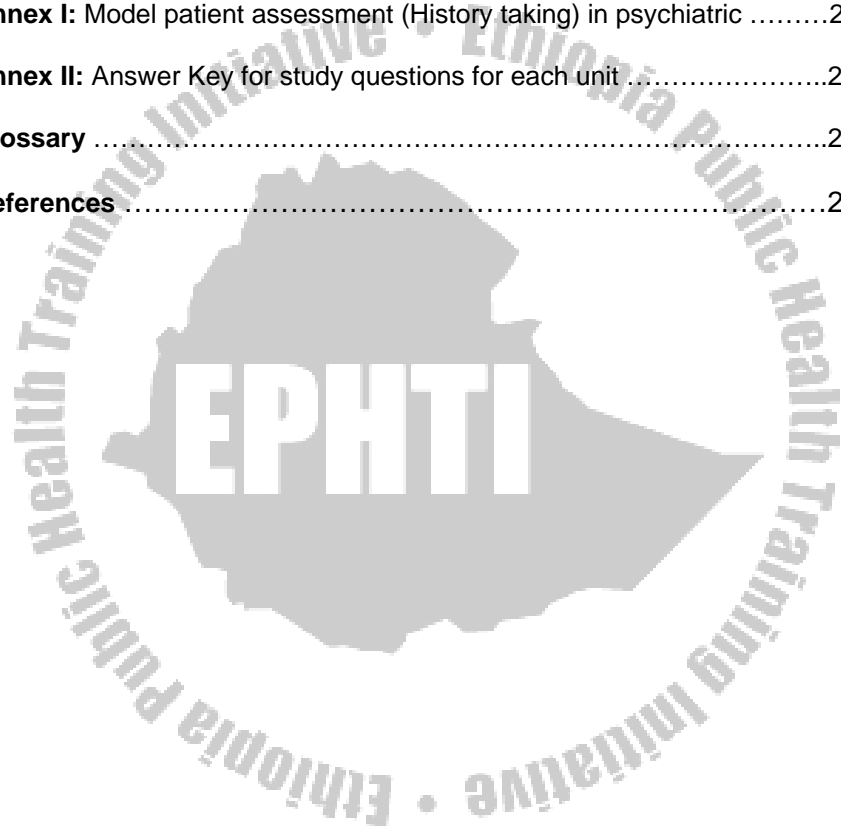
I am highly indebted to my students whose inquisitive minds and positive challenge which have motivated me to prepare this teaching material.

Last but not least I would like to thank W/t Tigist Nega for her cooperation in writing the first draft of this manual.

TABLE OF CONTENTS

Preface	i
Acknowledgements	iii
Table of Contents	iv
List of Tables	vi
Introduction	viii
List of abbreviations.....	x
CHAPTER ONE: Introduction to Psychiatric Nursing	1
CHAPTER TWO: History and trends in psychiatric nursing	12
CHAPTER THREE: General technique in psychiatric Nursing.....	18
CHAPTER FOUR: Counseling techniques in psychiatric nursing	29
UNIT TWO: Classifications of Mental illnesses and specific mental illnesses.....	35
UNIT THREE: Affective Disorders (Mood Disorders)	60
UNIT FOUR: Schizophrenia.....	73
UNIT FIVE: Epilepsy (Seizure Disorders)	84
UNIT SIX: Organic Mental syndromes and Disorders (Cognitive disorders)	92
UNIT SEVEN: Child and Adolescent Psychiatry	111
UNIT EIGHT: Alcohol and other substance abuse	124
UNIT NINE: Defense Mechanisms	141

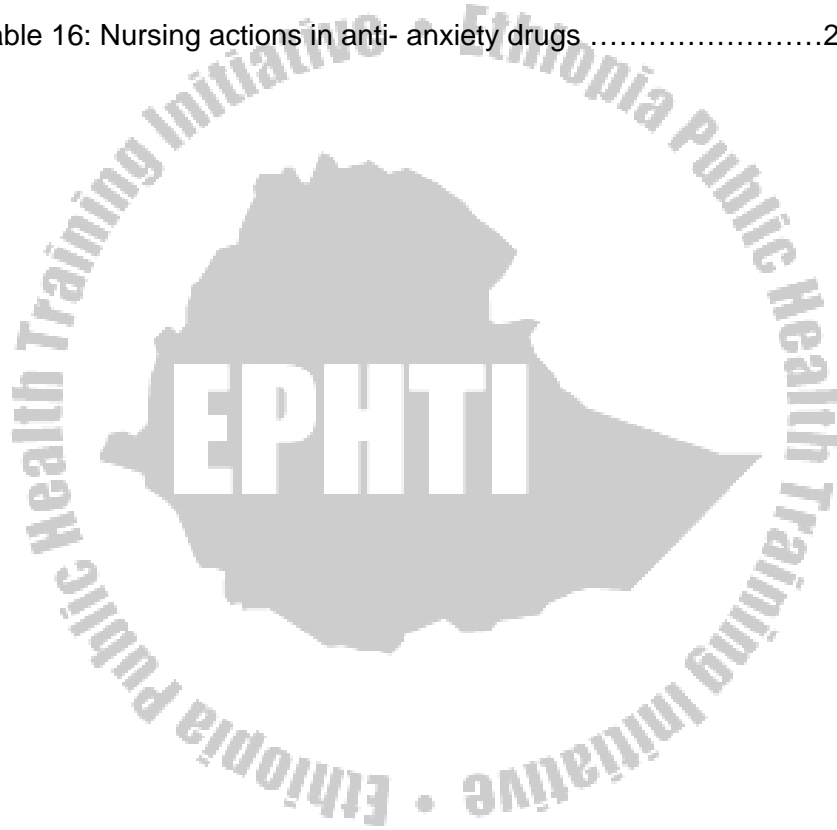
UNIT TEN: Personality Disorder	149
UNIT ELEVEN: Human Sexuality and sexual dysfunction	163
UNIT TWELVE: Psycho therapy	175
UNIT THIRTEEN: Psychopharmacology	191
Annex I: Model patient assessment (History taking) in psychiatric	215
Annex II: Answer Key for study questions for each unit	222
Glossary	231
References	236



LIST OF TABLES

Table 1: Comparative characteristics of a mentally healthy and a mentally ill person.....	7
Table 2: Jo-Hari's window of self.....	19
Table 3: Differences between neurosis and psychosis	52
Table 4: Nursing diagnosis and nursing interventions for patients with anxiety disorders	56
Table 5: Nursing diagnoses and nursing interventions for depressed and manic patients	70
Table 6: Nursing diagnoses and nursing interventions for patients with schizophrenic disorders.....	81
Table 7: Common nursing diagnoses and nursing interventions for organic mental disorders	108
Table 8: Nursing diagnoses and nursing intervention for withdrawal symptoms due to multiple drug abuse	138
Table 9: Examples of nursing diagnosis and nursing interventions for personality disorder	159
Table 10: Nursing diagnosis and interventions for patients who exhibit symptoms of sexual disorders	172
Table 11: Common phenothiazines antipsychotic drugs	193

Table 12: Commonly used anti psychotic agents198
Table 13: Commonly used anti depressant agents201
Table 14: Nursing actions: antidepressants203
Table 15: Commonly used anti anxiety agents (anxiolytics)211
Table 16: Nursing actions in anti- anxiety drugs212



INTRODUCTION

This lecture note on psychiatric nursing for nurses is designed to be used as a study and reference material by nurses, other categories of health students and teachers.

Each chapter in this manual contains the following components:

- (a) Objectives at the beginning of each chapter to guide students in their studies:
- (b) Study questions related to each chapter
- (c) A glossary for students to familiarize students with some new terms
- (d) A reference suitable for beginning students are listed at the end of the manual.

These lecture notes are intended to fill the gap created by the shortage and incompatibility of teaching and learning materials bring the colleges close together in terms of teaching and learning strategies to minimize variations. Hopefully this manual will alleviate the shortage of material and help to prevent and improve morbidity, disability and mortality caused as a result of accidents and disasters in all human environments in Ethiopia.

The Author was motivated to develop this teaching material based his ten years teaching and clinical experience in the field of psychiatric nursing in Alemaya University, Nekemte School of Nursing, Nekemte Hospital and Alemaya University student clinic. He

is glad to contribute to this particular profession by producing this teaching material which covers the university curriculum applicable in all higher teaching institutions and other training centers under the Ministry of Health as well as different regional states in Ethiopia. Nothing is left out from the standard, but in addition, some important content which will benefit students are added, for example, counseling in mental illness.

This teaching material is organized to thirteen units and the first unit is subdivided in to five chapters which are designed to assist the reader by its systematic and simplified organization.

Student readers are requested to this end to attend classes and take advantage of the support from their instructors so as their knowledge and skill of the subject area and their profession in general.

They are also advised to read about recent issues and advances from other references in order to keep up with new scientific knowledge on the subject.

This manual is designed to be covered by two credit hours lectures over a semester in the second year in the nursing course.

LIST OF ABBREVIATIONS

ABO	= Blood groups A,B and O
AWS	= Alcohol Withdrawal Syndrome
CNS	= Central nervous system
CPZ	= Chlorpromazine
CT scan	= Computerized tomography scan
CVS	= Cardio Vascular system
DSM-III R	= Diagnostic Statistical Manual of American psychiatrists Associations III Revised
ECG	= Electro cardiograph
ECT	= Electro convulsive therapy
GABA	= Gama amino butric acid
GIT	= Gastrointestinal Tract
I&O	= Input and Output
IM	= Intramuscular injection
IQ	= Intelligence quotient
IV	= Intra venus injection
JOMAC	= Judgment orientation memory affect and orientation
MOAI	= Mono Amine Oxidase inhibitor
PGA	=Psycho Galvanic Response
Kg	= Kilogram
MOH	= Ministry of Health

Mg = Milligram

MOAI = Mono amine oxidase inhibitor

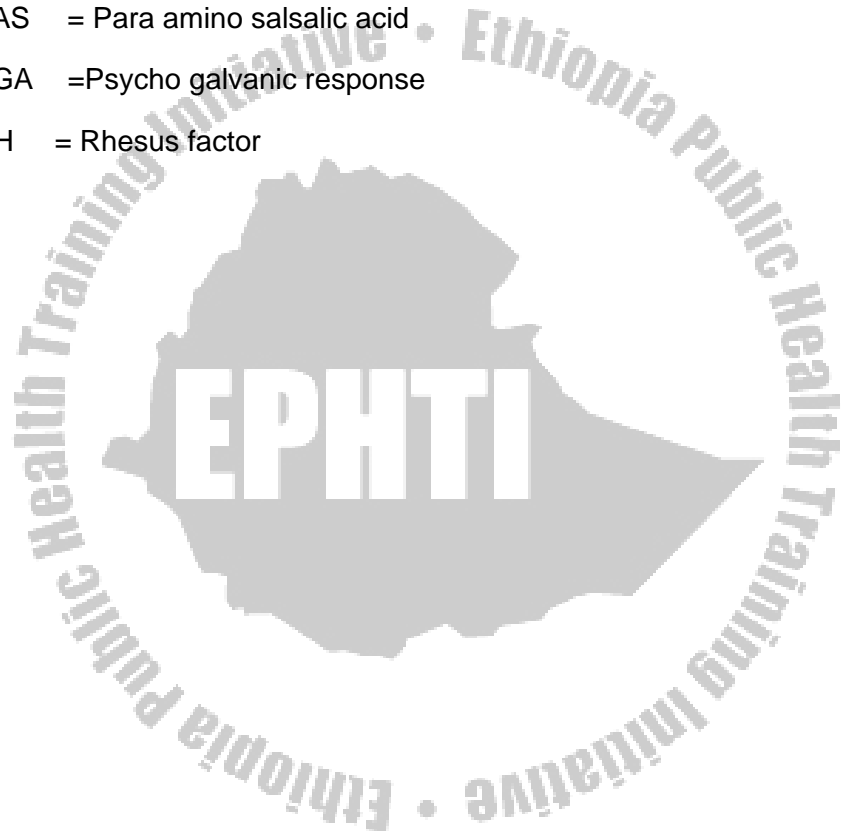
NPO = Nothing per os (mouth)

OPD = Out patient department

PAS = Para amino salicylic acid

PGA = Psycho galvanic response

RH = Rhesus factor



UNIT ONE

CHAPTER ONE

INTRODUCTION TO PSYCHIATRIC NURSING

Learning objectives

After studying this chapter, the student should be able to:

1. Define psychiatric nursing
2. Define common psychiatric symptoms and key terms in psychiatry
3. Describe normality
4. Describe mental illness
5. List the major criteria for the diagnosis of psychosis
6. Recognize the history and trends in psychiatric nursing
7. Describe general anxiety disorders and its sub classifications (clinical manifestations, differential diagnosis, diagnosis, treatment prognosis and complications)
8. List the sub-classifications of mental illness

Definition

Psychiatric nursing is the branch of nursing concerned with the prevention and cure of mental disorders and their sequel. It employs

theories of human behavior as its scientific frameworks and requires the use of self as its art or expression in nursing practice. (Urdang: 1983, p1901).

Common psychiatric symptoms and key terms in psychiatric nursing

1. Anxiety: A state of feeling uncertainty experienced in response to an object or situation.
2. Stress: A state of extreme difficulty, pressure or strain with negative effects on physical and emotional health and well-being.
3. Withdrawal: A state of habitual quiet and seeming un concerned with other people a focus on one's own thoughts.
4. Depression: A mood state characterized by a feeling of sadness, dejection (self dislike), despair, discouragement, or hopelessness.
5. Suicide: The act of killing oneself (self distracting behavior)
6. Neurosis: A condition in which mal adaptive behaviors serves as a protection against a source of unconscious anxiety.
7. Personality disorder: A non psychotic illness characterized by maladaptive behavior that the person uses to fulfill his or her needs and bring satisfaction to him or her self. As a result of the inability to relate to the environment, the person's actions conflicts socially
8. Hysteria (conversion disorder): The loss or impairment of some motor or sensory function for which there is no organic cause. Formerly known as hysteria or hysterical neurosis.

Psychiatric Nursing

9. Mental retardation: A disorder characterized by sub average intellectual functioning associated with or resulting in, the inability or impairment of the ability to think abstractly, adapt to new situations, learn new information, solve problem, or profit from experience.
10. Dementia: A diffuse brain dysfunction characterized by a gradual, progressive, and chronic deterioration of intellectual function. Judgment, orientation, memory, affect or emotional stability, cognition, and attention all are affected.
11. Trauma: A severe physical injury to the body from an external source; or a severe psychological shock.
12. Alcohol dependent: A person who can not break the habit of drinking alcoholic drinks too much, especially one whose health is damaged because of excessive alcohol intake.
13. Schizophrenia: A serious mental disorder characterized by impaired communication with loss of contact with reality and deterioration from a previous level of functioning in work, social relationships, or self care.
14. Paranoid disorder: A psychotic state characterized by moderately, or seriously, impaired reality testing, affect and sociability, accompanied by persecutory, grandiose, erotic or jealous content delusions.
15. Manic-depression: A mood disorder involving both mania and depressive episode.
16. Illusion: A false interpretation or perception of a real environmental stimulus that may involve any of the senses.

Psychiatric Nursing

17. Hallucinations: Sensory perceptions that occur in the absence of an actual external stimulus. They may be auditory, visual, olfactory, gustatory or tactile.
18. Delusion: False belief not true to fact ordinarily accepted by other members of the person's culture



Normality

What is normality?

It is often said that we are all 'a bit abnormal' is this true or nonsense? This question may be easier if the word 'normal' replaced by 'healthy' but the question remains whether it is normal to be a little unhealthy.

The difficulty which arises in answering these questions lies in the fact that 'normal' is used in more than one sense. It is sometimes employed for always or 'most usual' for example when considering normal height, normal weight and so on. In this sense, with regard to mental health, normality may be:

- A sense of well-being
- The use of sublimation as the main defense mechanism
- The ability to postpone present pleasures for future ones
- The presence of an intact sense of reality
- Good interpersonal relationship
- Optimal adjustment.

The activities of normal life in adults

Broadly speaking normal life, amongst other things involves the following activities:

- Adaptation to the work situation
- Leisure time activity
- Management of social contacts
- Adjustment to the opposite sex.

Mental health

It is difficult to define the idea of mental health without reference to society. It could be said that a person is healthy if he/she manages to deal with the demands made upon him/her by society in a way that is compatible with his/her idea both of society and of him/her self. He/she is ill to the degree that has failed in his/her adjustment to the demands either of society or his definition of him/her self.

This definition is not entirely satisfactory. There are those who deviate from the norms of society who are not mentally ill and the definition also gives rise to the impression that psychiatrists and psychiatric nurses are committed to maintain the status quo and preventing social change.

Mental illness

The definition of mental illness remains elusive and is usually based up on what constitutes socially accepted behavior norms. For example behavior that is normal in one culture may be considered abnormal in another culture.

Major criteria for the diagnosis of mental illness (Psychosis)

The criteria for psychosis include:

1. Bizarre behavior
2. Abnormal experience

3. Loss of reality contact
4. Lack of insight

Table 1: Comparative characteristics of a mentally healthy and a mentally ill person

MENTAL HEALTH	MENTAL ILLNESS
1. Accepts self and others	1. - Feelings of inadequacy - Poor self-concept
2. Ability to cope or tolerate stress. Can return to normal functioning if temporarily disturbed	2. - Inability to cope - Maladaptive behavior
3. Ability to form close and lasting relationships	3. Inability to establish a meaningful relationship
4. Uses sound judgment to make decisions	4. Displays poor judgment
5. Accepts responsibility for actions	5. Irresponsibility or inability to accept responsibility for actions
6. Optimistic	6. Pessimistic
7. Recognizes limitations (abilities and deficiencies)	7. Does not recognize limitations (abilities and deficiencies)
8. Can function effectively and independently	8. Exhibits dependency needs because of feelings of inadequacy

Psychiatric Nursing

9. Able to perceive imagined circumstances from reality	9. Inability to perceive reality
10. Able to develop potential and talents to fullest extent	10. Does not recognize potential and talents due to a poor self-concept
11. Able to solve problems	11. Avoids problems rather than handling them or attempting to solve them
12. Can delay immediate gratification	12. Desires or demands immediate gratification
13. Mental health reflects a person's approach to life by communicating emotions, giving and receiving. Working alone as well as with other, accepting authority, displaying a sense of humor, and coping successfully with emotional conflict.	13. Mental illness reflects a person's inability to cope with stress, resulting in disruption, disorganization, inappropriate reactions, unacceptable behavior and the inability to respond according to his expectations and the demands of society.

(Shives: 1990)

People who are mentally healthy do not necessarily possess all the characteristics of mental health listed. Under stress they may exhibit some of the traits of mental illness but are able to respond to the

Psychiatric Nursing

stress with automatic, unconscious behavior that serves to satisfy their basic needs in a socially acceptable way.



REVIEW QUESTION

1. In the context of mental health list at least six points the enable us to say someone is normal.
2. List some of the activities characteristics of normal life in adults human beings
3. Which of the following is not characteristic of a mentally healthy person?
 - a. Acceptance of self and others
 - b. Optimistic thinking
 - c. Inability to establish a meaningful relationship
 - d. Ability to delay immediate gratifications.
4. Identify the correct statements about criteria for the diagnosis of major mental illness.
 - a. Bizarre behavior is one of the criteria for the diagnosis of psychosis
 - b. Loss of reality contact is not a criteria for major mental illness
 - c. Loss of reality contact is an indication psychosis
 - d. Abnormal experience can be considered as criteria of psychosis.
5. Is it true or false that mentally health people may exhibit some of the traits of mental illness under stress but they are able to suspend to the stress with automatic, unconscious behaviors that serves to satisfy their basic needs in a socially acceptable why?

- a. True
- b. False



CHAPTER TWO

HISTORY AND TRENDS IN PSYCHIATRIC NURSING

Learning objectives

After studying this chapter, the student should be able to:

1. Recognize general history and trends in psychiatric nursing
2. Describe history and trends psychiatric nursing in Ethiopia

Mental illness began in the primitive age as human existence began: there is evidence that it existed at the time and attempts were made to treat it. It was thought to be caused by evil spirits entering and take over the body. People attempted to drive these evil spirits from the body through the use of incantations and magic. Some primitive tribes rejected their mentally ill and drove them from the community.

In the ancient civilization, Greeks, Romans and Arabs viewed mental deviations as natural phenomena and treated the mentally ill humanely. Care consisted of sedation with opium, music, good physical hygiene, nutrition and activity. The Greek philosopher Plato (429-348 BC) and the Greek physician Hypocrites (460-377 BC, known as the father of medicine), were concerned about the treatment of the mentally ill. Hypocrites described a variety of personalities and attempted to classify people according to their behavior

Psychiatric Nursing

In the middle ages (500 - 1450 AD) the Roman Empire fell (476 AD) the humanitarian ideas concerning the mentally ill were forgotten. People reverted to mysticism, witchcraft and magic. Sometimes, patients were humanely cared for by members of religious orders. However, the mentally ill were usually locked away in places where flogging, starvation, torture and blood letting were common.

During the renaissance (14th- 17th Century), the belief that mental illness was caused by evil spirit possessing the body continued to be a menace to proper care mentally ill people were often put in prison or society protected itself by locking the mentally ill in asylums where non-professional people were paid to care for them.

Mental illness was considered irreversible. The mentally ill were beaten for disobedience and confined to cages or closets. Generally, mental patients were viewed as incompetent, defective, and potentially dangerous. They had no rights and were left in social isolation to communicate primarily with other mentally ill patients. Their care-takers were untrained and often punitive. As a result, the mentally ill tended to become more ill and less able to function.

Bethlehem Royal Hospital, the first mental hospital in England, was opened during the 17th Century. In this hospital, the public was allowed to wander through the hospital and see the patients, and nurses lacked any interest in improving the care of mentally ill.

Franz Mesmer (1733-1815), an Austrian physician, was interested in a therapeutic approach to behavior. He believed that the universe was filled with magnetic forces. Mesmer professed that the mentally ill

Psychiatric Nursing

could be cured by having them hold rods filled with iron filings in water. Although Mesmer's techniques were later revealed as false, his idea of suggestive power has carried over to some modern psychiatric techniques.

The term mesmerized is from Mesmer; to be mesmerized is to be placed in a hypnotic trance.

A French physician Philip Pineal (1745 - 1826), began the movement toward more human treatment of the mentally ill when he removed the chains from twelve male patients at Bicker Hospital near Paris in 1792. Pineal disavowed punitive treatment of mental patients. He recognized the need for medical care and advocated freedom, useful work, and kindness for patients.

The first hospital in America to admit mental patients was the Pennsylvania Hospital located in Philadelphia.

The first American textbook on psychiatry was written, during this period by Benjamin Rush (1745-1813) a physician who used a humanistic approach in the treatment of mental illness. He is considered by many to be the father of American psychiatry.

In 19th Century one of the best known reformers was Dorothea Lynde Dix, who contributed much to the establishment of American hospitals for the care of the mentally ill. She traveled throughout the country in an effort to have legislation enacted for improved care for mental patients. As a result of her efforts, many hospitals were built in United States, Canada and in other countries.

Psychiatric Nursing

The first psychiatric training school in United States was established in 1882 at McLean Hospital in Belmont, Massachusetts. Participation in psychiatric nursing course becomes a requirement for a nursing license in the USA in 1955.

In the 20th Century an Austrian neurologist, Sigmund Freud made a significant contribution to the understanding and treatment of mental illness. His belief in the power of unconscious memories and repressed emotions led him to develop the theory and practice of psychoanalysis. Because of his work, he is called the founder of psychoanalysis. He studied the dreams, memories, and fantasies of his patients in search for unconscious impulses and conflicts. He identified three major divisions of the self or mind: the Id, superego, and ego. He also presented a theory of psychosexual personality development.

In Ethiopia the first mental hospital (Emanuel Hospital) was established after the end of the Ethio-Italian war to protect the royal family from mentally ill patients. The patients were collected and taken to jails to the corner of the town that is now known as Emanuel Hospital.

Slowly and gradually a more humanitarian type of care was introduced by one psychiatrist. Dr. Fikire Workineh. The first psychiatric nursing school was established in Emanuel Hospital in 1991 and twelve nurses graduated for the first time. Until this time there was no formal psychiatric nursing training in Ethiopia. The service started to be decentralized to other corners of the country,

Psychiatric Nursing

such as Jimma, Nekemte, Harar, Dire Dawa, Yirgalem, Bahirdar, Mekele and Asmara.

By now some of hospitals in Ethiopia have psychiatric units even though the quality is not yet of an appropriate level.



REVIEW QUESTIONS

1. Is it true or false that during the middle ages mental illness was considered curable and reversible during?
2. The first mental hospital in England was _____.
3. A French physician who begun the humanitarian type of treatment and who removed chain from the mentally ill patients was _____.
4. The first American textbook of psychiatry was written by _____ who was lived from _____ to _____.
5. In 19th Century the well-known American psychiatric nurse reformer who contributed for the establishment of mental hospitals and made an effort to have legislation enacted for improved care for the mentally ill patients was _____.
6. An Austrian neurologist in the 20th Century who made a significant contribution for mental illness treatment was _____.
7. The first and the only mental Hospital in Ethiopia is _____.
8. A prominent Ethiopian psychiatrist reformer is _____.
9. Psychiatric nursing training was started in Ethiopia in _____.
10. How many nurses were trained for the first time from Emanuel psychiatric nursing school?

CHAPTER THREE

GENERAL NURSING TECHNIQUES USED IN PSYCHIATRIC NURSING

Learning objectives

After studying this chapter, the student should be able to:

1. Recognize general nursing techniques
2. Define 'self'
3. Define communication
4. Identify the different purposes of communication
5. Differentiate different models of communication
6. Describe reasons for ineffective communication
7. Identify some barriers to effective communication
8. Identify psychological barriers to effective listening
9. Describe psychiatric assessment techniques

Understanding 'self'

Self is the sum of the attitudes that make up the personality. According to the psychologist Erik Eriksson, certain developmental tasks must be accomplished during each of stages of the life cycle (infancy, childhood, adolescence, adulthood, old age). Each step is necessary for self development.

An individual personality continues to develop throughout the life cycle. In personality development environment, heredity, and

nurturing play an important role. Joey Luft and Harry Ingham developed the Jo-Hari window.

Table 2: Jo-Hari's window of self

	Known to self	Not known to self
Known to others	the public self (1)	the blind self (2)
Not known to others	the private self (3)	the unknown area (4)

Source: Stoner (1996)

1. The public self: The first pane indicates knowledge about oneself that the person knows and others know about him or her.
2. The blind self: The second pane indicates knowledge about one self that the person does not know about him or her self and other people know.
3. The private self: In pane three there are all manner of things that a person knows about him or her self but does not choose to share to others.
4. The unknown area: The last pane represents information about oneself that neither the person nor anyone else knows.

Self acceptance

Self-acceptance is a regard for oneself with a realistic concept of one's strengths and weaknesses. Behaviors of the self-accepting person including the following:

- persevering
- minimizing weaknesses
- increasing strengths
- seeing reality
- trusting and accepting others
- continuing growth toward self-actualization
- recognizing and accepting one's own behavior
- reaching out to others
- learning from mistakes

The person who is self accepting accepts others more easily. Therefore, it is important that the nurse works toward self acceptance. The self-rejecting person is critical of others, more anxious, insecure and depressed.

Communication

Communication is a mutual interaction or reciprocal action that can occur between or among people. Shives1990.

Communication is the giving and receiving of information. The sender prepares or creates a message when need occurs and sends the message to a receiver or listener, through a proper channel: face to face or through electronic or other media. The receiver may then

return a message or feed back to the initiator (sender) of the message.

Communication is a learned process influenced by attitudes, socio cultural or ethnic background, past experience, knowledge of the subject matter and the ability to relate to others.

Interpersonal perceptions also affect one's ability to communication because they influence the initiation of and response to communication. Perception is affected by the sense of sight, sound, touch, and smell and environmental factors such as time, place and the presence of one or more people influence communication.

Therapeutic communication

Therapeutic communication is defined as a special form of communication that has a health-related purpose and develops as a continuous flow of interaction between nurse and patient, with input from both contributing to it is nature and progression. Non-verbal communication is sometimes considered a more accurate description of true feelings because one has less control over non-verbal reactions.

Non-verbal communication includes:

- Position or posture
- Gesture
- Touch
- Physical appearance
- Facial expressions

- Vocal cues and
- Distance or spatial territory.

Models of communication (elements of communication) There are four models of communication according to David and these are:

1. Source (a person who is responsible to create the message)
2. Message (the idea which is transmitted from the source to the receiver)
3. Channel (it is a means by which a message can be transmitted from a source to the receiver)
4. Receiver(a person who is receiving the message from the source)

The main goal of therapeutic communication is to develop or maintain a healthy personality. This is done by reliving stress and assisting the patient in developing better coping mechanisms.

Reasons for ineffective communication

Communication is usually thought of as an exchange of words but it also includes all methods used to relay message to another person, for example, through gestures, body movements and tone of voice. Communication that does not involve the spoken word is non verbal communication.

Effective communication occurs when the receiver understands the message as the sender intended. Unfortunately ineffective communication often occurs due to some barriers.

Some barriers to effective communication

1. Barriers caused by reception, need, attitude, environmental stimuli etc.
2. Barriers caused by a lack of understanding language, knowledge etc.
3. Barriers caused acceptance, prejudices, emotional conflict etc.
4. Psychological barriers to listening such as day dreaming, detouring, debating, private planning.

Communication skills

The following suggestions are given to enable the student psychiatric nurse to develop good communication skills for effective therapeutic interactions.

1. Know yourself
2. Be honest with your feelings
3. Be sure in your ability to relate to people
4. Be sensitive to needs of others
5. Be consistent
6. Recognize symptoms of anxiety
7. Watch your non-verbal reactions
8. Use words carefully
9. Recognize differences
10. Recognize and evaluate your own actions and responses.

Psychiatric assessment techniques

The student may experience difficulties in his/her first contact with psychiatric patients. Some of these difficulties arise from the nature of psychiatric symptoms and signs disorders of emotion of thinking or of intelligence, which are less easy to elicit and describe than physical signs and symptoms. The interviewer has to overcome his/her anxiety and preconceptions about the mentally ill.

The range of information that is sought about the patient and his illness is much wider than for other clinical disciplines and requires tact, time and patience to elicit scheme of case taking. This information may include:

1. The history-of the present illness
The social and personal history of the patient (supplementary history to be obtained from relative if possible)
2. A physical examination
3. Psychiatric examination
4. Further investigations
5. Formulation of the case

1. *History of present illness*

Record briefly mode of referral/admission reason for referral and patients complaints (in his own words) and their duration.

2. *Social history*

Record briefly accepts of the patient's family history such as:

- Father

Psychiatric Nursing

- Mother
- Siblings
- Social position
- Home atmosphere and influence.

Record also the patient's personal history, including details of their experiences relating to:

- Date and place of birth
- Early development
- Neurotic symptoms in childhood
- School
- Adolescence
- Occupations
- Sexual history
- Marriage
- Children
- Habits
- Medical history
- Previous mental illness
- Antisocial behavior
- Current life situation.

Record any information available about personality before illness (pre morbid personality):

- Social relations
- Activities and interests
- Mood

- Character
- Standards, moral, religious, social, economic etc.
- Energy and initiative
- Reaction to stress

3. **Physical examination**

The physical examination should be comprehensive and should be carried out within a day of admission. Special attention should be given to the central nervous system. Positive and negative findings should be recorded and a brief summary of abnormalities found should be given.

4. **Psychiatric examination (mental status examination)** Record the following aspects of the psychiatric patient's state General behavior, appearance, word behavior since admission attitude towards hospital staff etc.
- Talk (form of talk), much or little, spontaneous, answers to questions etc.
 - Mood
 - Form of thought; Does the patient experience blocking pressure or poverty in thinking?
 - Content of thought
 - Delusions and misinterpretations
 - Hallucinations
 - Obsessional phenomena
 - Orientation to time place and persons.
 - Memory

Psychiatric Nursing

- Attention and concentration
- General information
- Apparent intelligence
- Insight and judgement
- Staff attitude.

5. *Further investigations*

Further investigations may be indicated ,including:

- Physical investigations as indicated
- Psychological testing
- Psychiatric social worker's report

6. *Formulation of the case*

Discuss a range of potential diagnosis, giving evidence for and against the various possibilities. Make and record a provisional diagnosis, an estimate of prognosis, a problem list, and plans for further investigation and treatment.

REVIEW QUESTIONS

1. Self is a sum of the attitudes that make up the personality
 - a. True
 - b. False
2. Verbal communication is considered a more accurate description of true feelings because one has more control over non verbal reactions.
 - a. True
 - b. False
3. A special form of communication that has a health-related purpose and develops in a continuous flow of interaction between nurse and patient, with input from both of them contributing to its nature is termed as therapeutic communication.
 - a. True
 - b. False
4. List the complete scheme of patient assessment/history taking/ in psychiatric nursing.
5. Which of the following is not categorized under psychiatric examination /mental status communication?
 - a. Delusion and misinterpretation
 - b. Attention and concentration
 - c. Blood test for biochemical analysis
 - d. Content of thought.

CHAPTER FOUR

COUNSELING TECHNIQUES IN PSYCHIATRIC NURSING

Learning objectives

After Studying this chapter, the student should be able to:

1. Define counseling in mental health
2. Describe purpose of counseling
3. Describe the importance of listening in counseling
5. List major techniques in counseling

Purpose of counseling

The purposes of counseling include developing the patient's maturity and self control. It requires a focus on the whole person, not just the problem. This is because a mature person can solve problems and the problem presented is usually not the real problem.

A four part process can teach people to solve their own problems.

This process involves:

1. Listening
2. Exploring
3. Understanding
4. Problem solving

Listening

The goal of listening is to help the person to talk. This can be facilitated by the following behavior on the part of the psychiatric nurse:

A. Showing respect and care, this will make it easier for the person to talk.

B. Demonstrating the body language of listening:

1. Face them
2. Look at them
3. Keep an open posture
4. Lean forward
5. Be relaxed but not too relaxed.

C. Listening for non-verbal messages. Notice:

1. Body movements
2. Gestures
3. Facial expression
4. Tone of voice.

D. Listen to everything, even things you don't want to hear.

E. Listen to yourself

1. Saying yes or mmm or nodding your head at the right time tells someone you are listening.
2. Repeating a few words a person has said lets them know you heard them and encourages them to go on.

3. Very brief questions can help clarify things that are not clear or help the person continue talking.

Exploring the person and their problems

In order to learn all you can about the person and the problem you will need to pay attention to the following:

A. The counselor must try to understand.

1. What has happened
2. How the person feels.

The psychiatric nurse does not have to agree with a person to understand him or her. They should not make judgments at this point.

B. Try to make statements instead of asking questions

1. Start statements with “I” not “You”
2. Make statements that start with, “It seems to me,” or “I wonder if”, or “I think that you are telling me....”

C. If you must ask a question make it an open question, not a closed one for example, do not ask, “Why”, but rather, ask “What”.

D. Be concrete

E. If you don’t understand, say, “I don’t understand”

F. Do not give advice.

Understanding the person's point of view

The goal of understanding the person is to help them see the problem clearly. In order to achieve this:

- A. The counselor acts as a mirror
 - 1. We show how it looks from our point of view
 - 2. We show the good and the bad
 - a. Strengths
 - b. Resources
 - c. Ineffective response patterns
 - d. Inconsistencies
 - e. Other ways to label the problem
 - f. Hidden or double messages
 - g. Things he or she may be avoiding
 - h. Challenges to magical thinking.

This helps the person begin to change attitudes, beliefs, behaviors and feelings.

- B. Do not give advice.

Problem solving

The goal of problem solving is to encourage action that leads to change. In order to achieve this psychiatric nurse should:

- A. Help the person find a better way to solve his or her problem, but remember:

Psychiatric Nursing

1. People are usually doing the best they know how
 2. Perhaps the best way for you is not the best way for them.
- B. List alternatives:
1. Do not judge them, just list them
 2. Be creative
- C. Evaluate the alternatives, list advantages and disadvantages.
- D. Choose one solution
1. The person with the problem should make the decision if at all possible.
 2. Give your opinion if you want but remember to let the person have control and take responsibility.
 3. Be realistic
- E. Encourage the patient to try it:
1. Be specific
 2. Set time limits
- F. Evaluate results.
- G. If not successful explore the reasons why, list new alternatives and try again.
- H. Don't give up

REVIEW QUESTIONS

1. In counseling, the problem which is presented from a client is always a true problem.
A. True B. False
2. In counseling the four processes to teach people and solve their own problem are:- Listening, Explaining, understanding, and problem solving.
A. True B. False
3. During counseling as a counselor one has to listen to things to be listened and desired to be listened.
A. True B. False
4. A counselor, while listening to the client has also to listen to his/her self.
A. True B. False
5. During counseling, as a counselor it is desirable to make decision on behalf of the client.
A. True B. False

UNIT-TWO

GENERAL CLASSIFICATION OF MENTAL ILLNESS AND SPECIFIC MENTAL ILLNESSES

Learning objectives

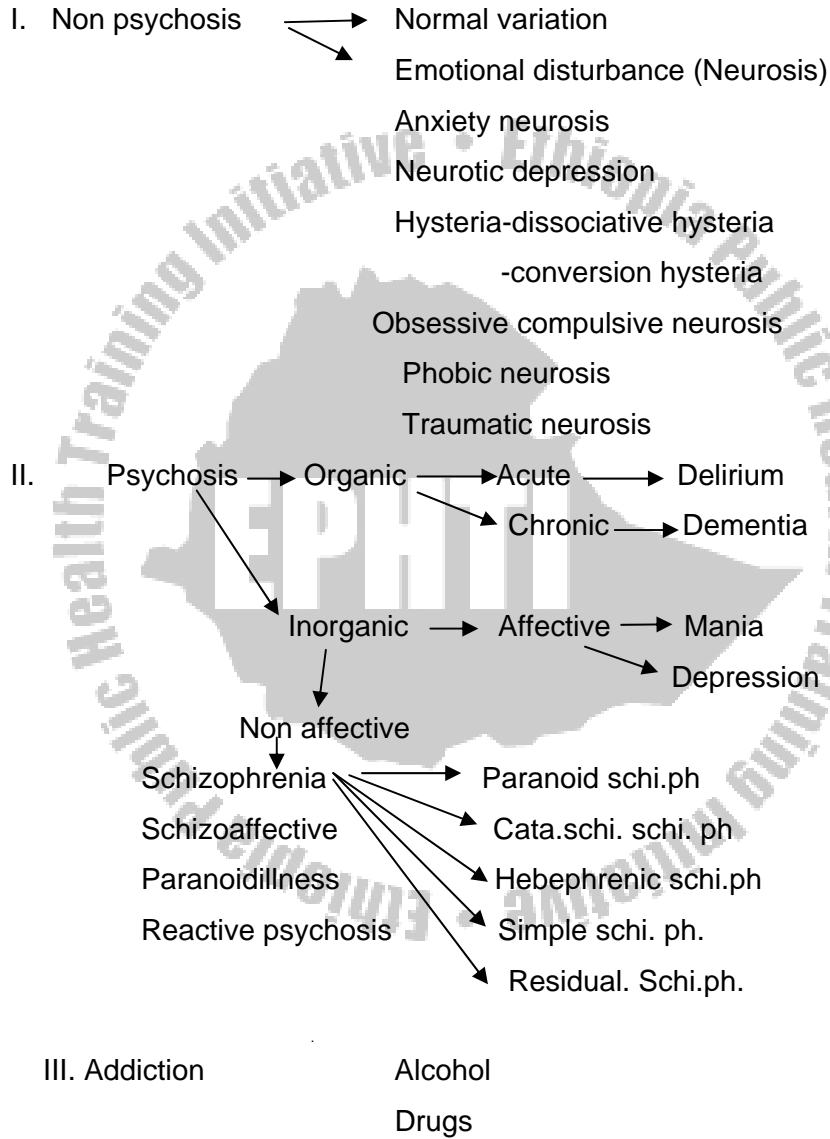
After studying this unit, the student should be able to:

1. Describe general classifications of mental illness
2. Define generalized anxiety disorders
3. Discuss classifications of generalized anxiety disorders
4. Identify different management criteria of Generalized Anxiety disorders
5. Identify nursing management for schizophrenia.

Classification of mental illness

There are various types of classification of mental illness according to their severity and different types of underlying causes. These have been described by Lalitha, (1995) A decision tree which shows the classification is outlined below.

Decision Tree



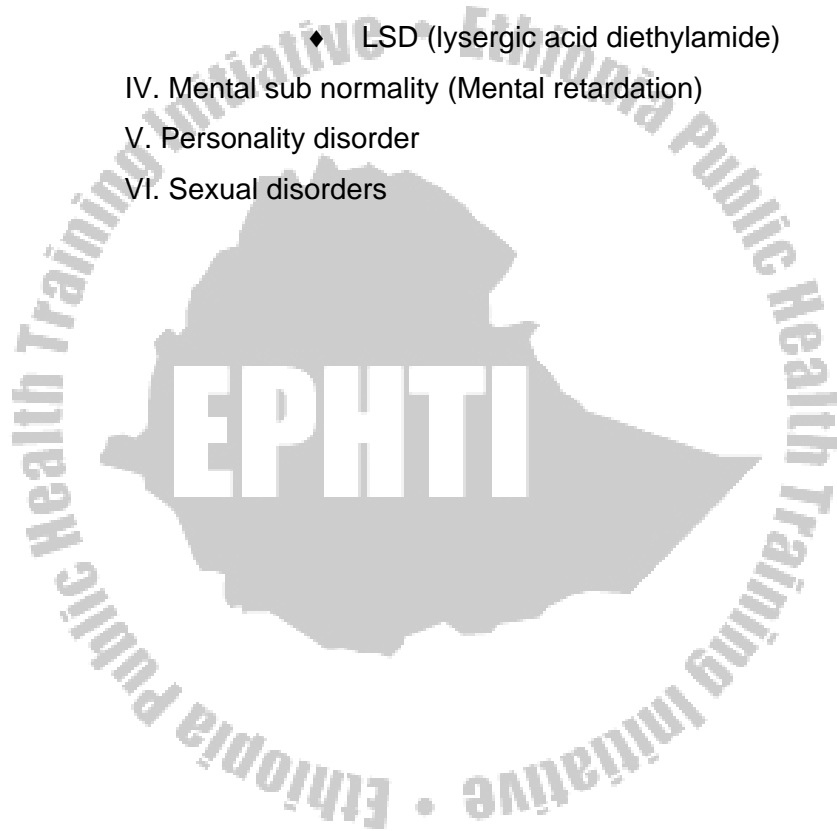
Substances abuse such as

- ◆ marijuana
- ◆ cannabis
- ◆ pot
- ◆ kaht
- ◆ LSD (lysergic acid diethylamide)

IV. Mental sub normality (Mental retardation)

V. Personality disorder

VI. Sexual disorders



Different minor mental illnesses

Anxiety disorders

Anxiety disorder is characterized by at least six months' duration of anxiety in the absence of panic attacks, disorders, depression or other psychiatric disorders.

According to DSM III- R classification there are three major categories of symptoms.

1. Motor tension, such as muscle aches, inability to relax, fidgeting, restlessness and being easily startled.
2. Autonomic hyperactivity, including cold and clammy hands, dry mouth, dizziness, frequent urination, flushing, increased pulse rate while resting, and upset stomach.
3. Vigilance and scanning, a state in which the person is hyperactive, easily distracted, has difficulty concentrating, experiences insomnia and is irritable or impatient.

The individual exhibits unrealistic or excessive anxiety and worry about two or more life circumstances during a six month period and may be mildly depressed. Symptoms rarely interfere with social or occupational functioning.

Below are listed sub classifications of general anxiety disorders:

Sub types of anxiety disorders

1. Anxiety
2. Phobia

3. Conversion disorder
 - a. Conversion reaction hysteria
 - b. Dissociative hysteria
4. Obsessive compulsive
5. Hypochondriasis
6. Neurotic depression.

1. Anxiety disorder

Anxiety is a common neurotic disorder with various combinations of physical and psychological manifestations not attributable to any real damage 'free floating anxiety' There are two types of anxiety:

- a. Normal anxiety
- b. Pathological anxiety can be subdivided into two sub categories:
 - panic anxiety
 - diffuse anxiety.

Panic (acute) anxiety is an episodic anxiety, which lasts for short period of time.

Diffuse (chronic or generalized) anxiety is characterized by marked apprehension, persisting or long lasting time.

Epidemiology

Anxiety disorder is a problem of about 5% adult population with female to male ratio of 2:1 and it runs with in family.

Etiology

Risk factors include:

1. Constitutional:
 - genetic (it can be inherited genetically)
 - developmental: if the developmental process is full of anxiety.
 - provoking conditions e.g. war, famine, home disturbance etc.
2. Physiological:
 - endocrine e.g. thyrotoxicosis
 - head injury (traumatic neurosis)
3. Psychological:
 - stress
 - interpersonal conflict
 - external:
 - social
 - occupational etc.

Clinical Features of Anxiety

- Palpitation
- Exhaustion
- Breathlessness
- Dizziness
- Chest pain
- Anxiousness
- Flashing of face
- Tachycardia
- Apprehensiveness

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- Head ache
- Faintness
- Insomnia
- Sweating
- Tachypnea
- Restlessness etc.

Differential diagnosis

1. Major mental disorders
 - schizophrenia
 - agitated depression.
2. Organic diseases such as:
 - pheochromocytoma (Cancer of suprarenal gland)
 - thyrotoxicosis
 - angina pectoris

Method of Diagnosis

1. History
2. Clinical findings

Treatment

1. Psychotherapy
2. Sedatives (anxiolytics) diazepam or chlorodiazepoxide 5-10 mg po/day at bedtime.

Prognosis:

Prognosis depends up on:

- Pre-morbid personality of the patient
- The frequency of occurrence of the anxiety inducing stimulus.

Complications

- Alcoholism (alcohol dependence)
- Drug abuse (drug dependence)

2. Phobia

Phobia is described as 'an irrational fear' of an object, activity or situation that is out of proportion to the stimulus and results in avoidance of the identified object, activity, or situation.

Epidemiology

Phobia occurs in 3-5% of population.

Etiology

The etiology of phobia is not clearly known

There are two types of phobias

1. Simple (specific phobia) mono-symptomatic phobia Simple phobia refers to fear caused by the presence (anticipation) of a specific object or situation, such as flying, heights, animal getting an injection or seeing blood.

Examples of simple phobias include:

- Zoophobia - fear of animals
- Claustrophobia - fear of closed spaces
- Acrophobia - fear of heights
- Nyctophobia - fear of the night.

2. Complex phobia (social phobia)

A complex phobia is defined as a marked and persistent fear of one or more social or performance situations.

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Examples of complex phobias include:

- Agoraphobia - fear of open place
- Social phobia - fear of public area
- Giminophobia - fear of marriage
- Gumnophobia - fear of being seen naked
- Minsnophobic - fear of going through child birth
- Sypridophobia - fear of having sexual relation etc.

Epidemiology

The epidemiology of complex phobia is not clearly, known, but it is more common in females than males and it increases in late teens or adulthood.

Etiology

According to psychoanalytic theory, phobias occur as a result of conflicts arising from unresolved castration anxiety (displaced phobia) which persists and tend to stay displaced to other objects during adulthood.

Clinical features

Signs and symptoms of anxiety are manifested in presence of the feared object or situation.

Differential diagnosis

Differential diagnoses include major mental illness (schizophrenia) or prodroma of schizophrenia.

Treatment

1. Behavioral therapy

- Desensitization - enabling the patient to adapt to a situation piece by piece or part by part.
- Systematic – slow and gradual adaptation and understanding of reality.
- Flooding - exposing the individual to the feared object.

2. Antidepressant - phenotizine

- MAOI (monoamine oxidase inhibitors)

Prognosis

- Some patients undergo a spontaneous cure.
- The majorities are resistant to treatment and become chronic.

Complications

- Alcoholism
- Drug abuse
- Social and occupational disabilities.

3. Conversion disorder

A conversion disorder is a psychological condition in which an anxiety-provoking impulse is converted unconsciously into functional symptoms, for example, anesthesia, paralysis, or dyskinesia. Although the disturbance is not under voluntary control, it meets the

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immediate needs of the patient and is associated with a secondary gain (Shives: 1990).

Hysteria is a conversion disorder that represents a goal oriented disease: the goal is attention seeking to avoid anxiety or to draw attention (sympathy) by transferring a mental conflict in to a physical symptom and in this way releasing tension or anxiety.

Epidemiology

- About 2% of the female population is affected
- It has wide age range distribution
- It runs with in family
- Married and single people are equally affected
- It is higher in populations with lower educational levels.

Etiology

According to psychodynamic theory, hysteria can be directed at:

- Fixation stage - during oedipal phase
- Anxiousness - the relief of unbearable somatic symptoms.
- Primary illness gain: obtaining relief from anxiety by using defense mechanism to keep an internal need or conflict out of awareness.
- Secondary illness gain: obtaining benefit or support as a result of being sick, rather than relief from anxiety.

Clinically there are two forms of hysteria

1. *Conversion reaction*

Signs and symptoms of conversion reaction include:

- a. Motor disturbance
 - Paralysis
 - Paraplegia, monoplegia
 - Gait disturbance
 - Tremor
- b. Sensory:
 - Aphonia
 - Anesthesia
 - Convulsions (hysterical fit)
 - Blindness
 - 'La belle indifference'

2. *Dissociative hysteria*

Dissociation is the act of separating and detaching a strong emotionally charged conflict from one's consciousness.

Signs and symptoms of dissociative hysteria include:

- Conscious disturbance
- Amnesia (psychogenic amnesia)
- Lack of Identity
- Fugue state (complete amnesia)
- Somnambulism (sleep walking)
- Multiple personality

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- Depersonalization
- Acute psychosis
- Gaunser's syndrome (clouded consciousness with approximate answers).

Differential diagnosis

- Organic illness such as epilepsy
- Schizophrenia
- Depression
- Depersonalization

Treatment

- Psychoanalysis
- Hypnosis
- Breaking secondary illness gain
- Sedative and anxiolytic drugs (valium and chlorodiazepoxide are recommended)

Prognosis

In patients with dependent and inadequate personality, the relapse rate is very high.

4. Obsessive compulsive disorder

Obsession

Obsession is defined by thought and feelings that the person cannot get rid off voluntarily and instead reoccur against their will.

Compulsion is defined by the performance of a certain acts as a result of irresistible thought and in order to reduce anxiety.

Epidemiology

- 0.05% of population encounters obsessive compulsive neurosis
- High in single (unmarried) people
- High in upper social class
- High in educated people

Etiology

- Constitutional function there is a heredity tendency
- Physical - brain injury and central nervous system (CNS)infection
- Psychological - conflicts between Id and superego conflict at anal phase.

Signs and symptoms

- Commonly anxiety features
- Depression
- Obsessional ideas

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- Obsessional impulses
- Obsessional phobias

Treatment

- Psychotherapy (reassurance)
- Behavioral modification
- Antidepressant (amitriptyline) 25 - 50 mg/d

Prognosis

- 50% will be chronic
- A few develop schizophrenia

5. Hypochondria

Hypochondriasis is neurotic disorder in which the predominant disturbance is unrealistic interpretation of physical signs as abnormal leading to a preoccupation with illness and a belief that the patient has a disease. Hypochondriac is a term used to describe persons who presents unrealistic or exaggerated physical complaints.

Epidemiology

- Incidence rate is not clearly known
- Occurs most frequently in the 40 – 50 age range

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- More common in females
- More common in single people or people in unhappy marriages
- More common in people with a poor occupation.

Etiology

When a person loses his or her attention towards other objects then he or she directs their attention to him or herself.

Signs and symptoms

- Ranges from simple preoccupation with illness to delusion
- Primarily mono-symptomatic (occurs with single disease symptom)
- It may develop into multi-symptomatic (many disease symptoms)
- Most common areas of the body involved are abdomen, chest and headache.

Diagnosis

- History
- Physical examination

Treatment

- Treat any underlying illnesses
- Antidepressant (amitriptyline)
- Psychotherapy and supportive ideas

Prognosis

Hypochondria is refractory in some cases

Differentiation between neurosis and psychosis

Neurosis is differentiated from psychosis in the following table

(Shives: 1990):

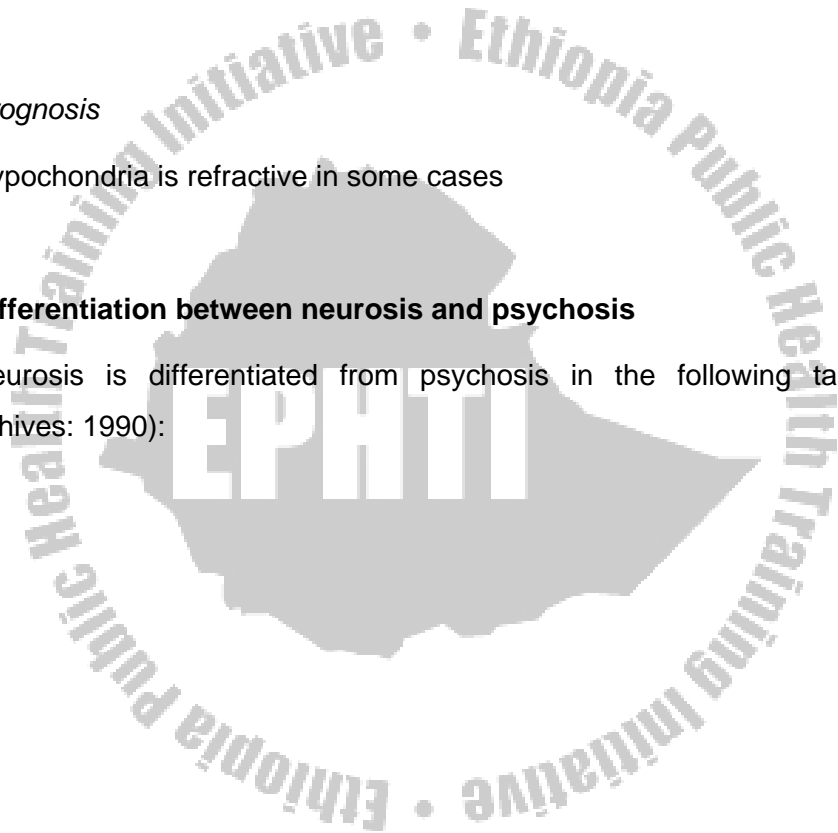


Table 3: Differences between neurosis and psychosis

NEUROTIC BEHAVIOUR	PSYCHOTIC BEHAVIOUR
Reality oriented	Out of contact with reality denies reality
Demonstrates acceptable behavior socially	Demonstrates bizarre inappropriate, behavior (as described in the chapters on schizophrenic disorders and manic- depressive psychosis)
Interacts with the real environment	Creates a new world or environment withdraws from reality in an effort to seek security in the newly created world
Doesn't exhibit maladaptive behavior (e.g. hallucinations or delusions)	Exhibits maladaptive behaviors (e.g. delusions, hallucinations, and autism)
Uses coping mechanism as attempt to decrease anxiety (primary gain)	Coping mechanisms are ineffective, resulting in disintegration of the personality

Nursing intervention

People who exhibit signs of acute anxiety or a panic state may harm themselves or others and need to be supervised closely until the anxiety is decreased. The person may need to be placed in a protective environment such as a general hospital, mental health center or psychiatric hospital.

The person may be in severe distress or immobilized, or he may be engaged in purposeless, disorganized, or aggressive activity. Feelings of intense awe, dread, or terror may occur. The patient may state he fear that he is 'losing control.

After the patient is examined, a nursing care plan is initiated to correspond to the physician's or psychiatrist's treatment plan for an acute anxiety attack or panic state.

During the panic state the nursing interventions may include:

1. Staying with the patient at all times
2. Remaining calm: he patient will sense any anxiety exhibited by the nurse.
3. Speaking in short, simple sentences
4. Displaying firmness to provide external controls of the patient
5. Keeping the patient in a quiet environment to minimize external stimuli. The patient is unable to screen such stimuli and may become over whelmed.
6. Providing protective care because the patient may harm him or her self or others. The patient's behavior also may elicit

Psychiatric Nursing

responses from other patients who are unable to tolerate his or her anxiety state.

7. Attempting to channel the patient's behavior by engaging him or her in physical activities that provide an outlet for tension or frustration.
8. Administering anti-anxiety medication to decrease anxiety. Persons who exhibit symptoms of mild or moderate levels of anxiety may be treated as outpatients. If the anxiety does not interfere severely with the patient's ability to function, he or she generally is seen as an outpatient.
9. Nursing interventions for mild to-moderate anxiety levels include assessment of the patient's anxiety level, reducing anxiety, providing protective care, encouraging verbalization of anxiety, meeting basic human needs and setting realistic goals for patient care.

The nurse provides supportive care by:

1. Recognizing the patient's anxiety and helping him or her to identify the anxiety and describe his or her feelings.

Reassuring the patient

2. Accepting the patient unconditionally and not passing judgment or responding emotionally to the patient's behavior.
3. Listening to the patient's concern. Being available but respecting the patient's need for personal space.

Psychiatric Nursing

4. Protecting the patient's defenses (e.g. ritualistic behavior). Any attempt to stop such behavior increases anxiety because the patient has no other defenses.
5. Encouraging verbalization of feeling and answering questions directly.
6. Allowing the patient time to respond to nursing interventions. Setting realistic goals for improvement. Allowing the patient to set the pace.
7. Exploring alternative coping mechanisms to decrease present anxiety to a manageable level. Assisting the patient in learning to cope with anxiety.
8. Identifying the patient's development stage and helping him or her to work through unmet developmental tasks
10. Exploring one's own feelings.
11. Administering treatments or medications to reduce anxiety or other discomfort

Hospitalization of the patient with an anxiety disorder may be short-term and intensive. Outpatient follow-up care is usually recommended to continue with supportive therapeutic care. Discharge planning will include an evaluation of the patient's present status, recommendations for outpatient referral and instructions regarding drug therapy if a maintenance dose is necessary. The patient should be instructed about whom to contact if anxiety increases and panic or a crisis occurs.

The following are examples of nursing diagnoses and nursing interventions for patients with anxiety disorders:

Table 4: Nursing diagnoses and nursing interventions for patients with anxiety disorders.

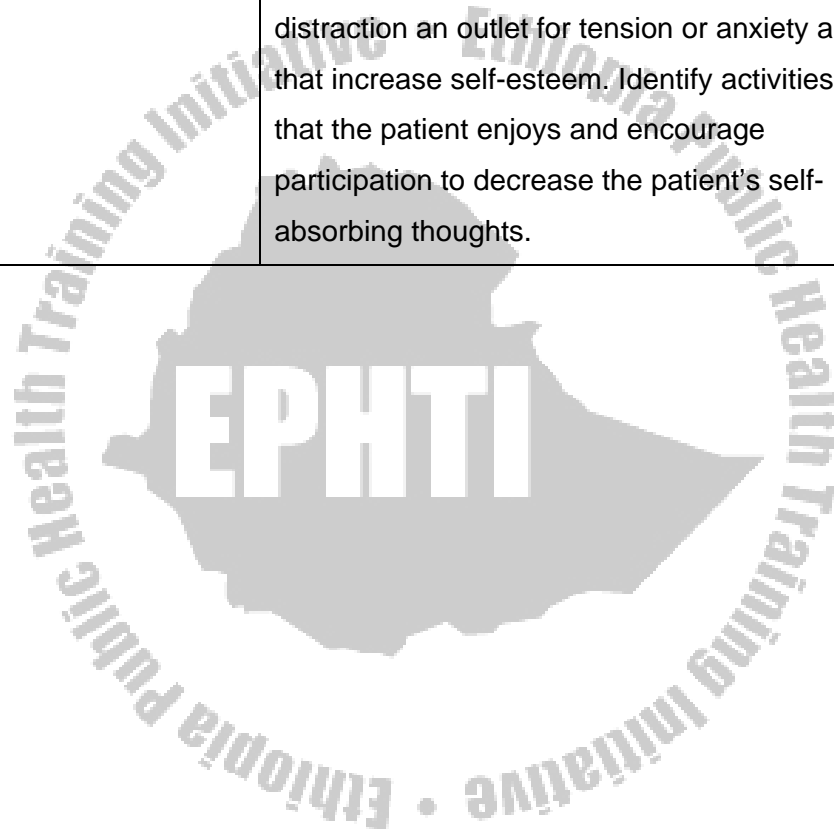
Nursing Diagnoses	Nursing Interventions
Anxiety	Assess the patient's level of anxiety. (Nursing interventions for the panic state and mild to moderate anxiety were covered in depth earlier in this chapter.) Assess for suicidal ideation.
Ineffective individual coping. Obsessive compulsive, ritualistic behavior.	Remove patient from any situation that stimulates or increases behavior. Observe for signs of increasing anxiety and intervene before the patient resorts to ritualistic behavior if possible. Establish trust and one-to-one relationship. Anticipate needs. Seek out and spend time with the patient. Discuss thoughts and behavior with the patient. Explore conflicts in relation to ritualistic behavior. Allow time for rituals if already established. Set priorities and time for other tasks to be done (i.e. eating, chores and personal hygiene). Protect the patient from ridicule. Encourage the patient to explore and develop new interests outside of

Psychiatric Nursing

	<p>him or herself. Seek opportunities to communicate your expectation of the patient's recovery. Encourage the patient to participate in planning activities after allowing time for ritualistic behavior to decrease. Support any positive decisions made by the patient. Plan divisional activities.</p>
<p>Alteration in thought process: Inability to concentrate</p>	<p>Encourage patient to share feelings. Speak concisely and clearly. Reassure the patient. Be really available. Keep decision-making and competitive situations to a minimum.</p>
<p>Ineffective individual coping: Demanding, manipulative behavior such as crying and talking excessively because of anxiety</p>	<p>Interpret behavior as a need for attention or pleas for help. Be alert to what the patient is trying to say and help the patient communicate more clearly. Anticipate needs Don't give false, generalized reassurance such as "everything will be fine" or "there's nothing to worry about."</p>
<p>Sleep pattern disturbance: insomnia due to anxiety</p>	<p>Recognize signs of increasing agitation. Decrease environmental stimuli that could be upsetting to the patient. Offer relaxing nursing measures such as back-rubs and warm baths. Teach relaxation exercises. Limit rest periods during the day.</p>

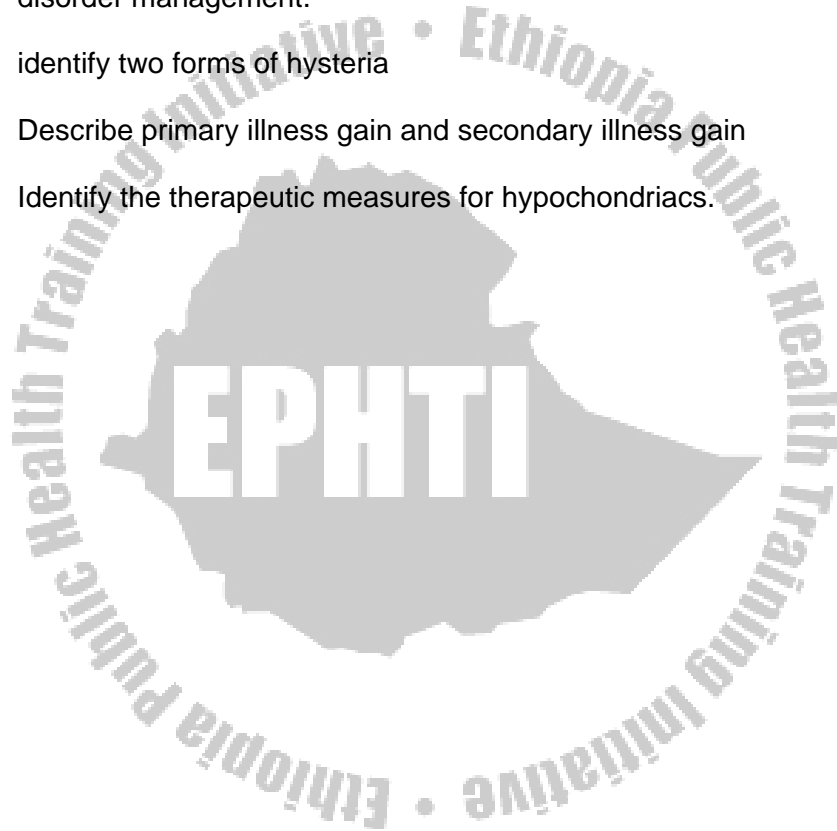
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Ineffective individual coping: numerous somatic complaints due to anxiety	Avoid reinforcing physical complaints (i.e. taking vital signs frequently increases preoccupation with symptoms). Present reality regarding physical condition. Encourage participation in activities that provide distraction an outlet for tension or anxiety and that increase self-esteem. Identify activities that the patient enjoys and encourage participation to decrease the patient's self-absorbing thoughts.
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REVIEW QUESTIONS

1. List at least five subtypes of generalized disorders.
2. Identify at least three approaches of behavioral therapy in phobic disorder management.
3. identify two forms of hysteria
4. Describe primary illness gain and secondary illness gain
5. Identify the therapeutic measures for hypochondriacs.



UNIT THREE

AFFECTIVE DISORDERS (MOOD DISORDERS)

Learning objectives

Upon accomplishing this unit, the student should be able to:

1. Define affective disorder
2. Describe manic psychosis
3. Explain clinical features of mania
4. Describe depression
5. NSG management.

Affective disorder

Affective disorder is defined as a mental disorder exhibiting prominent and persistent mood changes of elation or depression accompanied by symptoms such as fatigue and insomnia. An abnormality of affect, activity or thought process is present. The mood changes appear to be disproportionate to any cause. Affective disorders are classified as mania, depression and bipolar disorders.

Manic psychosis

The word mania is derived from Greek word, it is synonymous with 'madness' it is used to describe a behavior disorder in which three main symptoms predominate, euphoria, heightened psychomotor activity and flight of ideas.

Clinical features of mania

1. Restlessness
2. Over -talking
3. Irritability
4. Inflated self esteem (grandeur delusion)
5. Decreased need for sleep
6. Expansiveness
7. The speech is very loud, rapid and difficult to understand, often it is full of jokes, puns, plays on words, amusing irrelevance and theatrical with singing and rhetorical mannerisms
8. If the mood is more irritable, then expansive the person may become hostile and may go through three phases: contempt, control, and triumph.
9. Flight of idea which is incoherent
10. Due to grandiose idea and inflated self esteem, the patient may act as an advisor and consultant in areas they do not have special knowledge, such as how to fix an automobile and how to run government, writing novel, composing music or painting pictures.
11. Excessive energy

12. Intense feeling of well-being
13. Heighten sense of reality
14. Breach in the barriers of individuality
15. Inhibition in the sense of reality.
16. Release of sexual and moral tension
17. Sense of ineffable revelation.

Differential diagnosis (DDX)

- Organic states (cerebral tumor and arteriosclerosis)
- Hypomania
- Alcohol intoxication
- Catatonic excitement
- Frontal lobe lesions.

Methods of diagnosis (DX)

History and physical examination

Treatment (RX)

- 1 Lithium 600 mg po/day
- 2 Haloperidol (serinace) 5 mg - 100 mg/day
- 3 Chlorpromazine(CPZ) 100 - 600 mg po/day in divided dose
- 4 Thiaridazine(melleril) 100 - 600 mg po/day in divided dose.

Prognosis

Prognosis is good with good treatment, living condition, and family support.

Depression

Depression is a sense of hopelessness, in which the world seems totally unresponsive to one's effort to meet one's needs (Shives:1990) According to Mendls "the central symptoms of depression are sadness, pessimism, self dislike along with loss of energy, motivation and concentration".

Classification of depression

1. *Reactive Depression:*

Reactive depression is commonest type of depression It may be caused by a reaction to external events such as loss of a loved one or a disaster. It is not usually responsive to physical therapies i.e. drug and ECT. It is not genetically determined or it does not occur in cycles or reoccur, and it is usually milder than the endogenous depression.

2. *Endogenous depression (autonomous depression)*

Endogenous depression is due to some unknown origin or internal process, and it is not associated with external events. It usually occurs in cycles (on and off), responds to drugs and ECT(shock treatment) and it is suggested that hormonal and genetical predisposition are contributing factors. The symptoms are generally more serious than those of reactive depression.

3. *Bipolar depression*

- The patient experiences depression and manic episodes.

- Mania looks like extreme elation and excitement, a mirror image of depression

4. *Uni-polar depression*: has no manic episode.

Clinical features of depression

Regardless of age the classification of depressions are more alike than different. Their clinical features include changes of mood, thought behavior and appearances. In addition depressives are often characterized by somatic symptoms as well as anxiety. The following are clinical features of depression.

Mood: Sad, unhappy, blue and crying

Thought: Pessimism, ideas of guilt, self dislike loss of interest and motivation, decrease in efficiency and concentration.

Behavior and appearance:

- Neglect of personal appearance
- Psychomotor retardation or agitation

Somatic:

- Loss of appetite or voracious appetite
- Loss of weight or over weight
- Constipation
- Poor sleep (insomnia or hypersomnia)
- Aches and pains
- Menstrual change in female patients
- Loss of libido

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Anxiety features: such as

- Palpitation
- Sweating
- Tremor
- Suicidal thoughts, threats and attempts or self destruction behavior etc
- Psychomotor retardation
- Agitation

Not all these symptoms are likely to be observed in one person. Thus one person may show psychomotor retardation (general slowing down of movement, speech and thought disturbance) and another person may show agitation.

The common signs are

- Sad face
- Stooped posture
- Crying at intervals
- Slow speech
- Dejected mood
- Diurnal mood variation
- Suicidal wishes
- Indecisiveness
- Hopelessness
- Inadequacy
- Conscious quiet
- Loss of interest

Psychiatric Nursing

- Loss of motivation
- Fatigability
- Disturbed sleep (early morning awaking)
- Loss of appetite
- Constipation

Treatment Amitriptyline (elavil) 75 - 200 mg/d in divided dose

1. Imipramin (tofranil) 75 - 300 mg/d in divided dose
2. ECT (Electroconvulsive therapy)

Nursing interventions for depression and mania

Persons who are depressed may be difficult to communicate with or approach. Isolation, withdrawal, ambivalence, hostility, guilt or impaired thought processes are but a few symptoms that can interfere with the development of a therapeutic relationship. The manic patient's hyperactivity, pressured speech, and manipulation also interfere with attempts at communication.

The nurse must be aware of personal vulnerability to depressive behavior: working with such persons may cause one to react to the depressed atmosphere and in turn experience symptoms of depression.

The following is a list of attitudes that the nurse should display toward depressed and manic persons:

1. Acceptance
2. Honesty

3. Empathy

4. Patience

Assessment focuses on mood, affect, behavior, and appearance. Body language may replace communication skill because the person is unable to convey feelings of anger, hostility and ambivalence.

Questions the nurse can ask the patient to assess the level of depression, while observing facial expression, body posture, tone of voice, and overall appearance, include the following:

1. Do you have difficult falling asleep at night?
2. Do you wake in the middle of the night?
3. If so, are you able to return to sleep?
4. Do you wake earlier than usual in the morning?
5. Are you alert or depressed when you get up in the morning?
6. Do you sleep excessively?
7. Have you been experiencing feelings of worthlessness, self reproach, or guilt?
8. Do you have difficult concentrating or making decisions?
9. Can you watch an entire movie or television show?
10. Does your mood change or fluctuate during the day?
11. Has your sex drive lessened?
12. Are you frequently constipated?
13. Has your energy level decreased?
14. Have you lost interest in life?
15. Has there been a change in your appetite?
16. Do you feel alienated from those around you?

17. Have you ever considered or attempted suicide? (If so, ask the patient when and whether s/he has a plan at present.)

Simple activities are most effective for a person with a short attention span or an inability to concentrate. Completion of such tasks enhances the person's self-concept because they feel more worthwhile after the job is done. The nurse must also consider the person's energy level; the more energy the task requires, the less energy s/he will have to engage in hostile, aggressive behavior.

Protective care may be necessary for the manic as well as for the depressed person. Persons who exhibit manic behavior may injure themselves owing to excessive motor activity, inability to concentrate, distractibility and poor judgment. Their destructive tendencies may include self-inflicted and accidental injury. They also may provoke self-defensive actions unintentionally from others who fear injury.

Assisting with electro convulsive or electric shock therapy is another nursing intervention while caring for depressed patients. Such persons are given a complete physical examination before treatment. The nurse's role before treatment is to withhold breakfast and to administer anti cholinergic medication to decrease or dry up body secretions to lessen chances of aspiration, to provide supportive care, and to assist with the treatment and monitor the person's responses during a recovery period that usually lasts from a half hour to one hour.

Patient education is another nursing intervention for depressed and manic persons. Such persons should be informed about the

Psychiatric Nursing

importance of outpatient treatment as well as the continuation of prescribed drugs. They may relapse if they discontinue the drugs. They should be taught to recognize the onset of side effects, as well as the recurrence of symptom, to avoid re-hospitalization. A person diagnosed as having bipolar depression, mixed type, should be helped to describe the changes in affect and behavior in the initial phases of his illness.

Another aspect of nursing care is being supportive during psychotherapy sessions. The person may have difficulty expressing feelings of hostility, ambivalence, and guilt. Feelings of anxiety may occur or increase as the person begins therapy sessions. Such sessions may be directed at exploring feelings about self and the patient's relationship with the environment in an attempt to improve his or her self-esteem and decrease feelings of helplessness, hopelessness, and powerlessness. The nurse can be supportive simply by making him or herself available to the patient and by recognizing symptoms such as anxiety.

Table 5: Nursing diagnoses and nursing interventions for depressed and manic patients

NURSING DIAGNOSES	NURSING INTERVENTIONS
Potential for injury: Suicidal ideation	Suicide precautions It is advisable to follow suicide rating scale for protective care of the suicidal patient.
Social isolation	Establish trust. Assign the same staff members to work with the person whenever possible. Accept the patient as he or she is. When approaching the person, avoid being overly cheerful, sympathetic or superficial. Display empathy. Use therapeutic communication skills such as silence and active listening. Encourage ventilation of feelings.
Dysrhythmia of sleep-rest activity	Observe for signs of fatigue. Provide opportunities for rest. Set limits regarding time to arise in morning and the amount of time spent in bed during the day. Decrease external stimuli before hour of retiring. Offer warm milk and backrub at bedtime. Administer prescribed medication for insomnia
Alterations in nutrition: Less than body requirements	Monitor Input and output. Provide a high protein, high-calorie diet as needed. Attempt to include the patient's favorite foods. Provide frequent, nutritional snacks in the form of finger foods. Encourage adequate fluid intake. Offer high calorie drinks. Weigh the patient weekly or as ordered.

Psychiatric Nursing

Alteration in bowel elimination: Constipation	Monitor Input and output. Encourage the intake of fluids. Encourage exercise. Provide bulk and fiber in diet. Administer laxatives as needed.
Alteration in self-concept	Involve in activities directed toward raising self-esteem. Display a sincere interest and offer praise or recognition for accomplishments.
Activity intolerance because of hyperactivity and distractibility	Decrease or limit environmental stimuli. Provide adequate room for hyperactivity. Provide private room if necessary, to reduce external stimuli. Limit social interactions initially to prevent intrusive behavior. Select activities that provide an outlet for excessive energy yet do not trigger loss of control. Administer drugs as ordered to decrease hyperactivity.
Manipulation	Give simple explanations regarding hospital routine and nursing care. Contact the patient frequently but briefly to reassure him or her. Set limits and be consistent. Avoid arguing with the patient.

REVIEW QUESTIONS

1. Which of the following is not a clinical feature of mania?
 - a. Elation
 - b. Agitation
 - c. Dejected mood
 - d. Intense sense of well being
2. The prognosis of manic disorder depends on treatment, good living condition and family support.
 - a. True
 - b. False
3. In the case of bi-polar disorder, mania is considered as a mirror image of depression
 - a. False
 - b. True
4. Which one of the following is a true picture of depression?
 - a. Menstrual change in the female patients
 - b. Neglect of personal hygiene
 - c. Psychomotor retardation or agitation
 - d. All of the above
5. The endogenous depression is caused by a clear causal factor and yet it doesn't respond to drug therapy.
 - a. True
 - b. False

UNIT FOUR

SCHIZOPHRENIA

Learning objectives

After studying the material in this unit, the student should be able to:

1. Define schizophrenia
2. Describe different types of schizophrenia
3. Recognize DSM-IV-R diagnostic criteria of schizophrenia
4. Describe differential diagnosis of schizophrenia
5. Explain possible management of schizophrenia
6. List the nursing management of schizophrenia

Definition: The word schizophrenia is derived from a Greek word meaning

Schizo - split } = meaning split mind

Phrenia - mind}

Generally schizophrenia is a serious psychiatric disorder characterized by impaired communication with loss of contact with reality and deterioration from a previous level of functioning in work, social relations or self-care. Clinical types of schizophrenia include disorganized, catatonic, paranoid, residual, and undifferentiated schizophrenia (Shives: 1990)

Types of Schizophrenia

A. *Disorganized (hebephrenic type)*

Features include incoherence, lack of systematized delusions, and blunted, inappropriate or silly affect. The clinical picture usually includes a history of poor functioning and poor adaptation even before illness.

B. *Catatonic type*

A type of schizophrenia which is dominated by one of the following:

1. Catatonic stupor: Morbid lack of reactivity to environment reduction in spontaneous movements and activity and/or mutism.
2. Catatonic negativism: Apparently motiveless resistance to all instructions or attempts to be moved.
3. Catatonic rigidity: Maintenance of a rigid position against efforts to be moved.
4. Catatonic excitement: Excited motor activity apparently purposeless and not influenced by external stimuli.
5. Catatonic positioning: Assumption of inappropriate or bizarre posture.

C. *Paranoid type*

Features of the paranoid type of schizophrenia include persecutory and grandeur delusions, feeling and hallucinations.

Psychiatric Nursing

Associated features include anger, argumentative, violence, fearfulness, delusion of reference and sometimes loss of gender identity.

- Onset is relatively late
- Function remains more or less at constant level, and is not marked by deterioration.

D. Undifferentiated type

Features include grossly disorganized behavior, hallucinations incoherence or prominent delusion.

E. Residual type

Features include current schizophrenic symptoms and definite experience of at least one schizophrenic episode in the past. There may be some delusion and hallucination but the person is burned out. There is no treatment for the residual symptoms. The patient often functions poorly and experiences long term unemployment.

F. Simple type

The patient Experiences:

- Paranoid disorders
- Gradual insidious loss of drive, interest, ambition and initiative.
- Withdrawal
- Isolation
- Gradual decrease of performance

Later the patient may show indifference to environment, slow personality deterioration and drift aimlessly through life. Usually hallucination and illusion are absent.

DSM III diagnostic criteria for schizophrenic disorders

The DSM III diagnostic criteria include the following:

A At least one of the following at some point of the illness

1. Bizarre delusions, such as the delusion of being controlled, thought broadcasting, thought insertion and thought withdrawal, somatic, grandiose, religious, and nihilistic or other delusions without persecutory or jealous content.
2. Delusions with persecutory or jealous content, if accompanied by hallucinations of any type.
3. Auditory hallucinations in which either a voice keeps up a running commentator on the individual's behavior or thoughts, or two or more voices converse with each other.
4. Auditory hallucinations on several occasions with content of more than one or more words having no apparent relation to depression or elation.
5. Incoherence and marked loosing of association marked illogical thinking or marked poverty of content of speech, if associated at least with one of the following:
 - Blunted, flat or in appropriate affect

- Delusion or hallucination
- Catatonic or other grossly disorganized behavior.

B. Deterioration

Deterioration from a previous level of functioning in such area as work, social relations and self care.

C. Duration:

Continuous signs of the illness for at least six continuous months during the person's life, with some signs of the illness at present. The six month period must include one active phase during which symptoms from criteria A (outlined above) are exhibited, with or without pro-dromal or residual phase.

D. symptoms of depression or manic syndrome

The full depression or manic syndrome (major depression or manic episode) if developed after any psychiatric symptoms in criteria A (outlined) appear.

E. Onset of pro-dromal or active phase of the illness before age of 45 years.

F. Not due to any organic mental disorder or mental retardation.

Bawleres symptoms 'The 4 A's' Of schizophrenia

- Ambivalence
- Association loosening (incoherence)
- Affect disturbance
- Autism (turning towards self).

Differential diagnosis

- Organic mental disorder
- Major affective disorder
- Schizophreniform disorder
- Paranoid disorder
- Mental retardation
- The developmental straggle of adolescent.

Prognosis:

Prognosis depends on onset, stress, pre morbid personality and social and economic status.

Treatment (Rx)

1. Coma - Insulin coma is the ancient form of treatment. Nowadays it is not treatment modality of schizophrenia.
2. ECT is also seldom used today
3. Contemporary treatment:
 - a, Supportive psychotherapy
 - b, Drug therapy: The hoice of drug depends upon availability, cost and side effects
 - Chlorpromazine(CPZ) 100 - 600 mg/day in divided dose
 - Thioridazine (mellaril) 100 - 1000 mg/day

Nursing interventions

Nursing interventions focus on assisting the patient to meet the following goals:

Psychiatric Nursing

1. Establish a trusting relationship;
2. Alleviate anxiety;
3. Maintain biological integrity; and
4. Establish clear, consistent, and open communication.

The nurse must establish a therapeutic relationship so that effective communication with the patient can take place. The nurse must remember that all behavior is meaningful to the patient, if not to anyone else.

Reality should be presented when caring for the patient who is disoriented. The nurse can do this by pointing out what would be appropriate behavior, for instance, 'I'd like you to put your shoes on now' Recognizing the presence of hallucinations and delusion, but not reinforcing such behavior or thoughts is an appropriate response when interacting with patients. The nurse should look for factors causing hallucinations and attempt to intervene before they occur.

Safety measures may need to be incorporated to protect the patient who displays poor judgment, disorientation, destructive behavior, suicidal ideation, or agitation. Limit setting, acknowledging spatial territory giving the patient room to breathe and providing protective safety measures are examples of such nursing interventions. The patient must be protected from her or himself because she or he may injure her or himself accidentally, or may try to destroy her or himself or attack other patients as a result of auditory hallucinations or paranoid ideations.

Psychiatric Nursing

Efforts should be made to plan activities to increase the patient's self concept. Sincere compliments should be given as often as possible, focusing on positive aspects of the person's personality or capabilities. Encourage participation in activities.

The nurse must observe for extra pyramidal side effects of psychotropic drugs and monitor the patient's willingness to take the drugs. Patients may refuse to take medication, pretend to take medication by palming it, or pretend to swallow the medication while retaining the pill in the mouth (only to get rid of it at the first possible moment).

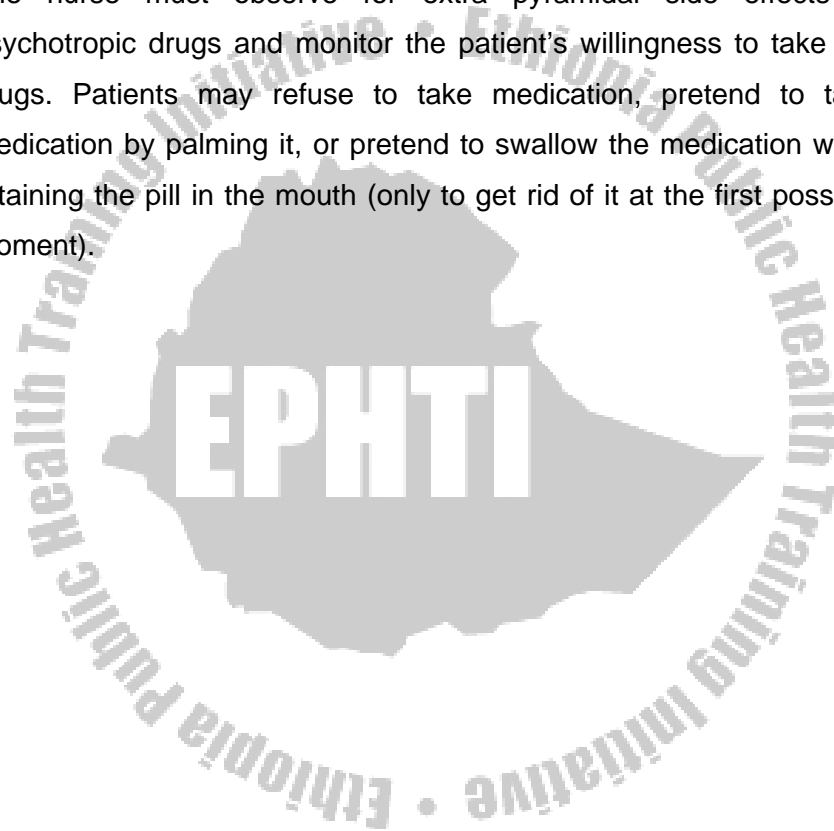


Table 6: Nursing diagnoses and interventions for patients with schizophrenic disorders.

Nursing diagnoses	Nursing Interventions
Sensory-perceptual alteration: Disoriented to place and person, disoriented in time.	Call the patient by name. Present reality when talking to or working with the patient. Keep a calendar in clear view to orient the patient daily. Provide a protective, safe environment.
Social isolation: Withdrawal	Assign one member of the health care team to establish a one-to-one relationship. Provide a structured list of activities such as times to awaken, shower, and eat. Spend a specific amount of time daily with the patient. Set limits regarding amount of times spent alone in room.
Alteration in thought process: Delusional	Present reality when talking to or working with the patient. Ignore the delusion but do not attempt to disprove it or argue with the patient. Set limits by instructing the patient not to discuss the delusion with others.
Alteration in thought process: Hallucinations	Decrease environmental stimuli such as loud music or television shows, extremely bright colors, or flashing lights. Present reality, for example: "The

Psychiatric Nursing

	<p>voices may be real to you but I don't hear anything." Attempt to identify precipitating factors by asking the patient what happened before the onset of the hallucination.</p>
<p>Ineffective individual coping: Regression</p>	<p>Assess the patient's present developmental level. State expected behavior to the patient. Set limits to discourage regressive behavior.</p>
<p>Dysrhythmia of sleep-rest activity: Agitation and unpredictable behavior</p>	<p>Recognize signs of increasing agitation. Decrease environmental stimuli that could be upsetting to the patient.</p>
<p>Sensory-perceptual alteration: Suspiciousness</p>	<p>Be sincere and honest when talking with the patient. Avoid making promises that can not be fulfilled. Face the patient while talking. Avoid whispering or any other behavior that may cause the patient to feel that you are talking about him. Give detailed explanations of tests, procedures, and so forth to the patient. Allow the patient to help to prepare food or have food brought from home if he or she refuses to eat (because s/he thinks food is poisoned).</p>

REVIEW QUESTIONS

1. Schizophrenia is a mild psychiatric disorder characterized by impairment of previous level of functioning in work, social relations or self care
 - a. False
 - b. True
2. Disorganized (hebephrenic schizophrenia) is characterized by inappropriate or silly affect and lack of systematized delusion.
 - a. False
 - b. True
3. Grandeur delusion and persecutory idea are mainly the characteristics of paranoid schizophrenia among the rest of types of schizophrenia.
 - a. True
 - b. False
4. In residual type of schizophrenia the patient has definitive experience of at least one schizophrenic episode in the present among other symptoms experienced in the.
 - a. False
 - b. True
5. List the Bawlers diagnostic criteria for schizophrenia

UNIT FIVE

EPILEPSY

Learning objectives

After this unit, the student should be able to:

1. Define epilepsy
2. Describe different classifications of epilepsy
3. Identify different clinical features of epilepsy
3. Diagnose epilepsy
4. Identify differential diagnoses of epilepsy
5. Explain appropriate medical and nursing management of epilepsy
6. Give health teaching for clients and family members (care takers) of epileptic patient.

Definition: Epilepsy is derived from the Greek word 'epilepsia' which means to take hold of or to seize. It is paroxysmal neurological disorder causing recurrent episodes of:

1. Loss of consciousness
2. Convulsive movements or motor activity
3. Sensory phenomena or
4. Behavioral abnormalities

(Brunner and Sundarth: 1998)

The following are important characteristics of epilepsy:

Seizure A paroxysmal, uncontrolled, abnormal discharge of electrical activity in the gray matter within the brain causes events that interfere with normal function, a symptom rather than a disease.

Prodromal phase: This phase precedes some seizures and may last minutes or hours: a vague change occurs in emotional reactivity or affective responses (e.g. depression or anxiety)

Aura: A brief sensory experience occurs e.g. a feeling of weakness, dizziness, strange sensations in an arm or leg, numbness, an odor that occurs at the onset of some seizures

Epileptic cry: A cry, occurring in some seizures, caused by a thoracic and abdominal spasm which expels air through the narrowed spastic glottis.

Ictus, post ictal: Ictus is synonymous with seizures, post ictal refers to the time immediately after a seizure during which the client usually experiences some change in consciousness, behavior, or activity.

Etiology

The etiology of seizures varies remarkably in adults and includes:

- Brain tumor is the most common cause for organic seizure (intracranial mass)
- Head injury

Clinical manifestations

There are various types and classifications of seizures. They can be classified into two major groups:

1. Generalized seizures:
 - Tonic clonic seizures (grand mal)
 - Absence (petit mall)
 - Minor motor seizures (akinetetic, myoclonic, atonic)
2. Partial seizures (focal epilepsy)
 - Partial seizures with motor components
 - Partial seizures with sensory components
 - Partial seizures with complex symptoms
 - Partial seizures that secondarily generalize

Diagnostic assessment

Assessment of a client experiencing seizures involves:

- History including, prenatal, birth, and developmental history, family history, age of seizure onset, trauma, illness and complete description of seizure including precipitating factors:
- Psychosocial assessment, including mental status examination
- Complete physical examination, including a detailed neurological examination
- Skull radiographs
- EEG
- CT scan to detect tumor

Medical management

Medical management includes:

- Eliminating factors that may cause or precipitate seizures.
- Improving the client's physical and mental health
- Specific medical treatment, and
- Possible surgical treatment.

The main focus in intervention for epilepsy is preventing seizures from occurring

Drug treatment

Drug treatment include:

1. Phenobarbital 30 - 100 mg po/daily (for grand mal epilepsy)
2. Phenytoin (dilantin) 100 mg po/day
3. Carbamazepine (tegretol)

Side effects of anti epileptic drugs include mental dullness, ataxia, diplopia, hypertrophy of gums, emotional and mental changes including depression, irritability, impotence, withdrawal seizures, if drug is not discontinued slowly.

Nursing management

Nurses have a role in supporting and educating clients and their significant others with epilepsy to provide information about the following important points.

1. How anticonvulsants prevent seizures
2. The importance of taking prescribed medication regularly
3. Care during seizure

Psychiatric Nursing

Nursing care help the client identify factors that precipitate seizures and ways of avoiding these factors. Such factors include:

- Increased stress
- Lack of sleep
- Emotional upset and
- Alcohol use

Certain dangerous activities should be avoided or performed with special safeguards including:

- Swimming
- Horse back riding
- Tree climbing
- Activity involving fire hazards
- Driving motor vehicles

Nurses should advise adequate diet, fluid intake, sleep ,and moderate recreation and exercise.

Emotional effects of epilepsy

Clients with epilepsy often have a poor self-image. They may experience:

- Feelings of inferiority
- Self-consciousness
- Guilt
- Anger
- Depression and
- Other emotional problems

Observation (assessment during the seizure attacks)

Nurses should make the following observations during seizures:

Duration of the seizure (tonic clonic 30 - 60 seconds)

- Were the seizure begun?
- Did eyes deviate?
- Were the respiration's labored or frothy?
- Was client incontinent?
- Status epilepticus (persistent and uncontrollable seizure).

Family education

The client's family needs to know what to do for the client in the event of a seizure. Nurses can advise the family about:

- Protecting the patient from self injury
- Loosening their clothing
- Protecting the patients head from impact and sharp objects
- Not to restrain the patient forcibly during seizure.
- Not to insert hard object or finger in the mouth
- Position the patient to their side when the seizure is over.

REVIEW QUESTIONS

1. List at least four major characteristics typical of epilepsy
2. Seizure is a paroxysmal, uncontrolled discharge of electrical activity in the brain's gray matter that interferes with normal function of the brain and also it is a symptom rather than a disease
 - a. False
 - b. True
3. Which one of the following activity is restricted or performed with maximum safeguards in epileptic patients.
 - a. Horse back riding
 - b. Swimming
 - c. Tree climbing
 - d. All of the above
4. Which one of the following doesn't trigger or precipitate the occurrence of seizure in epileptic patients
 - a. Increased stress
 - b. Increased sleep
 - c. Emotional upset
 - d. Alcohol use
5. Which one of the following should be included in family education about protection of the epileptic patient during the seizure attack?
 - a. Loosening of clothing's of the patient
 - b. Protection of head from impact and sharp objects

- c. Positioning of the patient to the side
- d. All of the above



UNIT SIX

ORGANIC MENTAL SYNDROMES AND DISORDERS (COGNITIVE FUNCTION DISORDERS)

Learning objectives

After studying this unit the student should be able to:

1. Discusses organic mental syndrome
2. Discusses organic mental disorder
3. Define dementia
4. Describe diagnostic criteria for organic mental disorder
5. Describe different forms of treatment and care for different organic mental disorders
6. Describe nursing intervention for organic mental syndromes and disorders.

Definition

Organic mental syndromes and disorders are due to transient or permanent brain dysfunction caused by a disturbance of physiologic function of brain tissue. Organic mental disorder refers to a particular organic mental syndrome in which the etiology is known or presumed. Organic mental syndromes refers to a constellation of psychological

or behavioral signs and symptoms without referral to etiology (Shives: 1990).

The following are lists of disorders and syndromes.

Organic mental disorders

Primary degenerative dementia of Alzhimers' type

Multi-infarct dementia

Alcohol intoxication

Alcohol withdrawal

Alcohol withdrawal delirium

Alcohol hallucinosis

Alcohol aminestic disorder

Organic mental syndromes

Delirium and dementia

Aminestic syndrome and organic hallucinosis

Organic delusional syndrome

Organic mood syndrome

Organic anxiety syndrome

Organic personality syndrome

Intoxication and withdrawal

Organic mental syndrome not otherwise specified

Some syndromes and disorders are described in more detail below.

A. Delirium

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This disorder is characterized by a clouding of consciousness, accompanied by

- Disorientation
- Memory impairment and
- A decreased ability to shift focus, or sustain attention to stimuli. Irrelevant environmental stimuli may easily distract a person with a diagnosis of delirium.

The person may misinterpret the environment or exhibit perceptual disturbances such as illusions or hallucinations.

The patient may exhibit insomnia or daytime drowsiness often occurs along with a disturbance of the sleep-wake cycle, resulting stupor, semi coma, hyper-somnolence, vivid dreams, or nightmares.

Diagnosis of delirium is based on evidence of a specific organic factor identified by a history, physical examination, or laboratory test. DSM - III -R diagnostic criteria include:

1. Clouding of consciousness
2. At least two of the following
 - a. Perceptual disturbance
 - b. Incoherent speech at times
 - c. Disturbance of sleep-wake cycle with insomnia or daytime drowsiness or
3. Disorientation and memory impairment
4. Clinical features develop with hours or days and fluctuate over the course of a day

B. Dementia

Dementia is a form of global or defused brain dysfunction that is characterized by a gradual, progressive and chronic deterioration of intellectual function. This deterioration affects judgment orientation, memory and emotional stability. Cognition and attention are affected either by a pattern of simple, gradual deterioration or by rapid complicated deterioration.

Diagnostic criteria for dementia

1. Loss of intellectual abilities, resulting in interference of social or occupational functioning
2. Memory impairment
3. At least one of the following
 - a. Impaired abstract thinking
 - b. Impaired judgment
 - c. Disturbed higher cortical function, such as aphasia

(loss of language comprehension or production) apraxia (loss of ability to perform skilled motor act), agnosia (loss of the ability to recognize objects) constructional difficulty (inability to copy three-dimensional figures, assemble blocks, or arrange sticks), or;

- d. Depression
4. Unclouded state of consciousness
5. One of the following specific organic factors related to the disturbance or, in the absence of evidence from the history,

physical examination, or laboratory tests, an organic factor can be presumed.

C. Alzheimer's disease (primary degenerative dementia)

Alzheimer's disease is pre-senile brain disease; it is not a natural course of aging, hardening of the arteries, an aftermath of a stroke, brought on by alcoholism, trauma, or over medication, a depressed state, communicable or curable.

It is considered to be a silent epidemic that begins with a slight and easily dismissed flattening of personality, characterized by confusion, restlessness, speech disturbances, withdrawal, decreased interest in hobbies, inability to carry out purposeful movements, and (sometimes)

Death can result from neglect, malnutrition, dehydration, incorrect diagnosis, inappropriate treatment or suicide.

Nursing interventions focus on identification and symptomatic management of the evident deterioration as well as other factors noted during the assessment process.

A calm supportive approach is necessary when handling the patient's emotional responses or defenses against the acknowledgment of intellectual deficits.

D. Mental handicap

Mental handicap (amentia, oligophrenia) is a defect of intelligence existing from birth or from an early age. The English Mental Health

Act, 1995, prefers 'mental sub normality' and recognizes sub normality and severe sub normality. The Scottish Act of 1960 retains the older 'mental deficiency' and makes no subdivision. While low intelligence is an essential feature for diagnosis, a low IQ is not the sole criterion. Personality and associated physical defects have significant effects on educability, and social competence has always been the main diagnostic criterion.

Prevalence

Two to three per cent of the population has some degree of mental handicap; it is generally identified between birth and 14 years, after which the figure remains steady. Some 70% live in the community and the remaining 30% may be institutionalized or isolated by the family members at home.

For every case of severe sub normality (IQ less than 50), and there are 15 mild cases of mild sub normality (IQ less than 75). Severe cases have a prevalence of 3.7/1000. Sub normality is nine times more common in high social class than lower social class. It is higher in rural areas, and in males (1.3 to 1). There is high association between family history and mental sub normality.

Etiology

There are two main types of sub normality: organic and sub cultural. The latter group comprises those individuals of low intelligence who

Psychiatric Nursing

can be expected to occur at one end of the normal distribution curve. Intelligence is normally distributed in the population, and most intelligence tests are standardized with a mean IQ of 100 and a standard deviation of 15. The subnormal population is usually defined as having an IQ of more than two standard deviations below the mean: i.e. an IQ under 70. The rate quoted above for illustrates the effects of the probability distribution on sub normality. In the case of severe defect IQ below 50 there are higher numbers than would be expected by from a normal distribution(a 'bulge in the tail') and the vast majority of this group have organic brain disease, compared with only 25 per cent in those with IQ's of 50 to 70.

Multiple handicaps: A substantial minority of mentally hand caped people have associated psychosis or neurosis, and up to 40% show difficult behavior in childhood. Accompanying handicaps include poor physical development, sensory defects such as deafness and poor vision, employment difficulties, but in people with an IQ above 50 education, upbringing, social class and temperament, together with associated handicaps all play a part in the final achievement or failure.

Diagnosis and assessment

Antenatal

Amniocentesis is a developing area of early diagnosis, together with ultrasound, foetoscopy and foetal blood sampling. Tissue culture

Psychiatric Nursing

used to detect chromosomal abnormalities, enzyme defects and the sex of the infant. Such tests may prove useful in older mothers with high risk of Down's syndrome, if an existing child has a genetic defect and risk is high, or if the disorder suspected is sex linked. Alpha fetoprotein estimation in amniotic fluid and blood are now used to detect neural tube defects (spina bifida) and may also indicate fetal death. The risk of error in such tests is 1 in 1000.

Infancy

The nurse should be aware of the risk of sub-normality when there has been anoxia and when there is low birth weight, dysplasia, cerebral palsy, convulsions or small cranial circumference. Probably 1% of live births show serious retardation, but at 7 years only 0.4 % of children have an IQ below 50. This is the effect of selective mortality.

Investigations in suspected cases include chromosome studies, amino-acid chromatography, specific blood and urine tests for inborn error of metabolism and detection of specific antibodies in mother and child. Developmental scales are available for diagnosis in infancy and childhood.

Childhood

Many children with mental handicap may be identified by failure to stand, walk or talk at the normal times.

School

Milder degrees of sub normality are commonly diagnosed in the early school years thought educational difficulties.

Classification of the causes mental handicap

Organic causes

1. Prior to conception
 - a. Chromosomal, e.g. Down's syndrome
 - b. Genetic: single, e.g. inborn errors, or multifactor
2. Pre-natal and peri-natal
 - a. Maternal infections (rubella, toxoplasmosis, syphilis, cytomegalic inclusion body disease)
 - b. Fetal infections (encephalopathy, maternal toxemia)
 - c. Maternal malnutrition-rate
 - d. Peri-natal damage (hypoxia, birth injury)
 - e. Kernicterus
 - f. Drugs or alcohol
 - g. Exposure to radiation.

E. Down's syndrome (mongolism)

Down's syndrome was described by John Langdon Down in 1866. This syndrome is due to chromosomal abnormality. It takes various forms, but 95% of cases are due to trisomy 21, an extra small acrocentric chromosome in group G, giving 47 rather than 46 chromosomes, caused by non-disjunction during meiosis of the oocyte. Thus, the ovum is involved and not the sperm. It is more common in older mothers: compared with a 25 years old mother, a mother of 40 has 20 times the risk and a mother aged 45 has 50 times the risk. Mongols born to young mothers usually show a

different abnormality translocation, in which there are 46 chromosomes, one of which is large and atypical. Clinically, mongolism is common, 1 in 700 live births, but up to 50 per cent of the infants die during their first year. Mongols formerly had a short life due to infection, but those who survive infancy now live longer. All show varying degrees of sub normality. In infancy hypo-tonia and hyper-flexibility are found. Down's syndrome is characterized by multiple abnormalities: microcephaly; flat face sloping eyes with epicanthic fold, big tongue; short neck; broad, flat hands with simian crease and short fingers; congenital heart lesions; infertility. Temperamentally such children are frequently jovial, and often musical. In early pregnancy Down's syndrome may now be identified by amniotic cell culture.

F. Metabolic abnormalities

Such abnormalities may be acquired, for example:

- a. Hypoglycaemia
- b. Hyperbilirubinaemia (kernicterus)
- c. Hypothyroidism (cretinism)
- d. Hypoproteinaemia
- e. Hypercalcaemia
- f. Lead poisoning

They may also be inborn, including:

- a. Lipid metabolism
- b. Carbohydrate metabolism
- c. Amino acids metabolism

Inborn errors of metabolism are interesting but very rare, acquired abnormalities are four times as common.

Some of these abnormalities are described in more detail below.

Acquired metabolic abnormality

Kernicterus: This results from Rh or ABO incompatibility or in prematurity. When level of un conjugated serum bilirubin exceeds 20 mg/100 ml, damage takes place in the basal ganglia and cerebellum. The result is often hyper tonus, cyanosis, and convulsions with later choreo-athetosis, deafness and sub normality. Antenatal detection can enable an exchange transfusion to be given.

sm (Cretinism): This has various causes: enzyme deficiencies, absent or mal developed thyroid, ingestion of drugs such as phenylbutazone, PAS. Symptoms may include persistent jaundice, lethargy, protruding tongue and umbilical hernia. Early thyroid treatment is essential to prevent damage.

Inborn metabolic abnormality

Inborn metabolic abnormality includes all autosomal recessives. Between 1 in 10 000 and 1 in 50 000 people are affected. It may be caused by deficient enzyme blocking a metabolic reaction. Symptoms arise from an accumulation of lipids, carbohydrate or amino acids before the block, or deficiency beyond the block.

Lipid disorder includes Tay-Sach's disease (ganglioside), Gaucher's disease (cerebrosid) and Niemann-Pick disease (sphingomyelin).

Psychiatric Nursing

Such disorder are commoner in Jewish people, begin early, have a rapid, fatal course.

Connective tissue disorders (mucopoly-saccharoidoses) include Hurler's syndrome (gargoylism).

Carbohydrate metabolism disorders include galactosaemia, in which there is jaundice, cataracts, proteinuria and galactosurea. It is treatable.

The best known amino acid metabolism disorder is phenylketonuria. Infants are screened by Guthrie inhibition test on blood for raised phenylalanine levels. The defect is caused by transforming phenylalanine to tyrosine from a deficiency of the enzyme phenylalanine hydroxylase. It occurs in 1 in 12000 births. There are no physical abnormalities, but often have blue eyes, fair hair and dermatitis there may be fits.

It may be treated through a phenylalanine free diet. Although this is artificial and unpalatable, it must be adhered to in childhood as soon as child will tolerate it. The diet can be stopped in adult life, but must be resumed during pregnancy.

G. Neurological defects

Sturge-Weber syndrome is caused by a naevoid defect. It is characterized by fits, hemiplegia, naevi (port wine stains) especially on face and neck, venous angioma of pia, and calcification of skull may be apparent on X-ray. Hemispherectomy may help.

Tuberous sclerosis eoukiua is characterized by sclerotic nodules in the brain, epilepsy, tumors elsewhere, especially kidney and heart, skin lesions, adenoma sebaceum, fibromatosis and phakomamta.

Laurence-Moon-Biedl Syndrome is characterized by mental defect, pigment degeneration of the retina, obesity, hypogenitalism and polydactyl.

H. Bony defects

Genetic micro-encephaly is probably caused by a single recessive gene.

Hypertelorism: is characterized by great breadth between eyes, due to abnormality of base of skull.

Oxycephally is characterized by telor skull or steeple-head. It is rarely associated with defect:hypertelorism and oxycephaly need not be associated with sub normality.

Treatment and care

Patients should be cared for at home where possible but of the benefits of this must be weighed against the stresses on other members of the family. Boredom and overcrowding may produce disturbed behavior and drugs (e.g. anticonvulsants) may further impair performance.

Education is essential and should emphasis practical social skills: learning to wash, dress, eat, travel and work. Subnormal people with an IQ of 50 or over can benefit from some form of schooling. Most

mentally handicapped people in the community are capable of some form of work and this may be in an occupation centered or sheltered workshop if open employment cannot be found. Very severely handicapped cases, with multiple handicaps or complicated by severe behavior disorder (e.g. aggressiveness, uninhibited sexual behavior) or psychotic illnesses may require care in hospital possibly throughout life. Prevention involves the pediatrician and obstetrician. Genetic counseling is developing in importance.

Treatment and nursing interventions

Assessment of persons with organic mental disorders is important, especially in the early diagnostic phase. The interview and the assessment of judgment, orientation, memory, affect, and cognition (JOMAC) are essential. Lancaster (1980) lists the following aspects that also should be considered during the assessment process:

1. Intellectual ability, past and present
2. Changes in personality (i.e., depression, irritability, loss of interest, and decrease or loss of interest in personal appearance)
3. Past and present health status
4. Any evidence of confabulation, negativistic behavior, preservation, feigning deafness, projection, or rationalization for lack of appropriate response.
5. Ability to provide self-care

Nursing interventions focus on identification and symptomatic management of any evident deterioration, as well as other factors noted during the assessment process. A calm, supportive approach is

Psychiatric Nursing

necessary when handling the patient's emotional responses or defenses against the acknowledgment of intellectual deficits. Smith (Lego, 1984) lists the following observable behavioral defenses frequently seen in persons with organic mental disorders:

1. Liability of affect or rapid fluctuations in emotional responses
2. Indifference or apathy
3. Lack of energy or anergia
4. Negativistic behavior
5. Impulsivity behavior or assault
6. Emotional incontinence or inability to control aggressive or sexual impulses
7. Depression
8. Refusal to communicate

Short-term nursing goals include maintaining the patient's contact with reality, preventing injury, promoting adequate nutritional and fluid intake, promoting adequate sleep and rest, encouraging expression of feelings, and stimulating the memory through various activities.

Long-term goals focus on promotion of optimal level of independence, decreasing socially inappropriate behavior, forming satisfactory social relationships with limitations, and assisting the patient to live in as nonrestrictive an environment as possible (Schultz, 1982). The environment should be simple and well-structured, providing the person with an opportunity to adapt to his or her impairments by doing things in less complex ways than in the past. Meeting basic needs becomes more demanding as physical deterioration occurs.

Psychiatric Nursing

Remaining learning potential should be maximized while the person is made to feel comfortable both physically and emotionally. New material or devices to provide self-care should be introduced simply and gradually.

Delusional thought processes may increase as the intellectual functioning deteriorates. Sudden deterioration may indicate a superimposed treatable disease.

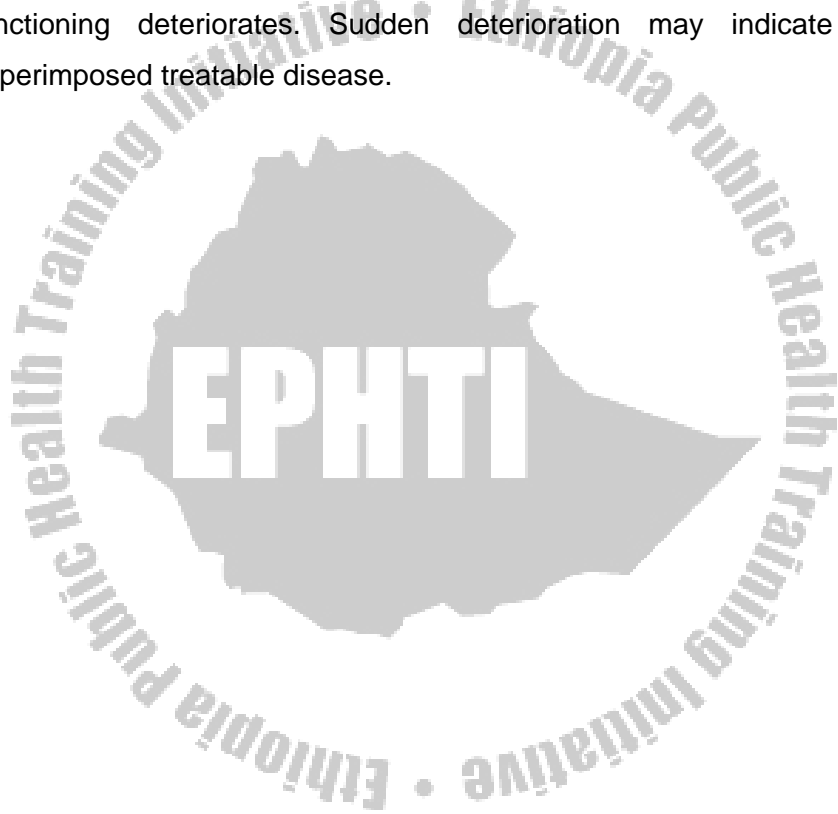


Table 7: Common nursing diagnoses and nursing interventions for organic mental disorders

NURSING DIAGNOSES	NURSING INTERVENTIONS
Alteration in thought process related to disorientation	<p>Assess level of disorientation. Use the following reality therapy:</p> <ol style="list-style-type: none"> 1. Orient to person, place, and time by using clocks, calendars, or other visual aids. 2. Refer to date, time of day, and recent activities during interactions with the patient. 3. Address the person by name 4. Correct errors in a matter-of-fact manner, Establish a set daily routine. <p>Encourage the person to have familiar personal belongings or possessions in his room.</p> <p>Assign the same nursing personnel to care the patient whenever possible.</p>
Self-care deficit because of loss of independent functions such as bathing and dressing	<p>Encourage independent functions by giving verbal step by-step instructions.</p> <p>Remain with the patient.</p> <p>Allow ample time to perform a given task to avoid frustration.</p> <p>Assist the patient if sensor motor impairment prevents him or her from functioning without help.</p>

Psychiatric Nursing

Alteration in thought process because of memory loss for recent information	Provide the patient with clear, simple, step-by-step directions while performing ADL routines. Use supportive statements if fabricated stories or untruths are given in defense of memory loss (i.e. "It's hard to find your glasses when their location slips your mind.").
Potential for injury owing to sensory motor deficits such as impaired vision and unstable gait	Establish a safe environment by <ol style="list-style-type: none">1. Providing adequate lighting in the patient's room2. Providing a night light3. Placing the light switch close to the bed for easy accessibility4. Assessing the patient's ability to ambulate independently, providing assistance as needed (i.e. walker, cane, or assist with ambulation)5. Providing adequate restraints such as a gait belt or vest if patient is disoriented as well as physically unstable

REVIEW QUESTIONS

1. Organic mental disorder refers to a particular organic mental syndrome in which the etiology is unknown.
 - a. True
 - b. False
2. List the diagnostic criteria of delirium according to DSM III R.
3. Which the following one is not the cause of death in Alzheimer's disease?
 - a. Neglect
 - b. Malnutrition
 - c. Suicide
 - d. None of the above
4. Two to three percent of the population has some degree of mental handicap.
 - a. True
 - b. False
5. List at least five acquired metabolic abnormalities that can cause mental handicap.

UNIT SEVEN

CHILD AND ADOLESCENT PSYCHIATRY

Learning objectives

After studying the material in this unit, the student should be able to:

1. Define child and adolescent psychiatry
2. Describe the general characteristics of mental illness in children and adolescents
3. List the causes of mental illness in children and adolescent age group.
4. Identify classifications of childhood psychiatry
5. Identify specific syndromes of childhood psychiatric disorder
7. Identify different types of childhood and adolescent psychiatric disorders.

Definition

Childhood and adolescent psychiatric disorders are types of mental illness which occur in childhood and adolescent age group.

Etiology

1. Genetic factors

Genetic factors are important. Wide individual variations in mood, level of activity, attention span are found in infants, and sex differences in aggressive behavior may be evident at two years. These temperamental differences may modify parental response to

children's aggression. The behavior of emotionally disturbed children often accurately predicts adult personality. The child is father of the man.

2. *Separation from parents*

For normal development, infants must form attachments and bonds (selective attachments persisting over a long period). The se may be disrupted, for example, by hospital admission. This is most stressful for children between six months and four years, of age, but children can be trained to accept separations gradually. Short separations can lead to acute but brief distress. One long separation rarely dose permanent emotional damage, but repeated hospitalization in a child from an unhappy home often causes psychiatric problems.

3. *Other stresses*

Other damaging stresses for children include moving house, bereavement and a broken home. The latter is especially associated with conduct disorders. The in the case of divorce, the associated marital discord is more important than the parents' separation. Children of one parent families have more psychiatric problems than average; children of working mothers do not.

4. *Delinquency*

Delinquency is associated with particular geographical areas which have poor or neglected housing, overcrowding, low family income and high adult crime rate. Children in inner cities are twice as likely

to have psychiatric disorder as those from elsewhere. These children are also more likely to come from overcrowded, unhappy homes with disturbed parents. Schools with high rates of teacher and pupil turnover have more disturbed children. In western country's, immigrant children, especially West Indian, have high rates for conduct disorders.

Classification

A World Health Organization Committee recommended that children be assessed on four dimensions:

1. Clinical psychiatric syndrome
2. Intelligence
3. Organic factors and
4. Psychosocial factors

Clinically, children show the same range of anxiety disorders, psychosomatic disorders and psychosis as those found in adults. The vast majority can be divided into two groups:

1. Children with predominantly neurotic symptoms. These children may suffer from anxiety, phobias, shyness, sleep and appetite disorders and tics. Most grow up to be stable adults.
2. Children with predominantly conduct disorders; stealing, aggression, lying, over-activity, truancy. These children have poor prognosis in adult life with higher rates of crime, alcoholism psychiatric admission and poor work record.

Children with behavior disorders are usually disturbed at home or at school; only in severe cases at both. About 7% of 10 to 11 year olds have some kind of psychiatric disorder. Boys have twice as much as girls and also exhibit conduct disorders more often.

A few disorders are specific to childhood and adolescence. These include early childhood autism, the hyperkinetic syndrome and anorexia nervosa. Specific developmental disorders include dyslexia, stammering, enuresis, encopresis and 'clumsy children'. Some of these are described in more detail below.

Specific syndromes of childhood psychiatric disorder

Nocturnal enuresis (bed wetting): This is more common in early years. At 14 years of age and above, the problem drops to 1 in 35. The problem is more common in males of below average intelligence living in poor social conditions. It is associated with a strong family history. 5% of cases are caused by urinary infections. Other cases may be neurotic, for example, regression after birth of a younger sibling. Yet other cases may be developmental. Treatment includes conditioning by an incontinence pad connected to a bell. Imipramine 25 or 50 mg may be given at night to older children; prolonged treatment is necessary.

Encopresis: This involves soiling; rather than enuresis. It is usually characterized by retention with overflow. Children with this problem are often of normal intelligence. The problem may be neurotic or

developmental. Treatment tends to be unrewarding, however, 50% of children experience spontaneous recovery in two years, and almost all recover before adult life.

Stuttering: There are two groups of children who may suffer from stuttering. The first are dull, often from poor social backgrounds and having suffered a birth injury. The second group tends to be of average or above average intelligence, and come from, ambitious families with anxious, obsessive mothers. In both groups the anxiety engendered by stuttering may lead to secondary neurotic disorders. Speech therapy is helpful.

Early childhood autism: This is a form of childhood psychosis beginning from birth or in the first three years. It should not be confused with schizophrenia, which is rare and occurs later in childhood. Autism is now generally agreed to be an organic condition, although formerly it was attributed to upbringing or the parents' personalities. The central defect is a difficulty in comprehension and the use of language. It is rare, occurring in about 1 in 2000 school children. Three boys are affected for every girl. The parents of autistic children tend to be intelligent. The symptoms comprise lack of speech: problem of comprehension, mutism or abnormal speech, with echolalia and the avoidance of the personal pronoun, and a monotonous mechanical voice. Autistic children have difficulty in copying movements: flicking movements of hands, spinning and jumping movements. They often exhibit a paradoxical response to sounds. They are resistant to change of routine. They are generally

Psychiatric Nursing

socially aloof, live in a world of their own. They often have tantrums. When testable, only 30% of autistic children have an IQ above 55. A third of autistic children develop fits in adolescence or adult life. Differential diagnoses include: deafness, partial blindness, elective mutism, mental sub normality.

The prognosis is poor. 60% of autistic children remain unchanged, only 15 per cent find open employment. The prognosis is slightly improved in those children with a higher IQ.

School refusal ('school phobia'): school phobia is relatively rare. Peak age for its occurrence is 11 to 12 years. It is often precipitated by change of school or illness in parents or grandparents. It is found most often in boys and children of intelligence average. It is more common in well behaved children doing well at school, who are often anxious and shy. The problem is associated with increasing anxiety, often with abdominal pain and vomiting, culminating in refusal to go to school. It is quite distinct from truancy. The mothers of children suffering from school refusal are often over-protective and subject to depression. The problem is generally due to separation anxiety rather than fear of school. The treatment may necessitate admission to a residential school or temporary separation from parents.

Tics (habit spasms): Ticks are sudden, brief, often repeated movements involving a group of muscles. They have no purpose but are usually based on purposive movements such as: blinking, head shaking and coughing. The most common tic is eye blinking; tics decline in frequency from head to feet. They are found in 10% of

children aged 6 to 7 years. They are twice as common in boys. There is often a family history of tics. Children with tics are commonly of average or above in intelligence and well behaved. They are often associated with emotional disturbance; sometimes with speech disorders, obsessions and hypochondria

The prognosis is good. Most tics are short-lived, the others spontaneously generally improve in adolescence. The very rare Gilles de la Tourette syndrome comprises multiple severe tics with compulsive swearing, and has a poor prognosis.

Hyperkinetic syndrome: This syndrome is characterized by overactive from an early age, sleeping little, wearing out clothes and shoes and an inability to sit still. Children with this problem are dangerously impulsive, distractible, with a short attention span. They exhibit day dreaming and lack of perseverance. They are excitable and have frequent temper tantrums. The syndrome is sometimes associated with organic brain disease, epilepsy or a low IQ. But often it is not. It is five times more common in boys and is not a rare condition, children with the syndrome show an excess of minor neurological abnormalities, for example, in coordination and clumsiness. Parents generally have above average rates of personality disorder and alcoholism. Children have similar risk in adult life. The prognosis is poor, although some respond to large doses of ritalin (methyl phenidate) or to imipramine.

Elective mutism: This is a neurotic disorder in which the child, usually male, is persistently mute in selected circumstances, for instance, at

school. Most are solitary and over-dependent on their parents. Treatment includes a change of environment on admission.

Adolescent psychiatry

The adolescent years are a time of major change for the individual. A growth spurt in early adolescence (13-14 years of age for boys and 10-12 years of age for girls) is followed soon after by sexual maturation. The adolescent becomes physically different in a very short time and is faced with a strenuous psychological adjustment to these changes throughout adolescence, intellectual maturation progresses. Although IQ does not continue to rise there, is an increase in logical and abstract reasoning. Emotionally, the adolescent generally strives for maturity and independence, particularly from their parents, but finds it difficult to give up the security and dependence of home and parents. Their ambivalent feelings lead to frequent inconsistencies in behavior. This in between state is accompanied by mild feelings of depression and emptiness in 50% of adolescents. Eriksson describes adolescence as a time of identity crisis when the individual has to decide who she or he is what she or he can do and what she or he will make of her or his life Social pressures are plentiful. He or she must learn many new roles at this time - changing from school to work, from child to parent. There is much pressure to conform to the peer group, whose standards may differ sharply from those of parents. It should be emphasized that although minor conflicts are common, serious and persistent difficulties between adolescents and their parents are rare.

Psychiatric Nursing

In a study of 14 year olds in the Isle of Wight, 20% demonstrated evidence of psychiatric disorder, but half of these were not handicapped by their symptoms either at school or at home. A survey of urban teenagers showed that 6% of boys and 3% of girls had severe disorders. In general, rates for psychiatric disorder are higher than those for adults. Those who are disordered often communicate poorly with their parents.

Types of adolescent disorder

As with children, adolescent disorders are may be classified as behavioral (conduct) or emotional (neurotic) disturbance. Many adolescents show both.

Neurotic disorder: As adolescence advances the symptoms are similar to those seen in adults. Depression and anxiety are common, the content of thought being the normal problems of the age group but this are magnified; appearance, sexual problems, status with friends are frequent preoccupations School refusal in adolescence may be a sign of severe neurotic difficulty.

Conduct disorder: This disorder is more common in boys form disturbed families. It is characterized by antisocial behavior in a wide range of settings and poor relations with others; it should not be confused with delinquency. The number of delinquents showing psychiatric disorder is not much higher than average. Conduct disorder is often associated with reading difficulties.

Psychiatric Nursing

Anorexia nervosa: This problem is a common and increasing disorder of adolescent girls. It occurs in 1 in 150 girls in this age group. Only 1 in 20 of the patients are male. The disorder generally begins with the wish to diet and feeling fat. It is characterized by progressive weight loss associated with early amenorrhea. The patient quickly becomes emaciated, but maintains s/he feels normal and looks normal and claims to be eating adequately. The disorder often includes self-induced vomiting and excessive purging carried out in secret. There may be intermittent over-eating (bulimia) especially after treatment. Patients are very resistant to accepting treatment. the disorder is potentially serious. In those whom the condition lasts for ten years the later mortality may be 10%. Poor prognosis is associated with disturbed body image.

The weight of patients with the disease typically falls to 30 to 35 kg. The may be best regarded as a phobic avoidance of adolescent weight gain and the physical and psychological changes of puberty.

The treatment target is to enable the patient to gain weight assisted by good nursing, high doses of phenothiazines and psychotherapy. Treatment requires extended and careful follow-up.

Other problems associated with adolescence. Suicide is rare but rates rise in adolescence. Those who commit suicide are often taller than average and above average intelligence. Attempted suicide is very common it may be associated with parental death.

Psychiatric Nursing

Affective disorders are rare, but schizophrenia is more likely. Schizophrenia often has an insidious onset and so cases may be difficult to distinguish from the normal difficulties of a shy adolescent with identity problems.

Brain damage resulting from road traffic accidents is a growing problem.

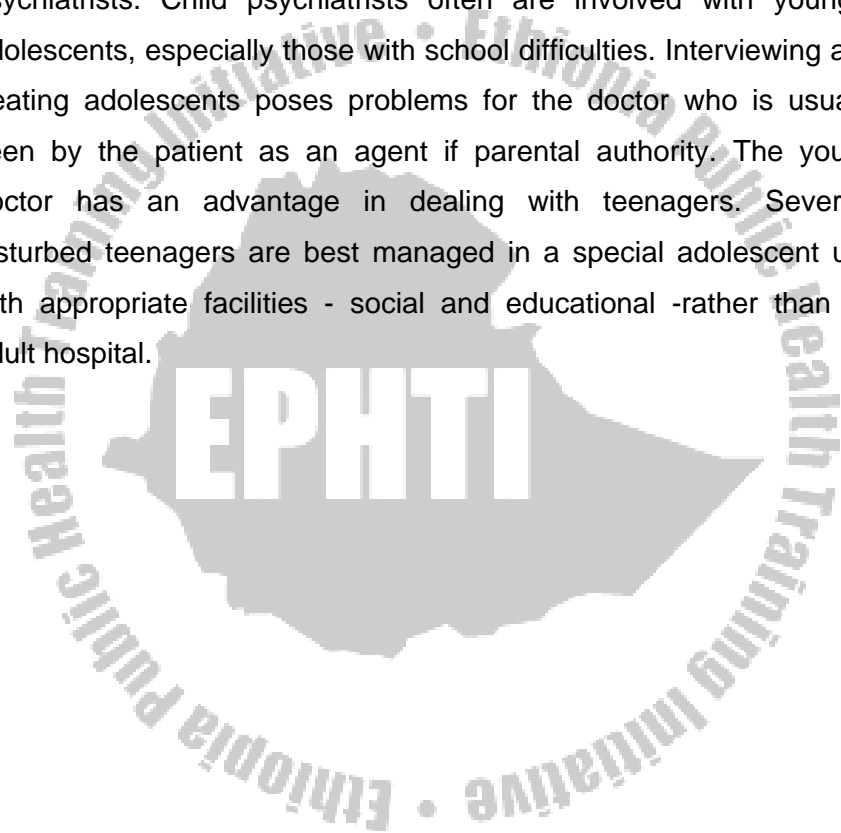
Drug abuse is common in adolescence and alcoholism increasing.

Treatment methods

In emotional disorders of childhood, family relationships are often relevant and most child psychiatric clinics employ a treatment team including a doctor, a social worker, a psychologist, a nurse and a play therapist. Individual or group therapy including the family members and the child may be indicated, especially where there a family history of suicide. Residential treatment in hospital or special boarding school may be needed when the home is unsatisfactory or where the behavior disorder cannot be contained by out-patient care alone. Drug treatments are less often used than with adults but tranquillizers and anti-depressants may be of value. ECT and psychosurgery are seldom, if ever, needed.

Treatment services

Many adolescents do not seek medical help with their symptoms. Some psychiatrists specialize in this age group, but many patients with conditions such as self-poisoning or anorexia are seen by adult psychiatrists. Child psychiatrists often are involved with younger adolescents, especially those with school difficulties. Interviewing and treating adolescents poses problems for the doctor who is usually seen by the patient as an agent of parental authority. The young doctor has an advantage in dealing with teenagers. Severely disturbed teenagers are best managed in a special adolescent unit with appropriate facilities - social and educational - rather than an adult hospital.



REVIEW QUESTIONS

1. Children from one parent families have more psychiatric problems than other children.
 - a. True
 - b. False
2. Juvenile delinquency is not associated with particular geographical areas, poor neglected housing, over crowding, low family income and high adult crime rate
 - a. True
 - b. False
3. List the four dimensions of children mental health classifications according to world health organization
4. Boys have twice as many conduct disorders as girls.
 - a. False
 - b. True
5. Anorexia nervosa is more common and increasing disorder of adolescence.
 - a. True
 - b. False
6. Suicide, brain damage due to accident, drugs and alcohol abuse are common psychiatric problems in adolescent age group.
 - a. True
 - b. False

UNIT EIGHT

ALCOHOL AND OTHER SUBSTANCE ABUSE

Learning objectives

After studying this unit, the student should be able to:

1. Define alcohol and alcohol related terms
2. Describe the characteristics of alcohol withdrawal syndrome (AWS)
3. Describe different treatment modalities for substance abuse
4. Describe alcohol withdrawal delirium
5. Describe alcoholic amnesic syndrome (Wernicke Korsaff's syndrome)
6. Describe nursing intervention for organic mental syndromes and disorders.

Definitions

Teetotaler: Person who do not drink alcohol at all

Social drinker: Person who drinks moderately but who may get drunk from time to time

Excessive drinker: Person who may drink excessively and may show either by the frequency with which they become intoxicated or by the degree of the social, economic or medical consequence of their continuous intake of alcohol. Not all excessive drinkers are alcoholics.

Tolerance: The need for markedly increased amount of alcohol to achieve the desired effect.

Withdrawal: The development of symptoms like morning shakes after cessation or deduction in drinking when alcohol is withdrawn.

Abuse of substance (non therapeutic use of substance): Implies a pathological pattern of use of substances such as drugs, an inability to control this use and impairment in social or occupational functioning, with the duration of the abuse of at least a month.

Alcohol

Alcohol (ethyl alcohol or ethanol) is perhaps the substance most intensively used for non-medical purpose. It can be produced by the growth of yeast in a sugar-containing medium (fermentation).

Alcohol acts on every cell of the body; however the CNS is its prime target. Its effects occur more rapidly in the CNS than in any other tissue of the body. It affects every level of organization with in the CNS: from its chemistry to its molecular structure and the integrated functions that govern thought process, emotions motor function and behavior.

A single dose of alcohol results in non - specific general depression of the CNS and subsequent behavioral changes. These changes are dose dependent. They are related to the blood alcohol concentration (BAC).However, some of the CNS changes may be longer lasting; acute alcohol intake increases synaptic membrane fluidity. However, chronic alcohol intake induces a long lasting resistance to its

membrane fluidizing effect. Elimination of alcohol from the system, or a marked decrease in BAC after long term use may cause the alcohol withdrawal syndrome (AWS)

Characteristics of AWS

Characteristics of AWS include hyper-excitability (opposite of depression) evidenced by tremors and agitation, convulsions, ataxia, dizziness, diaphoresis, dilation of pupils and hallucination.

The depression of the CNS by alcohol is dependent on the amount consumed. The effects on mood and behavior differ between individuals and depend not only on the amount consumed but also to a large extent, on the personality and the mental state of the individual and their environment.

Small amounts of alcohol will produce sedation and relief of anxiety. As the blood level increases, these symptoms become more pronounced. When a large amount is consumed depression, inadequate muscular coordination (ataxia), impaired psychomotor performance, poor judgment and inhibited or irresponsible behavior may be manifested. Excessive consumption will produce unconsciousness and may be lethal in the presence of other depressant drugs.

Alcohol is mainly absorbed directly in small intestine, but also in stomach. In the presence of food the rate of absorption decreases. Most of the absorbed ethanol is completely oxidized to CO₂. Alcohol affects the organs of the body as follows:

Psychiatric Nursing

CNS: Alcohol depresses brain function including behavior, cognition judgment, respiration, sexuality and interferes with motor functions.

GIT (gastrointestinal tract): Alcohol erodes the stomach and causes mucosa-gastritis, acute pancreatitis, cirrhosis in the liver and alcoholic hepatitis.

CVS: Alcohol may cause hypertension and alcoholic cardiomyopathy (erosion of the wall of the heart).

Kidney: Alcohol causes diuresis.

Eye: Alcohol causes pupillary dilation, hyper reflexia.

Alcoholism

According to USA National Council on Alcoholism, the alcoholic is powerless to stop the drinking that seriously alters his normal living pattern. Alcoholics Anonymous describes alcoholism as a physical condition associated with a mental obsession. It is considered to be partly physical, partly psychological partly sociological and partly caused by the effect of alcohol.

Chronic alcoholism is a disabling disorder which imposes on the sufferer physical, social and psychological handicaps often of great severity.

It has been repeatedly observed that the medical outpatients and causality departments note an increase in problems on Monday morning (Monday fever) as many of patients present with the

symptoms of hangover (body pains, dizziness and so on) and request to take sick leave.

Etiology

The precise causes of alcoholism are unclear; psychological and coping factors play an important role of causation. Alcoholism runs in families, various studies of alcoholic groups reveal that up to:

- 50% of alcoholics have alcoholic fathers
- 30% alcoholics have alcoholic brothers
- 6% alcoholics have alcoholic mothers
- 3% alcoholics have alcoholic sisters

Heavy drinkers tend to come from heavy drinking families and the children of alcoholics have a higher risk of alcoholism than do children of parents who are not alcoholics.

Females are more likely to become alcoholic if the mother is alcoholic or they have a monozygotic twin who suffers from the disorder. Certain races show clear cultural and racial links with alcoholism. The Irish appear to be highly vulnerable, Jews and Moslems nearly invulnerable. Alcoholism is common in men than in women (5:2) and is mainly a disorder of middle age.

According to DSM III R, The essential features of alcohol abuse are:

1. Continuous or episodic use of alcohol for at least one month
2. Withdrawal from social, occupational, or recreational activities.
Social problems such as arguments or difficulties with family or friends, violence, while intoxicated, missed work, being tired, legal

Psychiatric Nursing

problems resulting from alcohol intake such as being arrested for intoxicated behavior and traffic accidents while intoxicated

3. Either psychological dependence or compelling desire to use alcohol
4. Inability to cut down or stop drinking.
5. Frequent intoxication
6. Marked intolerance
7. Withdrawal symptoms

Alcohol dependence (alcoholism) is described in DSM III as having the features of either tolerance or withdrawal.

The social complications due to alcoholism include a high rate of marital separation and divorce, job troubles including absenteeism, high frequency of accident and economic crimes. Usually the patient has some alcohol –related impairment in at least one of the following areas: Work or school; health; family relationships; social functioning such as seeing only drinking friends or legal problems such as arrest for driving while intoxicated or alcohol related violence. Substances are often taken to relieve or avoid withdrawal symptoms despite knowledge of having impairment.

Alcohol-related disorders

Medical complications could result from acute effects of heavy drinking, chronic effects of heavy drinking or withdrawal; nearly every organ system can be affected directly or indirectly. Gastritis, gastric ulcer, acute hemorrhagic pancreatitis, liver cirrhosis, peripheral neuropathy and amnestic syndromes are but a few of the major

medical complications of alcoholism. Alcoholic paranoid psychosis and korsakoff- syndrome (dementia) are generally not reversible.

Medical complications like cirrhosis, peptic ulcer disease, thiamine deficiency and neurological diseases like cerebral degeneration can occur.

Treatment

Alcoholism, when it is recognized, requires a treatment program which has a total abstinence as the main goal. Sedatives are to be avoided and tranquilizers used only during the withdrawal phase. Antidepressants should be used if depression is present. The suicidal risk should always be considered. Suicide is 60 times more common in alcoholics than in non alcoholics.

Detoxification

Out patient detoxification requires a co-operative patient and a co-operative significant other person. The patient is given chlorodiazepoxide hydrochloride 20 - 25 mg four times daily, with the dose depending on the severity of the withdrawal symptoms.

Alcoholics who show signs of impending delirium, tremors, hyper irritability, increased pulse rate and high blood pressure require hospitalization for detoxification. Alcoholics who are seriously depressed, suicidal, psychotic or who are uncooperative also require a hospital setting for detoxification. Finally one must hospitalize those alcoholics whose drinking can not be interrupted.

Disulfiram (anti abuse) is useful in the treatment 250 mg/d starting 24 hours after the last drinking. This drug causes nausea; vomiting and distress which is often severe if the patient resumes drinking alcohol. Those patients who remain clinically depressed beyond the detoxification period often benefit from antidepressant medications.

Initially the alcoholic is likely require drying out in a hospital for about 10 days. Since alcoholics have a tremendous craving to drink some two or three weeks after drying out (stop drinking), hospitalization for a period of six to eight weeks may therefore be strongly advised.

Alcohol consuming individuals may present with alcohol dependence and abuse, withdrawal effects or intoxication.

Alcohol withdrawal symptoms occur several hours after cessation of or reduction in prolonged heavy alcohol consumption. At least two of the following must be present autonomic hyper-activity, hand tremor, insomnia, nausea or vomiting, transient illusions or hallucinations, anxiety, seizures and agitation.

Alcohol withdrawal delirium

Delirium tremens is the most severe form of the alcohol withdrawal syndrome. Among hospitalized patients about 5% develop delirium tremor. A transient organic psychosis may occur. Delirium will occur within one week of the cessation or reduction of heavy alcohol ingestion.

Additional features of withdrawal are:

1. Reduced wakefulness or insomnia
2. Perceptual disturbance (illusion, hallucination) mostly visual but may be auditory or tactile.
3. Increased or decreased psychomotor activity tremor is almost always present.

Treatment

Disulfiram-125-500 mg/day produces an unpleasant reaction when the patient ingests small amount of alcohol. The reaction may be headache, anxiety, weakness, dyspnea, hyperventilation and confusion.

Appropriate medical treatment includes vitamin saturation, fluid replacement, and antibiotics if infection develops.

Tranquilizers with a pharmacological cross tolerance to alcohol such as chlorodizepoxide should be given in a dose of 25-50 mg every 2-4 hours. Diazepam may also be used. Phenothiazines should be avoided because they may introduce the possibility of hepatitis superimposed up on preexisting impaired hepatic functioning. They also tend to reduce seizure threshold.

Alcoholic amnestic syndrome (Wernicke Korsakoff's syndrome)

The essential feature of alcohol amnestic syndrome is a short term but not immediate memory disturbance due to the prolonged heavy use of alcohol.

Other complications of alcoholism such as cerebral signs, peripheral neuropathy and cirrhosis may be present (the patient may or may not confabulate but disoriented in special for the time). It rarely occurs before the age of 35 years.

Etiology

The irreversible memory deficit known as Korsakoff's psychosis often follows an acute episode of Wernicke's encephalopathy manifested by ataxia, ophthalmoplegia, nystagmus and confusion.

Thiamine deficiency malnutrition is a predisposing factor.

Its prevalence is unknown

Treatment

The symptoms are usually irreversible; although various degrees of recovery have been reported with a daily regimen of 50-100 mg thiamin hydrochloride. Thiamine -100mg daily for 3 days may be given to prevent Wernicke encephalopathy.

Substance related disorders

A variety of substances may cause substance related disorders including alcohol, amphetamines and amphetamine-like substances such as khat, cannabis cocaine, nicotine, hallucinogens, opioids, etc.

Khat, alcohol and cannabis (Hashish) are the commonly used substances in Ethiopia.

Epidemiology

The prevalence of khat consumption in Ethiopia is 50% and alcohol consumption is 23.4%.

Khat

The chewing of the stimulant leaf khat is a habit that is widespread in certain countries of east Africa and the Arabian peninsula. It was noticed, long ago, that the plant of khat growing in some regions of East Africa including Ethiopia, has a certain influence on the psychic and physical state of persons who use it. 'Chat edulis' or khat is a short evergreen plant or shrub from the family Celastraceae which grows in higher altitudes, with green glossy leaves, a small crown and diminutive white flowers in small branches.

Khat is cultivated in Ethiopia both for export and for local consumption. Because of the economic importance of khat in Ethiopia, its control may be difficult at present, since the export potential of this agent is increasing. Between 1975 and 1982 an average of 2085 metric tons of khat were exported annually and the National Bank of Ethiopia estimated that the khat export value in 1982 alone was \$US 16 million. It is one of the top economic plants, particularly in the Hararghe zone near Alemaya University, namely 'Awaday'.

It is evident from different studies that the medical and psychosocial effects of khat chewing are harmful both to the individual and the community. The habit of khat chewing seriously affects the psycho

economic structure of the subject. It is important to be aware of the increasing prevalence of khat chewing in order to assess the health and socioeconomic problems of khat habituation and to take further, appropriate medical and social measures.

As stated by some investigators, the prevalence rate of khat consumption is 22.3% in Gondar College of medical sciences and it is higher among the youngsters between the ages of 21

– 24 years, which is an economically productive age group. The prevalence rate among the community in Jimma town is 54% and in Agaro it is 62.9%.

Khat is used because of the effect it has on the person's psychic and physical condition. Khat has an extreme social effect (individual sociability and ease within social gatherings). It provides a major motivation for people to engage in social gatherings, and is used in all major ceremonial occasions such as wedding, funerals and religious holidays

Nowadays the medical and socioeconomic problems related to khat have attracted the attention of many international agencies including the United Nations. In 1975 the United Nations narcotic laboratory in Geneva discovered the major active principle of fresh leaves, namely cthionone. Khat has been the subject of phytochemical investigations for over 100 years and so it is surprising that main active principle was discovered only in the mid 1970's. This delay was because earlier investigations on the plant were undertaken on dried leaves. Interesting enough people, who are using khat without knowing its

chemistry, consume the fresh leaf and stem of khat which contain the active ingredient which has stimulating effect.

It is now established that the effect of khatleaves on the central nervous system (CNS) are caused by cathionone, which exhibits properties similar to those of amphetamine. Furthermore phenylpentey amine merucathionone has been recently discovered in khat leaves. This makes a minor contribution towards khat's psychoactive effect.

Khat is known for producing amphetamine-like effect. It is an amphetamine-like substance with the following behavioral and physical effects: alertness, euphoria, hyperactivity, irritability, aggressiveness, agitation, paranoid trends and hallucinations. Other physical effects include mydriasis, tremor, dry mouth, tachycardia, arrhythmias, weight loss and convulsions. Patients can also develop psychotic disorder, mood disorder, and sexual dysfunction and sleep disorders.

The patient can also develop withdrawal symptoms upon cessation of heavy use which manifest with dysphoria, fatigue, sleep disorder, agitation and craving for the substance.

Treatment

For agitated patients, diazepam 5-10mg every 3hrs IM or P.O can be given.

Cannabis

Cannabis products include marijuana and hashish. Intoxicated patients may exhibit:

- Euphoria
- Anxiety
- Dry mouth
- Tachycardia
- Increased appetite
- (Rarely) hallucinations

Treatment

Treatment includes providing reassurance in a quiet place and diazepam may be given.

Nursing interventions

The attitude of nursing personnel can influence the quality of care given to persons who abuse drug. Nurses may view patients who overdose on drugs with disapproval, intolerance, moralistic condemnation, or anger, or they may not display any emotional reaction. They should display an accepting, nonjudgmental attitude, while coping with various behaviors such as manipulation, noncompliance, aggression or hostility. Nursing personnel need to be aware of the various signs and symptoms of drug abuse, if they are to administer appropriate nursing care.

Psychiatric Nursing

Nursing interventions include providing medical relief for symptoms such as nausea, vomiting, bruises, fluid and electrolyte imbalance and withdrawal symptoms.

There are several nursing diagnoses and interventions in multiple drug abusers, which include: potential for injury, sensory alterations, anxiety, sleep pattern disturbance, alterations in nutrition, possible fluid volume and electrolyte deficit, health maintenance alteration, noncompliance, ineffective individual coping and potential for violence.

Table 8: Nursing diagnoses and nursing interventions for withdrawal symptoms due to multiple drug abuse.

Nursing diagnosis	Nursing interventions
Sensory-perceptual alteration: delirium.	Provide a safe environment. Decrease environmental stimuli by placing the patient in a partially lighted room. Avoid loud noise. Asses level of sensorium.
Alteration in thought process: hallucinations.	Orient to person, time and place. Avoid conveying to the patient the belief that the hallucinations are real. Encourage the patient to make the staff aware of the hallucinations. Be alert for signs of increased fear, anxiety, or agitation.
Anxiety related to withdrawal	Asses level of anxiety. Decrease sensory stimulation.

Psychiatric Nursing

symptoms.	Provide reassurance and comfort.
Potential for injury owing to altered sensorium.	Assess for the causative factor of altered sensorium. Provide a safe environment by keeping the bed at lowest level at night, utilizing side rails as necessary, and restraining the patient if necessary (as a last resort). Orient to surroundings by explaining the call system, rationale for utilizing side rails, and so on. Provide a night light to familiarize the patient with the surroundings.
Alteration in nutrition: Less than body requirements	Provide diet as tolerated to supply adequate nutrition for nourishment and tissue repair unless the patient is NPO. Make sure that the dietary department serves appetizing meals, including special dietary preferences. Serve dietary supplements as needed to maintain an adequate intake of vitamins, minerals, and so forth. Maintain an intake and output (I&O) if necessary.

REVIEW QUESTIONS

1. In alcohol users, a need for markedly increased amount of alcohol use to achieve the desired effect is termed as tolerance
 - a. True
 - b. False
2. One of the following organ system is the main target of alcoholism in alcohol user individuals
 - a. GIT (gastrointestinal tract)
 - b. Cardiovascular system
 - c. Kidney
 - d. Central nervous system (CNS)
3. Alcoholism is a problem which needs, physical, psychological and sociological intervention, not only psychiatric intervention
 - a. True
 - b. False
4. Detoxifying an alcoholic requires a co-operative patient and a co-operative significant others.
 - a. False
 - b. True

UNIT NINE

DEFENSE MECHANISMS

Learning objectives

After studying this chapter, the student will be able to:

1. Define different defense mechanisms
2. Describe different uses of defense mechanisms.

Definition

Defense mechanism and mental mechanisms are terms used to describe the unconscious attempt to obtain relief from emotional conflict or anxiety. Coping mechanisms include both conscious and unconscious ways of adjusting to environmental stress. Such mechanisms are supposedly in action by age ten and are used as follows:

1. To resolve a mental conflict
2. To reduce anxiety or fear
3. To protect one's self esteem
4. To protect one's sense of security.

Approximately 20 different mental mechanisms have been identified. Some are considered to be healthy defense mechanisms, whereas others are considered pathologic or characteristic of a mental disorder. Some of these mechanisms are described below.

Psychiatric Nursing

1. *Repression*: This is an involuntary rejection of ideas, unconscious thoughts, feelings and memories that are painful (automatic forgetting): for example, the inability to remember the reason for an argument or recall feelings of fear following an automobile accident.
2. *Suppression*: This is the voluntary act of pushing unacceptable feelings out of one's consciousness. This mechanism is generally used to protect one's self-esteem.

A deliberate intentional exclusion from the conscious mind is referred to as voluntary forgetting "I had rather not talk about it right now "Let us talk about my accident later" etc.

3. *Rationalization*: This is the most common ego defense mechanism. It is used to justify ideas, actions or feelings by providing good, acceptable reasons and explanations. It is used to maintain self-respect, prevent guilt feelings, and obtain social approval or acceptance: for example, a teenage girl who was not asked to the junior prom might tell her friend someone really wanted to date her but felt sorry for Sue and took her to the prom instead.
4. *Identification (the imitator)*: This is an unconscious adoption of some of the characteristics of another person.
5. *Sublimation*: This is one of the defense mechanism that is not pathogenic. It involves re-channeling of consciously intolerable or occasionally unacceptable impulse or behaviors into activities that

are personally or socially acceptable: for example, a college student who has hostile feelings may re-channel them by joining the debating team.

6. *Displacement*: This is a mechanism that serves to transfer feelings such as frustration, hostility, or anxiety from one idea, person, or object to another: for example, a person might disagree at his boss but instead picks a fight with his wife or his children when he is back at home.
7. *Compensation*: This is the act of 'making up' for a real or imagined inability or deficiency with a specific behavior to maintain self respect or self- esteem: for example, a short girl may become the manager of the girl's basketball team because she is not tall enough to qualify for the team, or an unattractive man may select expensive, stylish cloths to draw attention to himself or an unattractive woman may dress like a fashion plate to attract attention.
8. *Introjection*: This involves attributing to oneself the good qualities of another: symbolically taking on the character trait of another person by 'ingesting' his philosophy ideas, knowledge, or attitudes. the term is often used loosely as synonymous with identification. An example would be a psychiatric patient who claims to be Moses or Jesus Christ or other biblical or well known person, who is observed dressing and acting like the personage they profess to be. One patient who claimed to be Moses grew a beard and long

hair, wore a blanket and sandals and read his bible daily. He refused to participate in activities unless he was called Moses.

9. *Projection*: This is often termed as the 'escaping goat' defense mechanism. The person rejects unwanted characteristics of her or himself and assigns them to others. He/she may blame others for faults, feelings, or shortcomings that are unacceptable to self. Examples would be: a man who is late for work states, "my wife forget to get the alarm last night so I overslept" or after spilling a glass of milk while playing cards with a friend, a 10-year-old tells his mother, "my brother made me spill the milk. He told me to hurry up and play."
10. *Regression*: This involves returning to past level of behavior to reduce anxiety, allow one to feel more comfortable and permit dependency: for example, a 5 year old boy who previously was toilet trained and who becomes incontinent when his mother gives birth for a new baby in order to get attention like a newly born baby.
11. *Conversion*: This is the transferring of a mental conflict in to a physical symptom to release tension or anxiety. Examples would be an elderly woman who experiences sudden blindness after witnessing a robbery or a middle-aged who man develops paralysis of his lower extremities after he learns that his wife has terminal cancer.
12. *Reaction formation (overcompensation)*: This involves acting the opposite way from what someone normally would in a given

situation (it is also referred to as overcompensation). Examples would be a young man who dislikes his mother-in-law who acts very polite and courteous towards her, a woman who hates children may talk very lovingly to a friend's young son, or a man, who has a strong desire to drink alcohol who condemns the use of alcohol by others.

13. *Undoing or restitution*: This is the negation of a previous consciously intolerable action or experience to reduce or alleviate feelings of guilt. An example would be a young man sends flowers to his fiancée after he embraced her friend at a cocktail party.
14. *Denial*: This is the unconscious refusal to face thoughts, feeling, wishes, needs or reality factors that are intolerable: for example, a student who is persistently late for a scheduled class because that student is actually very fearful of the topic, so he/she expresses the fear by being absent from the class, or a person who has just been admitted to a mental hospital states "I am really not sick, I am just in here to get a rest"
15. *Substitution*: This is defined as the replacement of consciously unacceptable emotions, drives, attitudes, or needs by those that are more acceptable or it is the act of finding another goal when one is blocked: for example, a student nurse in a baccalaureate program who decides she is unable to master the clinical competencies and elects to become a laboratory technician is using the mechanism of substitution

16. *Fantasy*: This refers to imagined events or mental images (e.g. day dreaming) to express unconscious ideas, conflict, gratify unconscious wishes, or prepare for anticipated future events: for example, in a popular television soap opera, a young woman character who does not have a child fantasizes she has a child, as she sits in a rocking chair, holding a baby doll, and singing lullabies.
17. *Symbolization*: This refers to an object, idea or act that represents another through some common aspect and carries the emotional feeling associated with the other. Symbolization allows emotional self-expression: for example, the engagement ring symbolizes love and a commitment to another person, wearing a white wedding gown generally symbolizes the bride's purity or chastity.
18. *Isolation*: This is the process of separating unacceptable feeling, idea or impulse from one's thought (also referred to as emotional isolation: for example, an oncologist is able to care for a terminally ill cancer patient by separating or isolating his feelings or emotional reaction to the patient's inevitable death. He focuses on the treatment, not the prognosis.
19. *Dissociation*: This is the act of separating and detaching a strong emotionally charged conflict from one's consciousness: for example, a woman who was raped was found wandering busy high way in torn, disheveled clothing. When examined by the emergency room physician, the woman was exhibiting symptoms

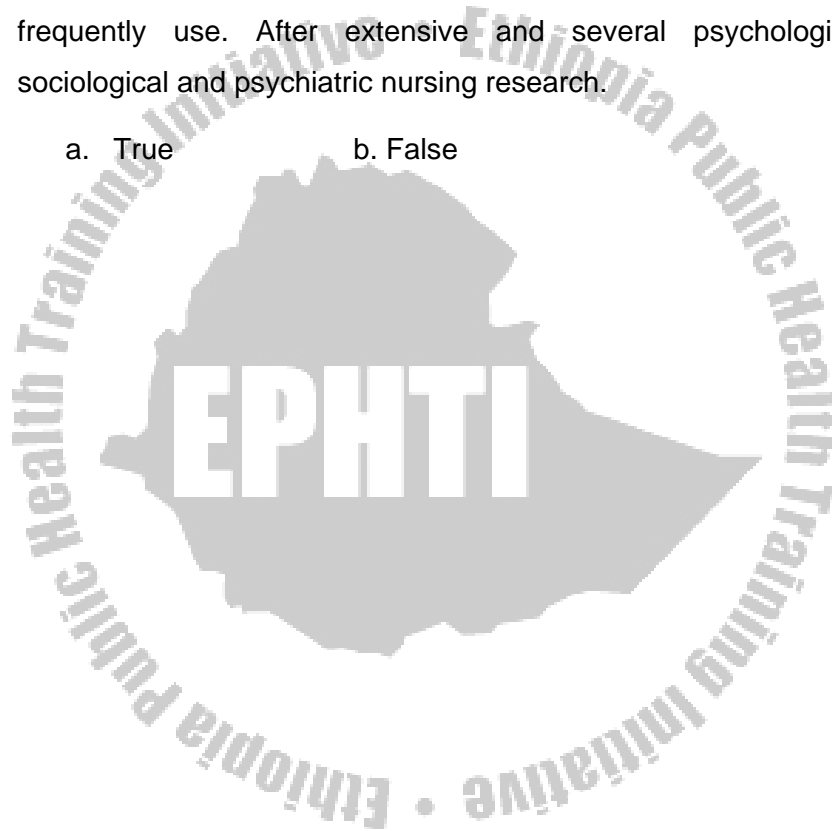
of traumatic amnesia. She separated and detached her emotional reaction to the rape from her consciousness.

20. *Intellectualization*: This refers to the act of transferring emotional concern in to the intellectual sphere: for example, a young man may use intellectualization as method of avoiding confrontation with his fiancé if she changed her mind about wishing to marry him.

In summary, defense mechanisms are categorized in various ways: from healthy to unhealthy, sophisticated to primitive, most frequent to least frequently used. Such lists of defense mechanisms have been developed after extensive research of several psychological sociological and psychiatric nursing texts and are based on the degree of personality disintegration and reality distortion that can occur when the mechanisms are used frequently.

REVIEW QUESTIONS

1. State the purpose of defense mechanisms and list them.
2. Defense mechanisms are categorized in various ways, health to unhealthy, sophisticated to primitive; most frequently used to least frequently use. After extensive and several psychological, sociological and psychiatric nursing research.
 - a. True
 - b. False



UNIT TEN

PERSONALITY DISORDER (CHARACTER DISORDER)

Learning objectives

After studying this unit, the student should be able to:

1. Define personality and personality disorder
2. List terms of psychological quality and psychological process
4. List the characteristics of personality disorders
5. Identify the etiology of personality disorder
6. Classify personality disorder in cluster forms
7. Describe personality disorder in terms of clinical types
8. Describe the nursing interventions appropriate for personality disorders.

Definition of personality

Personality is the total of a person's internal and external patterns of endowment and life experience. In general personality is the sum of all somatic process plus psychological phenomena.

Psychological phenomena equate to psychological quality combined with psychological process

Psychological quality

Psychological quality includes the following features:

- Character
- Interest
- Habit
- Skills
- Attitudes
- Ability
- Knowledge
- Motives, etc.

Psychological process

Psychological processes include

- Sensation
- Attention
- Feelings
- Memory
- Thinking
- Will
- Cognition, etc.

Personality disorder

Personality disorder is described as a non-psychotic illness characterized by maladaptive behavior, which the person utilizes to fulfill his or her needs and bring satisfaction to self.

Characteristics of personality disorder

1. The person denies the maladaptive behavior s/he exhibits; such behavior has become a way of life for him.
2. The maladaptive behaviors are inflexible
3. Minor stress is poorly tolerated, resulting in increased inability to cope with anxiety
4. Ego functioning is intact but may be defective therefore, it may not control impulsive actions of the id
5. The person is in contact with reality although s/he has difficulty dealing with it
6. Disturbance of mood, such as anxiety or depression may be present
7. Psychiatric help rarely is sought because the person is unaware or denies that his or her behavior is maladaptive.

Etiology of personality disorders

1. Biological predisposition may result from improper nutrition neurological defects, and genetic predisposition
2. Child hood experiences can foster the development of maladaptive behavior
3. Socially deviant persons may have defective egos through which they are unable to control their impulsive behavior
4. A weak superego may result in the incomplete development of or lack of a conscience. A person with immature superego will feel no guilt or remorse for socially unacceptable behavior

5. The drive for prestige, power and possession can result in exploitative manipulative behavior
6. Urban societies such as inner cities are characterized by a low degree of social interaction, thereby fostering the development of deviant behavior.

Clusters of Personality Disorders

Cluster A

Paranoid personality disorder

The defining trait of paranoid personality disorder is suspiciousness. Suspiciousness is some thing that we all feel in certain situations and with certain people, often for good reasons. However, paranoid personalities feel suspiciousness in almost all situations and with almost all people, usually for very flimsy reasons. When a paranoid person is confronted with evidence that their mistrust is unfounded, they will simply begin to mistrust the person who brought them the evidence "So he is against me too". This results in impairment in cognitive function.

Schizoid personality disorder

Schizoid personality disorder is defined by a fundamental eccentricity, a preference for social isolation. According to current thinking, schizoids are deficient in the capacity to experience social warmth or any deep feelings and unable to form attachments. Schizoid personalities rarely marry, have few friends (if any), seem indifferent to praise or criticism from others, and prefer to be alone. Because of

their self-absorption, they may seem vague or absent-minded: 'out of it', so to speak. However, such people do not show the unusual thoughts, behaviors, or speech patterns that one sees in the schizotypal personality. They may be quite successful in their work, if it is an occupation that calls for little social contact. On the other hand the disorder is more common among inhabitants of skid row.

Schizotypal personality disorder

The person with schizotypal personality disorder will seem odd in his or her speech, behavior, thinking, and /or perception, but not odd enough for a diagnosis of schizophrenia or the person may report recurrent illusions, such as feeling as if his dead mother were in the room: a situation nevertheless different from that of the schizophrenic, who is likely to believe that his dead mother is actually in the room. Schizotypal personality disorder may also show magical thinking, claiming that they tell the future, read the thoughts of others, and so on. They tend to be suspicious, aloof, and withdrawn. The disorder is more common in the families of diagnosed schizophrenics than in the population at large.

Cluster B personality disorder

Antisocial

The defining characteristic of antisocial personality disorder is a predatory attitude toward other people: a chronic indifference to and violation of the rights of one's fellow human being.

According to DSM-III-R's lists of criteria for the diagnosis of antisocial personality disorder can be summarized as five basic points:

1. A history of illegal or socially disapproved activity, beginning before the age of fifteen and continuing into adulthood
2. Failure to show consistency and responsibility in work, sexual relationships, parenthood or financial obligations
3. Irritability and aggressiveness, including not just street brawls but often abuse of spouse and children
4. Reckless and impulsive behavior. Unlike most 'normal' criminals, antisocial personalities rarely engage in planning. Instead, they tend to operate in an aimless, thrill-seeking fashion traveling from town to town with no goal in mind, falling into bed with anyone available, stealing a pack of cigarette or a car, depending on what seems easiest and most gratifying at the moment
5. Disregard for the truth. People with antisocial personalities lie frequently.

Borderline personality disorder

Theorists state that the borderline personality disorders may be a result of a faulty parent–child relationship, in which the child does not experience a healthy separation from mother to interact with the environment. Negative feelings are shared by parent and child, who are bound together by all feelings of guilt. Trauma experienced at a specific stage of development, usually 18 months may result in a weakening the person's ego and ability to handle reality and is another possible cause. Additionally, the person who experiences an unfulfilled need for intimacy is liable to develop the disorder.

According to the DSM-III-R, clinical symptoms may include:

1. Unstable interpersonal relationships
2. Impulsive, unpredictable behavior that may involve gambling, shoplifting, and sex. Such a person tends to use and can tolerate large amounts of drugs and alcohol
3. Inappropriate anger and inability to control anger.
4. Disturbance in self- concept, including gender identity
5. Unstable affect that shifts from normal moods to periods of depression, dysphoria (unpleasant mood), or anxiety
6. Chronic feeling of boredom
7. Masochistic behavior (self inflicted pain) and thoughts of suicide
8. Frantic efforts to avoid real or imagined abandonment.

Histrionic personality disorder

The essential feature of histrionic personality disorder is self-dramatization: the exaggerated display of emotion. Such emotional

Psychiatric Nursing

displays are often clearly manipulative, aimed at attracting attention and sympathy. Interpersonal relationships are usually fragile. Initially, upon meeting a new person, a person with this disorder will seem warm and affectionate. Once the friendship is established they become oppressively demanding, needing their friends to come right over if they are having emotional crisis. In general they will take from a relationship with out giving. The histrionic personality resembles a caricature of the most sexist image of femininity: vain, shallow, self dramatizing, immature, over-dependent and selfish. The disorder is more common in women than in men.

Narcissistic personality disorder

The essential feature of narcissistic personality disorder is a grandiose of self-importance, often combined with periodic feelings of inferiority. In general people with narcissistic personality disorder need constant admiration, expect favors from others without reciprocating, and react to criticism with arrogance and contempt.

Cluster C

Avoidant personality disorder

Avoidant personality disorder is marked by social withdrawal. However, this withdrawal is not out of inability to experience interpersonal warmth or closeness but out of a fear or rejection. Avoidant personalities, though they want to be loved and accepted, accept that they will not be, and therefore tend to avoid relationships

unless they are reassured again and again of the other's uncritical affection.

Not surprisingly, avoidant personalities generally have low self-esteem, and while this problem may be a cause of their social difficulties, it is also a result. They typically feel depressed and angry at themselves for their social failure, and these feelings further erode their self-esteem and create a vicious circle.

Obsessive compulsive personality disorder

Obsessive compulsive personality disorder is characterized by an excessive preoccupation with trivial details at the cost of both spontaneity and effectiveness. Obsessive compulsive personalities are so taken up with the mechanics of efficiency: organizing, following rules, making lists and schedules that they cease to be efficient, for they never get anything important done. In addition, they are generally stiff and formal in their dealings with others and are incapable of taking genuine pleasure in anything. They have difficulty of decision making. The disorder is more common in men than in women.

Passive aggressive personality disorder

The essential characteristic of passive aggressive personality disorder is an indirectly expressed resistance to demands made by others. At home and in the workplace, passive aggressive personalities find ways not to do what they are expected to do. Yet they never openly state their refusal; rather they covertly sabotage

Psychiatric Nursing

the job by procrastinating dawdling, making errors or some other means. Passive aggressive personalities tend to have troubled marriages and checkered job records. Passive aggressive maneuvering is not a cover for a laziness or job dissatisfaction but rather for an underlying hostility towards other people. The diagnosis should be given to only to those who show pervasive and long-standing passive-aggressive behavior, both on job and at home.

Dependent Personal Disorder

The dependent person lacks self-confidence and is unable to function in an independent role. In an attempt to avoid any chance of becoming self sufficient, the person allows others to become responsible for his or her life, letting them make all their major decisions. He or she avoids making demands on others to avoid jeopardizing any existing dependent relationships that meet his or her needs. Social relationships and occupational functioning may be impaired as a result of dependent needs. This disorder is seen in more frequently in women. Intense discomfort is experienced by a dependent person who is left alone for some time.

Nursing Intervention

The nursing care of a person who is diagnosed as having a personality disorder is directed at the specific behavior, characteristics, and symptoms that are common to the identified disorder.

Psychiatric Nursing

Maladaptive behaviors such as acting-out, stubbornness, procrastination, over-exaggeration, manipulation, and complete dependency can elicit negative responses from nursing personnel. A friendly, accepting environment should be established in which the patient is accepted but the maladaptive behavior is not. It is imperative that the nurse examines her feelings about such behavior so that she does not allow them to infect therapeutic nursing interventions.

The individual needs to be given an opportunity to develop ego controls such as the superego or conscience that is lacking or underdeveloped. This can be achieved by consistent limit-setting that is enforced 24 hours a day.

Table 9: Examples of nursing diagnosis and nursing Interventions for personality disorder

Nursing Diagnoses	Nursing Interventions
Ineffective individual coping: hostility or acting out	Recognize signs of increasing agitation. Attempt to 'talk down' the patient. Encourage verbalization of feelings to find reason for anger. Maintain a safe spatial distance to avoid physical contact. Evaluate appropriateness of hostility. Respond positively to reasonable demands and requests. Accept the patient, but inform him or her when behavior is unacceptable. Set limits and be consistent with realistic controls. Attempt to enrich behavior by providing a safe environment for acting out hostility, providing distraction, or assigning constructive

Psychiatric Nursing

	<p>tasks. Administer p,r,n, medication to decrease anxiety. Use external controls (e.g. restraints) as a last measure.</p>
<p>Noncompliance manipulative behavior</p>	<p>Be aware of 'power play' or attempts to manipulate members of the staff. Identify types of manipulative behavior exhibited by the patient. Explore your own feelings regarding such behavior. Confront the patient if necessary, but without anger, disappointment, or disgust. Assume a parental surrogate role to reinforce authority when necessary. Discuss expectations with patient. Set limits and be consistent with care. Maintain consistency and continuity of approach with staff.</p> <p>Observe interactions with other patients to discourage manipulative behavior. Intervene if necessary.</p>
<p>Self- care deficit: dependency on staff to meet basic human needs</p>	<p>Evaluate patient's developmental level and ability to carry out the activities for daily living (ADL)</p> <p>Identify dependency needs, physically and psychologically. Identify present coping mechanisms and support systems. Avoid assuming a parental role.</p> <p>Be firm when interacting with the patient. Set short-term goals with the patient to increase independence (i.e. daily responsibilities related to self-care, decision making. etc).</p>

Psychiatric Nursing

<p>Impaired verbal communication: inability to develop positive interpersonal relationships</p>	<p>Develop trust or rapport. Establish a one- to-one relationship. Encourage expression of self-concept, including positive and negative feelings. Explore feelings regarding inability to relate, positively to others.</p>
<p>Sensory perceptual alteration: inability to trust others (suspicious)</p>	<p>Develop trust. Be honest with the patient. Be non threatening when interacting with patient. Convey concern and interest. Listen for expressions of anxiety, fear, or mistrust. Face but keep a distance from the patient when speaking, Avoid being overly friendly. Be specific and clear when presenting information to the patient. Speak in a normal tone of voice. Do not whisper when near the patient. Be selective in the use of nonverbal gestures while speaking with or near the patient. Respect the patient's need for privacy. Discuss confidentiality. Include the patient in planning treatment to allow the patient some control. Plan brief contacts with the patient. Explain procedures to the patient in detail and discuss any changes in routine. Be honest; never trick the patient into taking medication.</p>
<p>Ineffective individual coping owing to increased stress or anxiety</p>	<p>Provide a calm, quiet atmosphere to decrease excitatory environmental stimuli. Attempt to identify the source or cause of increased stress or anxiety. Encourage the patient to verbalize feelings. Identify previous effective coping mechanisms. Medicate with anti anxiety agents per physician's order</p>

REVIEW QUESTIONS

1. A non psychotic illness characterized by maladaptive behavior, which the person utilizes to fulfill his or her needs and bring satisfaction to self is called personality disorder.
 - a. True
 - b. False
2. A type of character disorder which is marked by social withdrawal and a tendency to avoid relationships with others is termed as obsessive compulsive personality disorder
 - a. True
 - b. False
3. Avoidant personality disorder, obsessive-compulsive personality disorder and passive aggressive personality disorders are sub classifications of Cluster C personality disorders.
 - a. True
 - b. False
4. Cluster B personality disorders include, antisocial, borderline and histrionic personality disorders.
 - a. False
 - b. True

UNIT ELEVEN

HUMAN SEXUALITY AND SEXUAL DYSFUNCTION

Learning objectives

After studying this unit, the student will be able to:

1. Define human sexuality
2. Discuss the criteria for normal sexual behavior
3. Identify causal factors in sexual dysfunction
4. Define sexual déviation (sexual perversion) or paraphilias
5. Differentiate sexual deviation (sexual perversion) and paraphilias
6. Describe nursing interventions for human sexual deviations and dysfunction.

Definition

Human sexual behavior should be considered in the context of the whole personality. Normal sexual behavior takes a wide range of forms and depends upon moral, social and logical norms in a given culture or community. The aim of sexual behavior is pleasure and the relief of sexual tension. Pathological behavior may be a presenting symptom of an existing disorder or transient manifestation of an emotional or personality disorder or of organic disease.

Normal sexuality

Normal sexual behavior is generally described as a sexual act between consenting adults, lacking any type of force and performed in a private setting in the absence of unwilling observers. Abnormal and unwanted sexual behavior therefore would be considered as any act that does not meet the criteria set out in this definition.

According to Masters and Johnson's (1970) observation that the physiological process of sexual intercourse involves increasing levels of vasocongestion and myotonia (tumescence) and the subsequent release of the vascular activity and muscle tone as a result of orgasm (detumescence). The process occurs in the four phases of excitement, plateau, orgasm and resolution.

Excitement: This is brought on by physiological stimulation fantasy in the presence of loved object: physical stimulation including stroking or kissing or both. It may last several minutes to several hours.

Plateau: This is a continuous stimulation and characterized by an increase in intensity. It lasts from 30 seconds to several minutes depending up on the sexual stimuli and drive.

Orgasm: This involves subjective sense of ejaculatory inevitability which triggers the man's orgasm. It lasts from 3 - 45 seconds. The ejaculation consists of about one teaspoonful (2.5ml) of fluid and contains about 120 - 250 million sperm cells.

Resolution: Resolution through orgasm is characterized by a subjective sense of well being. If orgasm occurs resolution is rapid. If it doesn't occur, resolution may take 2 - 6 hours.

Sexual response of the female

Whether explicitly stated or not, discussion of 'normal' female sexual response sometimes seems to imply that a women should reach orgasm during intercourse, preferably without manual stimulation. Yet millions of women do not fit this description and some may feel deficient. One of the most common complaints women bring to sex therapists is a socially defined dysfunction: they reach orgasm only through manual or oral stimulation of the clitoris, or only through manual or oral stimulation of the clitoris, or only when the intercourse is combined with such direct stimulation. In fact, this is normal.

Causal factors in human sexual dysfunction

Most causes of sexual dysfunction seem traceable to psychological rather than physical causes. The following psychosocial factors are commonly found:

Faulty learning: Masters and Johnson consider faulty learning to be the primary cause of orgasmic dysfunction in females. In vaginismus, a some what different conditioning pattern may have occurred,

Psychiatric Nursing

leading the female to associate vaginal penetration with pain, either physical, psychological or both. On the other hand, in males a first sex experience with a prostitute, or some other situation in which hurried ejaculation was necessary, may result in premature ejaculation. Once this pattern is established the individual may be unable to break the conditioned response.

Feelings of fear, anxiety and inadequacy: Males who suffer from impotence are often anxious, frustrated and humiliated by their inability to produce or maintain an erection. Premature ejaculation can also lead to feelings of inadequacy and guilt.

Interpersonal problems (conflict with others)

Changing male-female relationships: Many men consider themselves as supposedly 'dominant' partners who take the initiative in sexual relations. This may not always be appropriate in modern relationships.

Homosexuality and other factors

Drug affecting sexual dysfunction

Drugs can lead to the following sexual dysfunctions:

- I) Impaired ejaculation
 - Guanethidine
 - Bethamedine
 - Thioridazine.

II) Decreased libido and impotency

- a. Oral contraceptive
- b. Sedatives
- c. Major tranquilizers
- d .Lithium
- e. Methyldopa
- f. Clamidine

Sexual disorders can be symptomatic of biological problems, intrapsychological conflicts, interpersonal differences or a combination of these. The sexual function can be adversely affected by stress of any fixed emotional disorders and by a lack of sexual knowledge.

Classifications of Sexual dysfunctions:

Erectile dysfunction or impotence: This is characterized by an inability to achieve or maintain an erection sufficient for successful sexual intercourse. In primary impotence the man is not able to have erection at all in his sexual life. In secondary impotence, the man has successfully achieved vaginal penetration at some time in his sexual life but is later unable to do so. But In selective impotence, the man is unable to do so in certain circumstances but not in others.

Premature ejaculation: This occurs when the man recurrently achieves orgasm and ejaculation before he wishes to do so. It is more common today among college educated men than among men with less education and it is thought to be related to their concern for

partner satisfaction. About 40% of men treated for sexual disorders have premature ejaculation as the chief complaint.

There are three types of premature ejaculation known as

- a. Habitual premature ejaculation
- b. Acute onset premature ejaculation
- c. Insidious onset premature ejaculation

Frigidity (inhibited sexual excitement) in female: This is characterized by the inability of the female to express sexual satisfaction. Its chief physical manifestation is a failure to produce the characteristic lubrication of the vulva and vaginal tissue during sexual stimulation, a condition that may make coitus uncomfortable.

Inhibited Female orgasm (anorgasmia): This is characterized by a recurrent and persistent inhibition of the female orgasm as manifested by a delay in or absence of orgasm following a normal sexual excitement phase during sexual activity. It refers to the inability of the women to achieve orgasm by masturbation or coitus.

Dyspareunia: This is a recurrent and persistent pain during coitus in either the man or the women. It often coincides with vaginismus. It is due to physical factors like trauma, inflammation, endometritis. It can also result from psychological cause.

Vaginismus: This is an involuntary constriction of the outer one third of the vagina that prevents penetration, insertion and coitus. It is less prevalent than anorgasmia. It often affects highly educated women

and those in higher socioeconomic groups. Sexual trauma as rape may result in vaginismus.

Sexual deviation (sexual perversion) or paraphilias

This is characterized by a sexual behavior which is not customarily accepted.

1. Homosexuality: This involves the attraction for sexual relation with persons of the same sex. Homosexuality between women is termed as lesbianism. In most cultures it is not considered a perversion.
2. Exhibitionism: This is sexual gratification by genital exposure in public. It is found in men who have directed towards children of either sex. It is a form of homosexuality and tends to occur in impotent males.
3. Pedophilia: This is a sexual deviation in which there is unusual sexual interest directed towards children of either sex. It tends to occur in impotent males.
4. Voyeurism: It is sexual gratification from observing others engaged in sexual activity.
5. Fetishism: This is a male sexual deviation in which the deviant is unable to love a person sexually because of immature sexual development. This involves sexual contact with inanimate article or fetish, such as clothes.

Psychiatric Nursing

6. *Transvestitism*: This involves sexual arousal and satisfaction by wearing the clothes appropriate to the opposite sex.
7. *Sadism*: This involves a sexual gratification from inflicting of pain on one's sexual partner.
8. *Transsexualism*: This involves a persistent sense of discomfort about one's anatomic sex and wish to live as a member of the opposite sex.
9. *Masochism*: This involves the enjoyment of pain, humiliation and punishment by the sexual partner.
10. *Zoophilia (bestiality)*: This involves obtaining sexual gratification through contact with animals.
11. *Rape*: Violence and the lack of consent by the sexual partner are the elements in rape that makes it both criminal and deviant.
12. *Incest*: This involves sexual union of close relatives. This is a taboo that is one of the strongest in our culture.
13. *Nymphomania*: This is excessive sexual derive or desire in females.
14. *Satyriasis*: This is excessive sexual drive or desire in males.
15. *Telephone scatologia*: Sexual gratification is achieved by telephoning someone and making lewd remarks or remaining silent on the line.
16. *Frotteurism*: Sexual excitement is achieved by touching and rubbing against a non consenting person.

Nursing intervention in sexual disorders

The nurse must examine their feelings about her/his own sexuality before she /he is able to care for the patients who sexually act out or present symptoms of sexual disorders. Nurses are not immune to the development of identity disorders, an unresolved Oedipal or Electra complex, or psychosexual dysfunction. Feelings of disgust, contempt, anger or fear need to be identified and explored so that they do not interfere with the development of a therapeutic relationship. This is one of the reasons patients do better with a team approach rather than with individual therapy. The quality of nursing care will depend on the nurse's ability to be nonjudgmental and to understand the behavior of a patient who is sexually acting out.

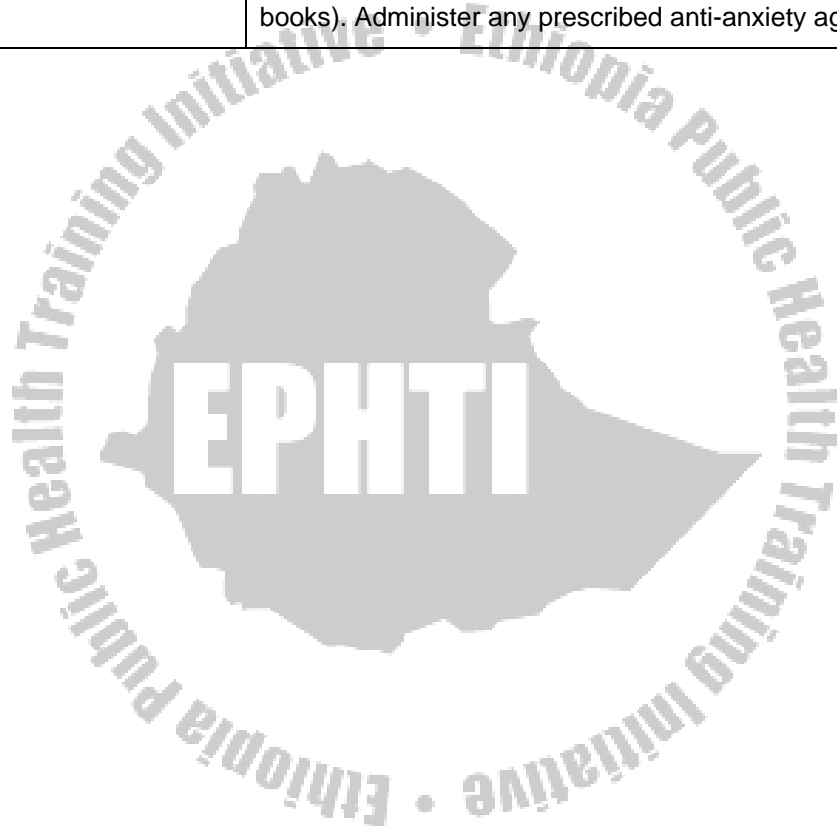
Nursing intervention for patients who exhibits symptoms of sexual disorders also includes planning care to meet the basic human needs, providing a protective care for the patient, exploring methods to re-channel sexually unacceptable behavior and participation in a variety of therapies, including behavior therapy, and psychotherapy. The nurse must also assume the role of patient advocate to ensure the promotion of sexual health when the opportunity occurs.

Table 10: Nursing diagnoses and interventions for patients who exhibit symptoms of sexual disorders

Nursing diagnoses	Nursing interventions
Alteration in pattern of sexuality: impulsive sexual actions resulting in physical contact.	Explain to the patient that touching makes you feel uncomfortable. Ask the patient to explain his feelings at the time he acted impulsively - Explore the meaning of specific behavior. Be firm but nonjudgmental when setting limits. Be consistent. Intervene in any overt acts towards other patients. Explain to the patient that he must respect the rights of others. Avoid placing the patient in activities requiring physical contact. Provide protective isolation for other patients if necessary since his overt behavior may provoke hostility.
Alteration in pattern of sexuality: verbal comments with sexual overtones	Respond by recognizing the patient's feelings (i.e., "it must be difficult to be away from your fiancée"). Allow the patient to ventilate the reason for his comment without encouraging his behavior. Explore alternative ways to channel the patient's advances to result in a more positive outcome.
Alteration in pattern of sexuality: masturbatory behavior	Request that the patient limit his activity to private area to avoid offending others. Intervene in any attempt by the patient to involve others in his activity. Explore the meaning behind the patient's behavior. Discuss alternative behavior with the patient.

Psychiatric Nursing

Sexual dysfunction owing to increased anxiety.	Encourage verbalization of feelings. Explore reasons for increased anxiety. Assess the patient's knowledge of cause of sexual dysfunction. Inform the patient of various resources available (e.g., sex education courses, clinics, counseling therapy, and reference books). Administer any prescribed anti-anxiety agents.
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REVIEW QUESTIONS

1. List at least four types of drugs which can affect libido and cause impotency.
2. List at least five types of human sexual dysfunctions.
3. Sadism is a sexual gratification from inflicting of pain on one's sexual partner.
 - a. False
 - b. True
4. Homosexuality between men is called lesbianism.
 - a. True
 - b. False
5. List the four consecutive process of human normal sexual responses according to Masters and Johnson's observations.

UNIT TWELVE

PSYCHOTHERAPY

Learning objectives

After studying this unit, the student should be able to :

1. Define psychotherapy
2. Identify Freud and psychoanalysis method
3. Identify indications for psychotherapy
3. Differentiate different types of psychotherapy
4. Identify different methods of psychotherapy
5. List the advantages of psychotherapy

Definition

Psychotherapy may be broadly defined as any treatment designed to influence behavior by verbal or non-verbal means. It includes techniques as varied as confession, reassurance, hypnosis, psychoanalysis and brain-washing.

There is ample evidence from outside medicine that what one person says to another may greatly influence behavior and doctors have always realized the therapeutic, as well as the diagnostic value of intelligent history-taking. Historically, much treatment relied on suggestion, reassurance and the doctor's prestige, administered directly or through placebo therapy. Such psychotherapy is informed, unplanned, and usually lacks any theoretical foundation. Formal

psychotherapy proceeds in a planned way and is based on a theory explaining the psychogenesis of the patient's complaints and the relationship between doctor and patient. The doctor-patient relationship remains immeasurably important in all specialties.

Freud and psychoanalysis

All modern psychotherapy owes much to Sigmund Freud (1856-1939), the originator of the theory and technique psychoanalysis. His work has been criticized as unscientific, but his ideas permeate twenty first century thought and have perhaps been more influential outside medicine than within.

The theory of psychoanalysis includes:

1. The role of unconscious factor in normal and neurotic behaviors; known long before Freud and easily proven in experimental hypnosis. Freud developed the idea of an active or dynamic unconscious
2. Psychological determinism: The view that seemingly chance or absurd dreams, slips of the tongue and neurotic symptoms have a meaning, usually unconscious and symbolic.
3. Infantile sexuality: Freud's libido theory stated that energy attached to the sexual instincts become linked to different objects at different developmental stages. The oral phase lasts from birth to 18 months, and from 18 months to 3 years the phallic stage. Seven years until puberty, there is a latency period. During the

phallic stage boys develop the Oedipus complex in which the father is seen as a rival for mother's affection

4. Topographical model: Freud's structural model of the mind comprising the id (instinctual, childish, unconscious forces), the ego (the conscious, rational, adult part of the mind) and the superego (which contains a harsh conscience derived from parental ideas)
5. Psychogenesis: The view that symptoms have psychological origins, particularly through conflict and anxiety and in childhood experiences
6. Mechanisms of defense: Mental mechanisms that are often typical of the individual or a particular neurosis and are used to deal with anxiety.

Defense mechanisms include:

Projection: attributing one's own intentions (usually unconscious) to others, for example in paranoid personalities.

Reaction-formation: behaving consciously in a way opposite to unconscious wishes, for example, the over-polite person concealing hostility.

Rationalization: attempting to provide logical reasons for emotional and illogical attitudes.

Displacement: an undesirable idea is not allowed to reach consciousness but is transferred to a more acceptable object or person, for example, an outburst of anger is directed at the cat instead of the parent.

Identification: modeling behavior on that of another, e.g. the boy identifying with his father. In developing the technique of psychoanalysis.

Freud's methods

1. *Free association.* The patient is encouraged to say whatever enters his or her head at any time during the daily hour of treatment (the 'basic rule').
2. *Interpretation.* The analyst remains largely silent; refusing to ask or answer questions, but may offer interpretations of the patient's dreams, fantasies and behavior.
3. *Analysis of the transference.* Transference phenomena are the feelings, positive and negative, developed by the patient for the doctor (the doctor may have counter-transference feelings). They have no realistic foundation in the present and are related to the patient's feelings for significant figures, usually parental, in the past, for example, the patient may treat the male psychotherapist as though s/he were his or her parent. Psychoanalysis, and indeed any kind of intensive understanding of the patient's problems, is

insufficient and emotional understanding, as relived in transference, is essential for improvement.

4. Working through. Insight gained in the above way must be put into practical use in real life as part of successful treatment.

As a practical procedure, psychoanalysis occupies some five daily hours each week over several years and is carried out by a psychoanalyst, usually medically qualified, who himself has undertaken a lengthy training analysis. There are few analysis carried out in the National Health Service and clearly they can treat only a handful of patient.

Freud has had many disciples, some of whom, notably Adler and Jung, broke with the master and formed their own schools. C.G. Jung (1875-1961) did not agree with Freud's views on infantile sexuality, coined the terms 'introversion' and 'extraversion', and took a mystical view of a collective unconscious. Alfred Adler (1870-1937) paid more attention to the individual's willpower and to social factors. There have been many influential neo-Freudians. In the U.S. Erich Fromm, H.S. Sultana and K. Horney, and in Great Britain Anna Freud, Melanie Klein and R.Fairbairn have all added to psychoanalytic theory. Despite the multiplicity of theories and schools, studies of psychotherapists show that their actual practice differs surprisingly little. Current practice tends to more active participation by the therapist, concentration on interpersonal events in the present rather than the past, and on analysis of transference and the patient's typical defense mechanisms rather than to a search for traumatic

events in the patient's childhood. Successful therapists have qualities of accurate empathy, non-possessive warmth, and genuineness.

Indications for psychotherapy

Psychotherapy may be useful in psychoneurosis and some personality and psychosomatic disorders. For intensive psychotherapy the patients selected are usually young intelligent, highly-motivated, with an ability to verbalize freely and capacity for insight. Brief and supportive psychotherapy is used in all the milder psychiatric disorders.

Types of psychotherapy

Psychiatrists and many others practice psychotherapy of varying degrees of intensity, ranging from brief and infrequent interviews to weekly sessions of one hour continuing over months and years.

1. *Brief therapy.* A variety of techniques are exploited, usually in combination: ventilation, in which the patient confides, confesses, and is given the opportunity to ventilate his past and present difficulties; clarification, where problems are discussed and their nature and relations made clear; abreactions, verbalizing emotionally charged material, with the release of anxiety, anger or grief; and desensitization, in which repetitive ventilation of feelings, as in mourning, has a therapeutic effect.
2. *Intensive psychotherapy.* Such treatment is usually practiced by those with specialist training and includes psychoanalysis. In contrast to brief therapy the interviews are longer and more frequent. The

therapist assumes a more neutral attitude, there is more detailed examination of the patient's past and present problems, and some analysis of the transference is used in the treatment.

3. *Group therapy.* This involves treating psychoneurotic patients in small groups, usually of 6 to 8 people. It is more economical than individual psychotherapy and has advantages for patients with marked social and interpersonal difficulties. Defense mechanisms and transference reactions are seen, akin to those that occur in individual therapy, and are made use of by the therapist. Sessions are generally held weekly, last one to one and a half hours, and continue for one to two years. Group theory has developed to explain the type of leadership, the life of a group, interaction. This theory uses social psychology and sociology as well as psychoanalysis as sources.

Group therapy has flourished in the social climate of the United States with a bewildering variety of techniques, much subject to fashion. Psychodrama was an early technique, in which patients are encouraged to act out their problems and family conflicts by role-playing and improvisation. 'T' (training) groups (Lewin) were developed as an educational group experience, emphasizing the present and self-disclosure. Encounter groups were developed to heighten awareness in normal people rather than patients. They also emphasize group confession. Transactional analysis (Berne) has had wide success. There are many fringe groups with untrained leaders or

run as self- help groups. They may attract potential patients, including the psychotic and have a detrimental effect on them.

4. *Conjoint family therapy.* This is a form of psychotherapy in which one or two therapists see several members of a family together. It can be regarded as a special form of group therapy. As well as using analytic ideas it has made use of sociological concepts of role and of general systems theory in explaining what happens in normal and pathological family relationships, e.g. scapegoat, when one member of the family is consistently blamed for all the family's problems for unproven efficacy.

5. *Administrative therapy.* Because interpersonal relationships are so important in the genesis and treatment of psychiatric disorders, considerable attention is given nowadays to staff-patient relations in psychiatric hospitals and wards. The concept of the hospital as a therapeutic community, developed by Maxwell Jones, involves organizing the hospital in a democratic way, with patients having a say in the conduct of their affairs and staff relinquishing authoritarian habits. There must be free communications between doctors, nurses, other staff and patients and all should feel able and have the opportunity to express their feelings to one another. To this end staff and patients meet regularly, and ward meetings become an extension of group psychotherapy. When such principles were neglected, patients become apathetic and experience a loss of individuality, a condition which has been called institutional neurosis.

Effectiveness of psychotherapy

Despite its use over 80 years there are no entirely satisfactory trials of psychotherapy because of the technical difficulties of such research; those studies that have been completed are equivocal about the efficacy of psychotherapy. A well-known research project by Sloane (1975) compared three groups of patients, assigning them to 14 weekly analytic psychotherapy sessions, to a similar period of behavior therapy, or to a waiting list. All patients improved including those on the waiting list who had an initial assessment, telephone contact and emergency services as needed. The two groups having active treatment improved more than the 'control' group. There was little change in those results one and two years later.

Behavior therapy

Behavior therapy is the most active area of growth in psychotherapy. It has been developed largely by psychologists from their studies on experimental learning in humans and animals. It attempts to change symptom directly rather than seek for underlying causes, and assumes that neurotic symptoms stem from faulty learning. Many of its ideas are commonsensical and have long been used by parents and teachers. It involves the following concepts:

Learning: The term is used to describe any relatively permanent change in behavior resulting from past experience; it need not be intentional, nor need the learner be aware that he or she is learning.

Classical conditioning: This as first described by Pavlov (1849- 1936). An unconditioned response (a dog salivating) to an unconditioned stimulus (sight or smell of food) is modified by pairing a conditioned stimulus (a bell ringing) with the unconditioned stimulus. After a number of trials the conditioned stimulus (bell) alone will produce the conditioned response (salivation). After a while extinction or the response will occur. The response can be generalized to other sounds or discrimination may be taught (e.g. high pitched bells).

Operant conditioning: This is also known as instrumental learning. It involves changing the frequency with which a certain behavior occurs in a particular situation. The typical experiment involves a pigeon in a Skinner box. When a lever is pecked, at first by accident, food enters the box. The pigeon learns to press the lever more frequently for the reward. The behavior is reinforced by the reward. This can be done continuously, intermittently or at second hand. As well as reward training, animals can be trained to escape from or avoid painful stimuli. Operant learning can be complex, developed by successive approximation (shaping) and building up sequences (chaining). Avoidance responses are very lasting (e.g. agoraphobia).

Mowre's 2 - factor theory explains this by:

1. Development of a conditioned response pairing fear and the place or situation to be avoided.
2. Reinforcement of the avoidance. Fear occurs on approach to the place or situation and the subject reacts by avoidance.

Observational learning; This is found in human beings when they model actions of others, for example in sports and new social situations. It can teach others to do things and to avoid things.

Types of behavior therapy

Systematic desensitization: This technique was developed by a South African psychiatrist, Wolpe (1969) from animal experiments on the principle of reciprocal inhibition of neurotic responses. If a response incompatible with anxiety can be made to occur at the same time as an anxiety provoking stimulus, then the anxiety will be reduced. The patient's detailed history is used to construct a hierarchy of response from the least to the most anxiety provoking. He is taught relaxation exercises or is relaxed by drugs and asked to imagine himself in the anxiety provoking situations: progressive desensitization occurs.

Token economy: Severely socially handicapped patients in long stay wards may be re-motivated by the use of tokens. The basic essentials of nursing care are provided, but extra food, attention, privileges are bought with tokens. The tokens are used by the staff as an operant conditioning device. The desired behavior, when it appears, is immediately rewarded and shaped by tokens.

Aversion treatment: Pleasant but undesirable behavior (alcoholism, deviant sexual fantasies) can be reduced by aversive conditioning, pairing the pleasant stimulus with an unpleasant response (alcohol and apomorphine, fantasy and electric shock). Thought stopping

techniques are used to abolish obsessional ruminations. The patient signals when such thoughts begin and the therapist shouts 'stop' or gives a shock to the patient. Later the patient may control the symptom by saying 'stop' to him or herself or flicking a rubber band on the wrist to produce a painful stimulus.

Flooding and response prevention: Research on systematic desensitization suggests that exposure to the feared object is the sole essential ingredient. Flooding involves direct prolonged contact with the feared object with the therapist's support, encouragement and modeling. In the treatment of obsessional rituals response prevention a similar and effective treatment is used. Both require skilled therapists (often specially trained nurses) and may be very time consuming.

Social skills training: Argyle's work on social interaction led him to compare social skills to complex motor skills, capable of being broken down into separate parts and of being analyzed in terms of cues, responses and feedback. Individuals with social difficulties can be taught social skills, often in groups. They can be instructed in how to move and what to say. They may model their performance from a live person or a TV film, rehearse the skill and be socially reinforced by the watching a videotape of their performance.

Other behavioral techniques: An animal model of neurosis is provided by Pavlov's dogs conditioned to a painful stimulus they cannot avoid. Subsequently when put in an operant conditioning experiment where they can evade punishment, they do not so.

Psychiatric Nursing

Seligman has called this learned helplessness and compared it to the behavior of people with neurotic depression. Treatment by assertive marital therapy involves teaching the couple to mutually reinforce each other. Weekly contracts are made, in which each lists positive actions he or she would like the other to do. This 'giving to get' approach is also used in treating sexual dysfunction.

Biofeedback: The development of small, light and sensitive electronic apparatus makes it possible for the patient to be given immediate, portable feedback on physiological activities not normally available to his conscious mind: for example, pulse, EEG, alpha activity, psychogalvanic response (PGR), blood pressure and muscle activity. Much clinical experimentation is exploring the possibility that patients may thus be able to control responses normally not within their awareness. Relaxation can certainly be facilitated and there have been results indicative of success in treating tension headaches, migraine (temporal artery flow) and hypertension.

Recreational therapy

This is used in mental health and psychiatric nursing (Lalitha: 1995). Recreation is a form of activity therapy used in most psychiatric settings. Recreation or play activities provide patients with the opportunity for fun and for feeling good. It adds balance to their daily schedule and helps in treating the whole patient. Therapeutic recreations can occur as:

- Informal playing
- Card games

Psychiatric Nursing

- Trips outside the hospital
- Structured soft ball
- Basket ball or volley ball games
- Attending sport events and so on.

Occupational therapy

Occupation is variously defined as 'any activity which engages a persons resources of time and energy and is composed of skills and values (Lalitha: 1995). Occupational therapy is a potent and uniquely valuable approach to health care that enables people to take control of their own lives and over come their own disabilities. The essence of occupational therapy lies in the use of activities of every description as the treatment medium, with a minimum aim of improving the quality of life and a maximum aim of complete rehabilitation.

Points to be kept in mind include the importance of:

- Selecting an activity that interests the client
- Starting at the point the client is at and progress slowly
- Providing ample in enforcement for even shall achievements.

Advantages:

- It helps to build a more healthy and integrated ego
- It helps to express and deal with needs and feelings
- It assists in a gratification of frustrated basic needs.
- It may strengthen ego defenses
- It may reverse psychopathology
- It facilitates personality integration

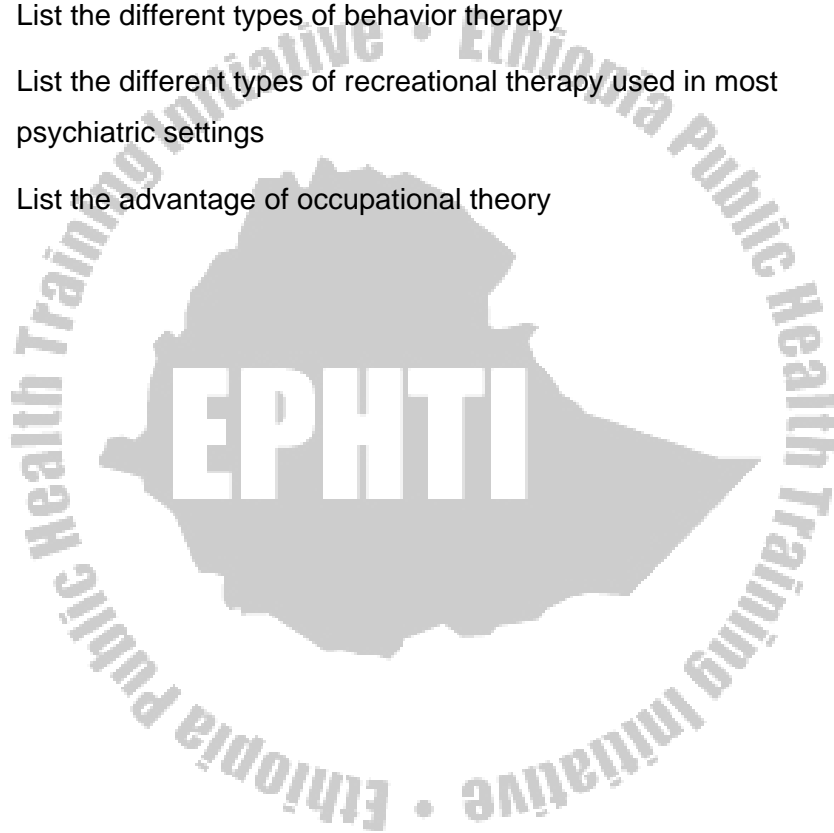
Psychiatric Nursing

- It offers opportunities to explore and see value self concepts and object concepts
- It develops a more realistic view of the self in relation to action and others.



REVIEW QUESTIONS

1. List theories of psychoanalysis in psychotherapy
2. List the different types of psychotherapy
3. List the different types of behavior therapy
4. List the different types of recreational therapy used in most psychiatric settings
5. List the advantage of occupational theory



UNIT THIRTEEN

PSYCHOPHARMACOLOGY

Learning objectives

After studying this unit, the student should be able to:

1. Define psychopharmacologies
2. Identify different antipsychotic drugs
3. Identify commonly used antipsychotic drugs
4. Identify commonly used antidepressants
5. Identify commonly used anxiolytic drugs
6. Identify commonly used antiepileptic drugs
7. Identify different reasons for choice of drugs
8. Discuss nursing actions in drug administration.

Definition

Psychopharmacology is the scientific study of medicines and drugs acting upon psychic aspects of human being and animals.

Antipsychotic (Psychoactive drugs)

Antipsychotic drugs are used mainly for treatment of severe mental illnesses such as schizophrenia and other psychotic disorders. They include:

- Antipsychotic
- Antianxiety (anxiolytics)
- Antidepressants.

Antipsychotic (neuroleptics)

Antipsychotic drugs are derived from several chemical groups and are broadly categorized as phenothiazines and non phenothiazines. Despite chemical differences, their pharmacologic actions and antipsychotic effectiveness are similar.



Table 11: Common phenothiazines antipsychotic drugs

Generic name	Trade name	Routs of administration and dosages for adults	Major side effects	Remarks
Chlorpromazine	Thorazine	200-600mg/ day IM, PO	High sedation -Moderate to low hypotension	Tablets, capsules and suspensions are available
Fluphenazine decanoate and enanthate	Prolixin decanoate; Prolixin enanthate	12.5 mg initially followed by 25 mg every 2 weeks rarely exceeds 100mg 2-6 weeks IM	Low to moderate sedation High extra pyramidal reaction Low sedation	
Fluphenazine hydrochloride	Prolixin Permitil	2.5-10 mg initially, gradually reduce to maintenance dose of	Low to moderate sedation High extra	2 mg of the oral hydrochloride salt is

Psychiatric Nursing

		1-5 mg PO/IM	pyramidal reactions Low hypotension	equivalent to 100 mg of chlorpromazine
Thioridazin	Mellaril	150-300 mg daily in divided dose gradually increased if necessary to a maximum daily dose of 800 mg PO	High sedation Low extra pyramidal reactions Moderate hypotension	100 mg is equivalent to 100 mg of chlorpromazine
Trifluoperazine	Stelazine	2-4 mg daily in divided dose for out patient PO	Moderate sedation High extra pyramidal reactions Low hypotension	5 mg is equivalent to 100 mg of chlorpromazine

Commonly used non-phenothiazines

Haloperidol (haldol): This is a butyrophenone compound and the only drug of this group available for use in psychiatric disorders. Haloperidol is a frequently used antipsychotic agent that is chemically different but pharmacologically similar to phenothiazines. It is potent and long acting drug, readily absorbed following oral or intramuscular administration, metabolized in liver and excreted in urine and bile. Haloperidol may cause adverse effects similar to those of other antipsychotic drugs. Usually it produces a relatively low incidence of hypotension and sedation and a high incidence of extra pyramidal effects.

A 2-mg dose is therapeutically equivalent to 100 mg of chlorpromazine.

Routes and dosage ranges: 1-15 mg/ daily initially in divided doses, gradually increased to 100 mg /day if necessary: usual maintenance dose, 2-8 mg daily is a recommended dose for adult.

Actions of neuroleptics: The antipsychotic drugs act primarily by occupying dopamine receptors in brain tissue, thereby decreasing the effects of dopamine, a catecholamine neurotransmitter. Excessive dopamine activity is believed to be an important factor in the development of schizophrenia. This concept is supported by observations of the effects of drugs that increase dopamine levels in the brain (e.g. amphetamines, levodopa), which can cause psychotic or schizophrenic symptoms.

Psychiatric Nursing

The drugs act within hours to decrease manifestations of hyperarousal (e.g., anxiety, agitation, hyperactivity, insomnia, aggressive/combatative behavior, hallucination, and delusion). Several weeks or months may be required for elimination of thought disorder and increased socialization.

Choice of drug: The choice of particular anti-psychotic drug is largely empirical because no clear cut guidelines exist. Some general factors to consider include the client's age and physical condition; severity and duration of illness; frequency and severity of adverse effects produced by each drug; response to antipsychotic drugs in the past; subjective response to the drug (such as the adverse reaction a person is willing to tolerate); supervision available; and the experience of the personnel with a particular drug. The following are among some specific factors.

1. Antipsychotic drugs are apparently equally effective regardless of the client's symptoms. Drugs producing greater sedation are often prescribed for agitated, over active persons and drugs producing less sedation are prescribed for those who are apathetic and withdrawn.
2. Some clients who do not respond well to one type of antipsychotic drug may respond to another. Unfortunately, there is no way of predicting which drug is likely to be most effective for particular client.

3. There is no logical basis for giving more than one antipsychotic agent at a time. There is no therapeutic advantage, and risk of series adverse reactions is increased.
4. If lack of therapeutic response requires that another antipsychotic drug be substituted for the one a client is currently receiving, this substitution must be done gradually. Abrupt substitution may cause re appearance of symptoms. This can be avoided by gradually decreasing doses of the old drug while substituting equivalent dose of the new one.
5. Nonphenothiazine antipsychotics are probably best used for clients with chronic schizophrenia whose symptoms have not been controlled by the phenothiazines and for clients with hyper sensitivity reactions to the phenothiazines.
6. Unless the choice of a drug is dictated by the client's previous favorable response to a particular drug, the preferred drug should be available in both parenteral and oral forms for flexibility of administration.
7. Clients who are unable or unwilling to take daily doses of a maintenance antipsychotic may be given periodic injections of a long- acting form of fluphenazine.
8. Any person who has had an allergic or hypersensitivity reaction to antipsychotic drug should generally not be given that particular drug again or any drug in the same chemical group.

Duration of therapy: Antipsychotic drugs are usually given for months or years. There are no clear guidelines on duration of drug therapy.

Table 12: Commonly used anti psychotic agents

Nursing actions	Rationale / explanation
1. Administer accurately	Peak sedation occurs about 2 hours after administration and aids sleep. Hypotension, dry mouth and adverse reactions are less bothersome with this schedule. etc.
2. Observe for therapeutic effect	The sedative effects of antipsychotic drugs are exerted with in 48 to 72 hours. Sedation that occurs with treatment of acute psychotic episodes is a therapeutic effect. Sedation that occurs with treatment of non acute psychosis disorders, or excessive sedation at any time, is an adverse reaction etc.
3. Observe for adverse effects	Excessive sedation is most likely to occur during the first few days of treatment of an acute psychosis episode, when large doses are usually given. Psychotics also seem sedated because the drug lets them catch up on psychosis-induced sleep deprivation. Sedation is more likely to occur in elderly or debilitated persons. Tolerance to the drugs' sedative effects develops, and sedation tends to decrease with continued drug therapy.
4. Observe for drug interaction	Additive ant cholinergic effects, especially with Thioridazine. Potential for sedative and ant cholinergic effects. Additive CNS depression, sedation, orthostatic hypotension, urinary retention, and glaucoma, may occur unless dosages are decreased. Apparently these two drug groups inhibit the metabolism of each other, thus prolonging the actions

Psychiatric Nursing

	of both groups if they are given concomitantly.
5. Teach clients	<p>Anti acids may decrease absorption of these drugs from intestines.</p> <p>To avoid low blood pressure, dizziness, and faintness, which may occur in standing</p> <p>To avoid falls or other injuries</p> <p>Dryness of mouth which can predispose to mouth infection, dental cavities, and ill fitting dentures.</p> <p>-Sensitivity to sunlight is an adverse reaction of these drugs.</p> <p>-Fever (hyperthermia) and heat prostration may occur with high environmental temperatures.</p>

Antidepressants

Types of antidepressants: Antidepressant drugs are derived from several chemical groups mainly as tricyclic antidepressants and monoamine oxidase inhibitors. Several newer agents differ chemically from the tricyclics but are similar in pharmacologic actions and antidepressant effectiveness.

Tricyclic antidepressants: Tricyclic antidepressants (TCA) are a group of eight chemically and pharmacologically similar drugs. These compounds contain a triple-ring nucleus from which their name is derived. The drugs are structurally similar to phenothiazine anti psychotic agent and have similar anti adrenergic and anti cholinergic properties. They produce relatively high incidence of sedation, orthostatic hypotension, cardiac arrhythmias, and other adverse

Psychiatric Nursing

effects in addition to dry mouth and ant cholinergic effects. TCAs are well absorbed after oral administration. Once absorbed, these drugs are widely distributed through body tissues and metabolized by the liver to active and inactive metabolites. Amitriptyline (elavil) and Imipramin (Tofranil) are commonly used TCAs. And there are miscellaneous antidepressants.



Table 13: Commonly used anti depressant agents

Tricyclic antidepressant	Generic name	Trade name	Route and dosage range for adults
	Amitriptyline	Elavil, Endep	Po 75-100 mg/daily in divided dose gradually increased to Po150-300 mg/ daily if necessary
	Imipramin	Tofranil	Po 75-mg /daily in three divided doses gradually increased to a maximum of 300 mg daily if necessary
Miscellaneous Anti Depressants	Eg. Bupropin	Wellbutrin	PO 100 mg/ day
Mono amine oxidase inhibitor	Eg. Isocarboxide	Marplan	Po. 30 mg in divided dose
Ant manic agents	Lithium carbonate	Eskalith	For bipolar disorder (manic depressive disorder)Po 900-1200mg daily in divided dose, gradually increased in 300 mg increments if necessary.

Mechanisms of action

The mechanisms by which most antidepressant drugs exert therapeutic effects are directly related to the hypothesized cause of depression, that is the drugs increase the amount of neurotransmitter (norepinephrine, serotonin) available to stimulate receptors on postsynaptic nerve fibers and/or decrease sensitivity (and possibly numbers) of the receptors.

After neurotransmitters are released from presynaptic nerve endings, they are normally inactivated by reuptake in to the presynaptic nerve fiber that released them or metabolism by the enzyme MAO. The tricyclics (TCAs) prevent reuptake of one or more neurotransmitters. The MAO inhibitors prevent the metabolism of neurotransmitter molecules. Apparently all of the currently available drugs decrease the sensitivity of receptors, especially postsynaptic beta-adrenergic receptors, with chronic use.

Drug Selection

The choice of an antidepressant depends upon the following major factors: the type of depression present; its severity; a drug's effectiveness and adverse effects.

Guidelines for choosing a drug include the following:

1. A tricyclic (TCA) has been the primary drug of choice for most depressed clients; even though there is relatively little base for choosing.

Psychiatric Nursing

2. MOA inhibitors are considered second line drugs for treatment of depression because of the potential interactions with other drugs and certain foods.
3. Lithium is the primary drug of choice in clients with bipolar disorder. When used therapeutically, lithium is effective in controlling mania in about 80% of clients. When used prophylactically, the drug decreases the frequency and intensity of manic cycles.

Table 14. Nursing actions: antidepressants

Nursing actions	Rationale/ explanation
1. Administer accurately	Give lithium with or just after meals to decrease gastric irritation
2. Observe for therapeutic effects	Therapeutic effects usually do not occur for 2-3 weeks after drug therapy is started
3. Observe for adverse effects	Most adverse effects result from anti cholinergic or anti adrenergic activity
4. observe for drug interactions	Adverse anti cholinergic effects (e.g. Dry mouth blurred vision, urinary retention, constipation. etc.)
5. Teach clients	Inform about potentially serious adverse effects , low salt intake(with lithium therapy), regular measurement of blood lithium etc.

Anticonvulsants

Anticonvulsant drugs are used to treat seizure disorders.

Types of anticonvulsants: Anticonvulsant drugs belong to several different chemical groups, including long-acting barbiturates, benzodiazepines, hydantoins and succinimides. The drugs can control seizure activity, but they do not cure the underlying disorder. Long-term administration is usually required. Therapeutic and adverse effects depend primarily on serum drug levels.

Most anticonvulsant drugs can be taken orally and are absorbed through the intestinal mucosa. After absorption, the drugs pass through the liver and undergo transformation by liver enzymes, during which some of the drug is inactivated. All anticonvulsant drugs are metabolized in the liver.

Mechanisms of actions of anticonvulsants

Anticonvulsant drugs have similar antiseizure properties. The precise mechanism and site of action are unclear. However, it is thought these drugs act in two ways to control seizure activity.

First, they may act directly on abnormal neurons to decrease their excitability and responsiveness to stimuli. Consequently, the seizure threshold is raised and seizure activity is decreased.

Second, and more commonly, they prevent the spread of impulses to the normal neurons that surround the abnormal ones. This helps to

prevent or minimize seizures by confining excessive electrical activity to a small portion of the brain.

The drug's ability to reduce the responsiveness of normal neurons to stimuli may be related to alterations in the activity of sodium, potassium, calcium, and magnesium ions at the cell membrane. Such ionic activity is necessary for normal conduction of nerve impulses, and changes engendered by the anticonvulsant drugs result in stabilized, less responsive cell membranes.

Indications for use

The major clinical indication for anticonvulsant drugs is in prevention or treatment of seizure activity, especially the chronic recurring seizures of epilepsy. Indications for particular drugs depend on the types of seizures involved.

Contraindications

Anticonvulsants are contraindicated or must be used with caution in clients with central nervous system depression. Hydration, succinamides, and carbamazepine are contraindicated with hepatic or renal damage and bone marrow depression (e.g. leukopenia, agranulocytosis).

Individual anticonvulsant drugs (commonly used anticonvulsant)

Barbiturates: Phenobarbital is a long acting barbiturate and is one of the safest, most effective, and most widely used anticonvulsant drugs. It is most effective in generalized tonic clonic epilepsy (major

motor or grand mal), temporal lobe and other partial seizures, and febrile convulsions in children.

Drug dependence and barbiturate intoxication are unlikely to occur with the usual doses of phenobarbital used in epilepsy treatment. Since phenobarbital has a long half-life, it takes about 2 to 3 weeks to reach therapeutic serum levels and about 3 to 4 weeks to reach a steady state concentration.

Hydantoins: Phenytoin (dialantion) is the prototype of a group of anticonvulsant drugs called the hydantoins. It is the most widely used and effective drug for generalized tonic-clonic and some partial seizures such as psychomotor seizures. Phenytoin is usually the initial drug of choice, especially in adults. It is often given with phenobarbital or prim done where a single agent does not control seizures. The drug may also be used in some cardiac arrhythmias, especially those resulting from digitalis toxicity, but such usage is declining with the availability of newer ant arrhythmic drugs.

The adult dose is as follows:

PO = 3.5.7 mg/kg/day

IM = 8.6 mg/kg/day in multiple sites

IV = Same as PO dose; maximum 50mg/minute.

Benzodiazepines:

a) Clonazepam (klonopin) is a benzodiazepine used as anticonvulsant. It may be used alone or with other anticonvulsant

Psychiatric Nursing

drugs in myoclonic or akintic seizures. Tolerance to anticonvulsant effects develops with long term use. Clonazepam also produces physical and psychological dependence as well as withdrawal symptoms. Because of its long half-life, withdrawal symptoms may appear several days after administration is stopped. Abrupt withdrawal may precipitate seizure activity or status epilepticus.

Adults dose is PO 1.5mg/day, increased by 0.5 mg/day every 3-7 days if necessary to a maximum dose of 20mg/day.

b) Diazepam (valium) is a benzodiazepine widely used as antianxiety or sedative agent. In seizure disorders, it is used to terminate acute convulsive seizures. It is the drug of choice for treating the life threatening seizures of status epilepticus.

The dose in adults for acute convulsive seizures, status epilepticus is IV 5-10mg at no more than 2mg/min. Repeat every 5-10 minute if needed to a maximum dose, 30 mg. If necessary, repeat regimen in 2-4 hours to a maximum dose, 100mg/24 hours.

Other Anticonvulsant drugs:

Carbamazepine (tegretol) is related chemically to the tricyclic antidepressants and pharmacologically to the hydantoin anticonvulsants. It is used mainly for psychomotor, generalized tonic-clonic, and mixed seizures.

Since carbamazepine may cause life threatening blood dyscrasias (e.g. aplastic anemia agranulocytosis, thrombocytopenia,

Psychiatric Nursing

leucopenia), its use should be reserved for clients whose seizures can not be controlled with other drugs. Carbamazepin is contra indicated in clients with previous bone marrow depression or hypersensitivity to carbamazepin or tricyclic antidepressants or clients who are receiving monoamine oxidase (MAO) inhibitors. MAO inhibitors should be discontinued at least 14 days before carbamazepine is started. It is also used to treat facial pain associated with trigeminal neuralgia (tic douloureux).

The adult dose for epileptics is PO 200mg twice /day initially, increased gradually to 600-1200 mg if needed, in 3 or 4 divided doses. For trigeminal neuralgia the dose is PO 200mg/day initially, increased gradually to 1200 mg if necessary.

Anti-anxiety drugs

Ant-anxiety agents are central nervous system (CNS) depressants with sedative-hypnotic properties. They are commonly prescribed drugs.

1. *Benzodiazepines*: These are by far the most commonly used drugs for treatment of situational anxiety and other anxiety disorders. Chlordiazepoxide (librium) is the prototype of the group, although diazepam (valium) and others are more frequently prescribed. This drug may cause physical and psychological dependence, so that it is recommended to be prescribed more selectively and for short periods of time.

Psychiatric Nursing

These drugs are highly lipid-soluble, widely distributed in body tissues, and extensively bound to plasma proteins. They are well absorbed with oral administration. Chlordiazepoxide, diazepam, and lorazepam (ativan) are available for parenteral use. When given intramuscularly, chlordiazepoxide, and diazepam are usually painful, erratically absorbed, and produce lower serum levels. lorazepam is well absorbed with intramuscular use. Diazepam is often given intravenously.

Pharmacologically, all the benzodiazepines have similar characteristics and produce the same effects.

Mechanisms of action

The benzodiazepines are thought to decrease anxiety by binding with benzodiazepines receptors in the brain and there by increasing the effects of gamma-aminobutric acid (GABA). GABA is an inhibitory neurotransmitter.

An increase in GABA activity results in decreased ability of excitatory neurotransmitters to stimulate nerve impulses.

Indications for use

Major clinical uses of the benzodiazepines are as anti-anxiety, hypnotic, and anticonvulsant agents. They are also used for preoperative sedation, sedation before or during invasive diagnostic tests such as endoscopy, and angiography, and prevention of agitation and delirium tremens in acute alcohol withdrawal. Diazepam

(valium) has been extensively studied and has more approved use than others.

Contraindications for use

Contraindications include severe respiratory disorders, severe liver or kidney disease, hyper sensitivity reactions, and a history of drug abuse.

Non benzodiazepine antianxiety agents

Busprone (buspar): This differs chemically and pharmacologically from other antianxiety drugs. Its mechanism of action is unclear, but it apparently interacts with serotonin and dopamine receptors in the brain. Compared to other anti-anxiety drugs, buspirone causes less sedation and does not apparently increase the CNS depression of alcohol and other drugs. It is only indicated in short-term treatment of anxiety.

Buspirone is rapidly absorbed following oral administration. It is metabolized by the liver to inactive metabolites, which are then excreted in the urine and feces. Its elimination half-life is 2 to 3 hours.

Meprobamets (equanil, miltown): This is an anti-anxiety agent that is chemically different from the benzodiazepines and hydroxyzing. It is also used as a muscle relaxant, but its effectiveness for that purpose is questionable. Drug tolerance, abuse, dependence and withdrawal symptoms occur with long term use.

Table 15: Commonly used anti anxiety agents (anxiolytics)

Generic Name	Brand Name	Clinical indications	Route and dosage range for adults
Chlordiazepoxide	Librium	Anxiety	PO 0.25-0.5 mg 3 times daily, maximum dose 4 mg daily in divided dose
Diazepam	Valium	Anxiety, seizure disorders acute alcohol withdrawal muscle spasm, preoperative sedation hypnotics	PO 2-10mg 2-4 times daily sustained release PO 15-30mg once daily IM, IV 5-10mg repeated in 3-4 hours if necessary.
Halazepam	Paxipam	- Anxiety	PO 20-40mg 3-4 times daily
Lorazepam	Ativan	- Anxiety - Preoperative sedation	PO 2-6 mg/day in 2-3 divided doses. IM 0.05 mg/kg to a maximum of 4mg. IV. 2mg diluted with 2ml of sterile water, dextrose sodium chloride, or 5% dextrose injection, injected over 1minute or longer

Table 16: Nursing actions in anti-anxiety drugs

Nursing actions	Rationale/explanation
1. Administer accurately	To avoid excessive sedation and adverse effects
2. Observe for therapeutic effects	As with most other drugs, therapeutic effects depend on the reason for use. Observations of individual recipients of anti-anxiety drugs can be more accurate if the same nurse assesses the person before and after the drug is given.
3. Observe for adverse effects such as:- - Over sedation - Hypotension - Pain and in duration at injection site - Paradoxical excitement, anger aggression and hallucinations - Skin rashes and others.	Most adverse reactions are caused by CNS depression. Drowsiness is the most adverse effect. They are more likely to occur with large doses or if the recipient is elderly, debilitated or has liver disease that slows drug metabolism.
4. Observe for drug interactions such as alcohol: barbiturates, sedative hypnotics, narcotics, analgesics, phenothiazines and other antipsychotic.	These drugs cause addictive CNS depression, sedation and respiratory depression others such as cimetidines interferes with the hepatic metabolism of diazepam and other benzodiazepines.

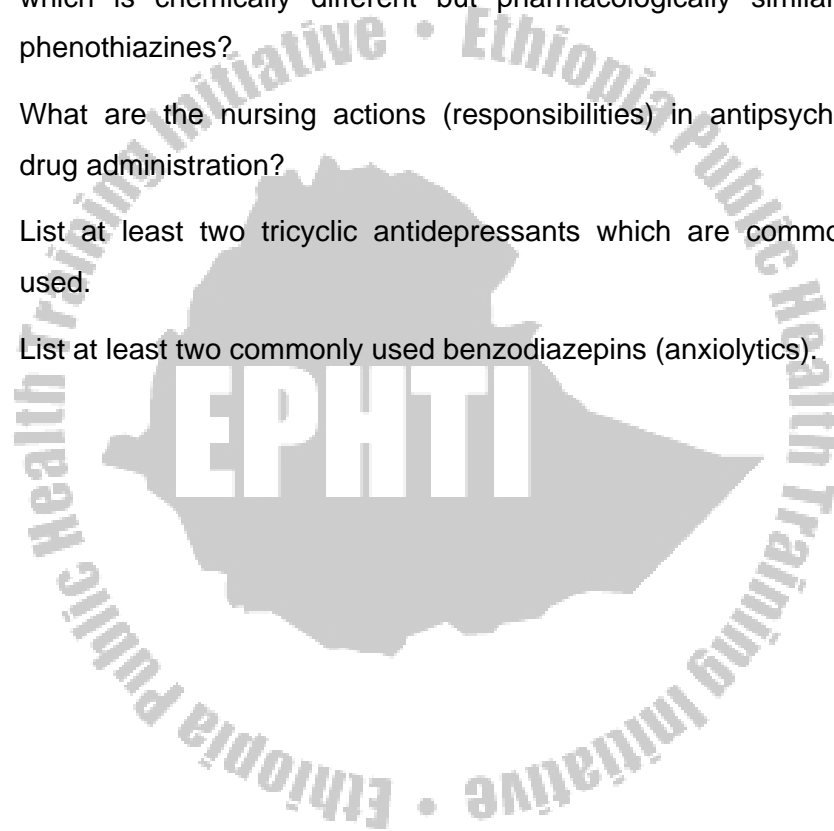
Psychiatric Nursing

5. Teach clients	To avoid falls and injuries or adverse effects. These drugs may interfere with both mental and physical functioning.
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REVIEW QUESTION

1. List at least three commonly used phenothiazines.
2. What is the commonly used nonphenothiazine antipsychotic drug which is chemically different but pharmacologically similar to phenothiazines?
3. What are the nursing actions (responsibilities) in antipsychotic drug administration?
4. List at least two tricyclic antidepressants which are commonly used.
5. List at least two commonly used benzodiazepines (anxiolytics).



ANNEX I

Model of Patient Assessment (History Taking) in Psychiatric Nursing

I. Personal identification of patient

Name: Ato. X

Age: 27 years

Sex: Male

Marital status: Married

Occupation: Carpenter.

Address: Finkile

II Chief Complaints: The client claimed that he is ok. However, the family members brought him chained and escorted to the hospital labeling him as a mad.

III History of present illness: A 25 years old male patient was brought to the hospital, escorted by 2 brothers and his wife. On interview he claimed that he is OK. But as per the informant (his wife) stated that he was relatively OK before 3 months ago but then started to become sleepless, inappropriate, insulting and started to refuse social harmonies both at home and at work place. More recently, he became jocular insulting, easily irritable, laughing at nothing and energetic so that no one is willing to approach him except herself.

IV Social and personal History

Family history:

His father is quite healthy except he is sleepless and occasionally he has moody characteristics. He is 65 years old; a farmer by occupation and a sociable person in his interaction with the environment.

His mother died at the age of 30 when the patient was a two year old child. He does not know the reason for her death. She was housewife by occupation. These facts were confirmed from his brothers.

Siblings: He has two brothers and one sister; he is the last child in the family. All of his siblings are married and in a poor occupational and professional standard. There was poor social interaction between and among the family members because of the hatred of the step mother had to them and vice versa. Two of the siblings are complaining of health problems which he clearly does not know about.

There was history of mental illness in the family. His grandfather died due to mental problem. Also his uncle attended a mental hospital on a monthly regular base.

Personal History

He was born in 1967 but does not exactly remember the exact date, but the elder brother informed that he was born at home by the assistance of traditional birth attendant. The patient and his family do not know his birth weight and of any complications during pregnancy, except at that time there was starvation on that community.

Psychiatric Nursing

In his early development, he appeared to be no gross problem except he was fat among other siblings. He walked and talked and commanded his sphincters at appropriate developmental time. The patient and his family report:

No night terrors, sleepwalking, bedwetting, thumb sucking, nail biting, stammering and stuttering and no mannerism.

He did not have any major illness in his childhood.

He had good school performance during his education. He started primary school at age of 6 and learnt up to 8th grade. His performance was good (he stood 1-3) up to the 8th grade. He has special ability in mathematics. He has hobby of driving gears and was interest in manual works and social interaction with his age mates.

At age of 16 he started to roam out of home and developed special interest towards the opposite sex, especially adolescent girls and rejected the home values. He had high sociogram among his classmates and peer groups outside classroom. He had a friendly approach outside the home in general.

He started work at the age of 20 after the interruption of his study. He is carpenter and he earns good money but he is extravagant, so that he can not control his money and so he is poor in his economic status.

He is sexually active and seductive and he had multiple sexual partners prior his marriage and even after he is married. He is a father of one daughter who is 1 1/2 years old.

Psychiatric Nursing

He has a habit of chewing khat, smoking cigarettes, and drinking alcohol.

He has no history of medical and surgical illness in the past.

He has no history of previous mental illness.

Pre-morbid personality

- Prior to his illness he has harmonious relation with family and workmates

He has a special inclination in group work with youngsters

- He had hobby of listening music, reading fiction books, watching television and cinemas.
- Mood wise he was cheerful, not wary and not fluctuating
- His tended to be irritable and over-sensitive.
- He was extravagant (not economical) he has inflated self steam.
- He is Muslim by religion.
- He was energetic and he was clear cut decision maker.
- He was tolerant to stress, not easily frustrated by things but sometimes he was fearful person.

Physical examination.

- On arrival at hospital psychiatric OPD he appeared aggressive, destructive, chained and energetic.
- He was not appropriately gloomed, although his hair was trimmed
- He demonstrated no CNS abnormality except agitation and aggression
- He exhibited to have no physical disability or organic illness.

Psychiatric examination (mental status examination)

His behavior appeared generally inappropriate on physical examination. He was aggressive to family members and hospital staff. He is sleepless, hyperactive and avoidant of food (he claimed a shortage of time to eat food).

He talked loudly and spontaneously. The rate of speech was fast and non coherent: from his talk he appeared to think of himself as an advisor and expert as well as a leader: he claimed that he is the leader of the country.

He was irritable but occasionally claimed that he felt happiness. In general he exhibited inappropriate mood on physical examination. It was noted:

- He has no suicidal thoughts ideas or wishes
- He is hopeful, energetic and courageous.
- He is able to think abstractly (explains poems) consistently and without interruption of flow
- Has no thought block, or poverty of ideas
- Thought contents are full of delusions (grandeur delusion): his main worry is, in his absence, this world will perish.
- He claims that he sees objects such as prophets and angels and he prefers to be a friend of them, has no tactile, and auditory hallucination.
- He has as no ideas of reference or persecution
- He exhibits ideas of self inflation (grandeur delusion)
- He has the obsessional idea of leading and controlling the world

Psychiatric Nursing

- He is oriented to place, person and time
- He has no memory impairment of either recent, remote or immediate matters (he recalls the name of persons, remote events and serials of numbers and address immediately and after 5 minutes)
- He is not attentive, he is easily distracted and distracts others and he answered to test of questions on days and months in reverse order; he subtracted serial 7's quickly
- He answered general information tests quickly.
- The intelligence test was not done
- He has poor insight and judgment e.g. he suspects food, treatment, and he has a plan of leading the world
- He has a negative attitude towards hospital staff because they caused him pain with an injection needle.

Further investigation

Further investigation, a hematology test and psychological testing from psychologist, are needed.

Formulation of the case

Differential Diagnosis:

- Organic states (cerebral tumor and arteriosclerosis)
- Hypomania
- Alcoholic intoxication
- Catatonic excitement
- Frontal lobe lesions.

Impression: Mania

Treatment

1. Lithium; it can only be given in hospital where it is possible to monitor sodium (Na) level.
2. Haloperidol (serinace)
3. CPZ Chlorpromazine.

Prognosis

- Good, with good living condition, treatment and family support.



ANNEX II

Answer Key to Study Questions

Unit One

Chapter One

1.
 - a) Sense of well being
 - b) The use of sublimation as the main defense mechanism
 - c) The ability to postponed present pleasures for future
 - d) The presence of an intact sense of reality
 - e) Good interpersonal relationship
 - f) Optimum adjustment
2.
 - a) Adoption to the work situation
 - b) Leisure – time activity
 - c) Management of social contacts
 - d) Adjustment to the opposite sex
3. C
4. B
5. A

Unit One

Chapter Two

1. (False)
2. Bethlehem Royal hospital
3. Philip Pineal
4. 5Benjamin Rush(1745-1813)
5. Dorothe Lynde Dix
6. Sigmond Freud
7. Amanuel Hospital
8. Dr. Fikire Workineh
9. 1991 Gc
10. 12 Nurses

Unit One

Chapter Three

1. A
2. B
3. A
4. a) History of present illness
b) Social and personal history (Supplementary history to be obtained from relative if possible)
c) Physical examination
d) Psychiatric examination
e) Future investigation
f) For mutation of the case
5. C

Unit One

Chapter Four

1. False
2. True
3. False
4. True
5. False

Unit Two

1. a) Anxiety disorder b) Phobia
 c) Hysteria d) Obsessive compulsive disorder
 e) Hypochondria
2. a) Desensitization
 b) Systematic
 c) Flooding
3. a) Conversion reaction hysteria
 b) Dissociative hysteria
4. a) Primary illness gain is obtaining relief from anxiety by using defense mechanism to keep an internal need or conflict out of awareness.
 b) Secondary illness a gain is any benefit or support that obtained as a result of being sick, other than relief from anxiety.
5. a) Treating the underlying illness
 b) Administration of antidepressant
 c) Psychotherapy and supportive idea

Unit Three

1. C
2. A
3. B
4. D
5. B

Unit Four

1. A
2. B
3. A
4. B
5.
 - a) Ambivalence
 - b) Association loosing (incoherence)
 - c) Affect disturbance
 - d) Autism (turning towards self)

Unit Five

1.
 - a) Loss of consciousness
 - b) Convulsive movement
 - c) Sensory phenomena
 - d) Behavioral administrates
2. B
3. D
4. B
5. D

Unit Six

1. B
2. a) Clouding of consciousness
3. b) At least two of the following
 - 1) Perceptual disturbance
 - 2) Incoherent speech at a times
 - 3) Disturbance of sleep-wake cycle with insomnia or day time drowsiness
4. D
5. A
6. a) Hypoglycemia
b) Hyperbilirubinaemia (kernicterus)
c) Hypothyroidism (cretinism)
d) Hypoproteinaemia
e) Hypocalcaemia
f) Lead poisoning

Unit Seven

1. A
2. B
3. a) Clinical psychiatric syndrome
b) Intelligence
c) Organic factors
d) Psychosocial factors
4. B
5. A
6. B

Unit-Eight

1. A
2. D
3. A
4. B

UNIT NINE

1.
 - a) To resolve a mental conflict
 - b) To reduce anxiety or fear
 - c) To protect one's self esteem
 - d) To protect one's sense of security
2. A

UNIT TEN

1. A
2. B
3. A
4. B

UNIT ELEVEN

1.
 - a) Oral contraceptive
 - b) Sedatives
 - c) Major tranquilizers
 - d) Methyldopa and others

2. a) Erectile dysfunction or impotence
 - b) Premature ejaculation
 - c) Frigidity (inhibited sexual excitement) in female
 - d) Inhibited female organism (anorgasmia)
 - e) Dyspareunia and others
3. B
4. B
5. a) Excitement
 - b) Plateau
 - c) Organism
 - d) Resolution

UNIT TWELVE

1. a) The role of unconscious factors in normal and neurotic behavior
 - b) Psychological determinism
 - c) Infantile sexuality
 - d) Topographical model
 - e) Psychogenesis
 - f) Mechanisms of defence
2. a) Brief therapy
 - b) Intensive psychotherapy
 - c) Group therapy
 - d) Conjoint family therapy
 - e) Administrative therapy

3. a) Systematic desensitization
 - b) Token economy
 - c) Aversion treatment
 - d) Flooding and response prevention
 - e) Social skills training
4. a) Informal ping pong
 - b) Card games
 - c) Trip outside the hospital
 - d) Structured soft ball
 - e) Basket ball or volley ball games
 - f) Attending sport events and so on
5. a) Helps to build a more healthy and integrated ego
 - b) It helps to express and deal with needs and feelings
 - c) Assist in a gratification of frustrated basic needs]
 - d) Strengthens ego defenses
 - e) Reverse psychotherapy

UNIT THIRTEEN

1. a) Chlorpromazine
 - b) Thiorizadine
 - c) Fluphenazine
2. Haloperidol (halidol)
3. a) Accurate administration
 - b) Observation for therapeutic effect

Psychiatric Nursing

- c) Observation for adverse effect
 - d) Observation for drug interactions
 - e) Teaching client
4. a) Amitriptylin
b) Imipramin
5. a) Chlordiazepoxide (librium)
b) Diazepam (valium)



GLOSSARY

Akinesia: Absence or poverty of movements

Alcoholism: A disorder marked by a pathological pattern of alcohol use that causes serious impairment in social or occupational functioning (alcohol abuse).

Amnesia: Pathogenic impairment of memory

Anesthesia: Loss of feeling or sensation, especially the loss of pain sensation induced to permit the performance of surgery or other painful procedures.

Anoxia: Absence of oxygen supply to tissues despite adequate perfusion of the tissue by blood (hypoxia)

Aphonia: Loss of voice, inability to produce vocal sounds.

Apraxia: Loss of ability to carry out familiar purposeful movements in the absence of major or sensory impairment, especially inability to use objects correctly.

Atonic: Lack of normal tone of the muscle or strength.

Autism: The condition of being dominated by subjective, self-centered trends of thought or behavior which are not subject to correction by external information.

Cataract: An opacity of the crystalline lens of the eye or its capsule

Cerebral Palsy: Persistent qualitative motor disorder, appearing before age three.

Delusion: A false personal belief based on incorrect inference about external reality and firmly maintained in spite of incontrovertible and obvious proof or evidence to the contrary.

Dementia: Diffuse brain dysfunction characterized by a gradual, progressive and chronic deterioration of intellectual function.

Depersonalization: Alteration in the perception of self so that the usual sense of one's own reality is temporarily lost or changed. It may be a manifestation of a neurosis or another mental illness or can occur in mild form in normal persons.

Downs syndrome: Mongoloid features, short phalanges, widened space between the first and second toes and fingers, and moderate to severe mental retardation: associated with a chromosomal abnormality usually trisomy of chromosome 21.

ECT : Electroconvulsive therapy.

Ego: Segment of the personality dominated by the reality principle comprising integrative and executive aspects functioning. The ego is able to adapt the forces and pressures of the superego and the requirements of external reality by conscious perception, thought and learning.

Fixation stage: The cessation of psycho sexual development before maturity.

Fugue state: A dissociative reaction in which amnesia is accompanied by physical flight from customary surroundings.

Hyperbillirubinemia: Excess of bilirubin in the blood classified conjugated or unconjugated, according to the predominant form of bilirubin present.

Hypoglycemia: Deficiency of glucose concentration in the blood which may lead to nervolegness, hypothermia, headache, confusion, and sometimes convulsions and common.

Hypothyroidism: Deficiency of thyroid activity.

ID: That part of the personality that is an unconscious reservoir of primitive drives and instincts dominated by the pleasure principle.

illusion: A mental impression derived from misinterpretation of an actual experience.

Judgment: Orientation, memory, affect or emotional stability, cognition, and attention.

Kernicterus: A condition with severe neural symptoms, associated with high levels of bilirubin in the blood.

Labelle indifference: An inappropriate lack of concern, indifference.

Mania: It is an abnormally elated mental state, typically ccarecterized by feelings of euphoria, lack of inhibitions, racing thoughts,

Psychiatric Nursing

diminished need for sleep, talkativeness, risk taking, and irritability. In extreme cases, mania can induce hallucination and other psychotic symptoms. (www.wordreference.com/definition/mania-12k-18dec2004)

Myoclonics: Shock-like contractions of a muscle or a group of muscles.

Neurosis: A descriptive term used to differentiate non psychotic clinical symptoms.

Paranoia: A rare condition characterized by a delusional system that develops gradually, becomes fixed, and is based on the misinterpretation of actual event.

Personality disorder: A non psychotic illness characterized by maladaptive behavior that the person uses to fulfill his/her need and bring satisfaction to self. As a result of the inability to relate to the environment, the person acts out conflicts socially.

Petitimal epilepsy - is one type of epilepsy seen in children, in which there is sudden momentary unconsciousness with only minor myoclonic jerks

Phetoscope: A specially designed stethoscope for listening to the fetal heart beat.

Primary illness gain: obtaining relief from anxiety by using defense mechanism to keep an internal need or conflict out of awareness.

Psychosis: A severe mental disorder in which a person experiences an impairment of the ability to remember, think, communicate, respond emotionally, interpret reality, and behave appropriately.

Schizophrenia: A serious psychiatric disorder characterized by impaired communication with loss of contact with reality and deterioration from a previous level of functioning in work, social relations, or self care.

Secondary illness gain: Any benefit or support that a person obtains as a result of being sick, other than relief from anxiety.

Somnambulism: Sleep walking; rising out of bed and walking about during an apparent state of sleep.

Spina bifida: A developmental anomaly marked by defective closure of the bony encasement of the spinal cord through which the meninges may or may not protrude.

Status epilepticus: Rapid succession of epileptic spasms with out interlining periods of consciousness.

Super ego: the aspect of the personality that acts as a monitor and evaluator of ego functioning comparing it with an ideal standard, In psychoanalysis.

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