DIPLOMA IN REGISTERED NURSING

eLEARNING TRAINING PROGRAMME

Course Title: Mental Health and Psychiatric Nursing

Course Code: MHP 026

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LIST OF ABBREVIATIONS AND ACRONYMS

CCHS	:	Chainama College of Health Sciences
CMHN	:	Community Mental Health Nursing/Community Mental Health Nurse
COP	:	Clinical Officer Psychiatry
CPN	:	Community Psychiatric Nursing/Community Psychiatric Nurse
EPN	:	Enrolled Psychiatric Nurse
MHN	:	Mental Health Nursing
MoH	:	Ministry of Health
RMHN	:	Registered Mental Health Nurse

INTRODUCTION TO THE COURSE

You are welcome to this interesting specialty nursing course offered in the general nursing curriculum. The course focuses on the study of mental health and psychiatric nursing as part of general nursing and it is designed to provide you the opportunity of applying the nursing sciences in the care of patients suffering from psychiatric illnesses. This course will broaden your knowledge and skills needed for meeting the ever changing needs of psychiatric clients/patients, their families and society. The whole course will take 84 hours on theory and 210 hours practical experience which embraces community psychiatry. It is a full course similar to medicine and medical nursing. Psychiatry is a branch of medicine which deals with the study and treatment of mental diseases. It deals with the mind, emotions and behaviour of man precisely; the least understood portion of the human being.

Psychiatric illness is characterized by a breakdown in the normal pattern of thought, emotion and behaviour. Psychiatric symptoms, problems and illness of all kinds are very common throughout life. Psychiatric nursing is a specialized branch of nursing in which the nurse utilizes personal knowledge of psychiatric theory and the available environment to effect therapeutic changes in the patients' thoughts, feelings and behaviour. The nurse's ability to effect these changes varies according to the nurse's experience and education. The therapeutic role of the psychiatric nurse cannot be described only in terms of attitudes, feelings, relationship and understanding. What the nurse brings as a person to the treatment situation is directly related to her therapeutic effectiveness.

Psychiatric nursing is concerned with the identification, promotion, prevention and care of patients suffering from mental disorders (Keltner, Schwecke and Bostrom, 2007). Thus, psychiatric nursing is the process whereby the nurse assists persons, individuals or groups in developing a more positive self-concept, a more harmonious pattern of interpersonal relationships and a more productive role in the society.

MAIN COURSE OBJECTIVE

Students will be equipped with knowledge and skills in mental health to enable them understand human behaviour and manage clients with mental disorders.

COURSE OBJECTIVES

At the end of the course, you should be able to:

1. Describe normal human behaviour
2. Describe abnormal human behaviour
3. Describe common psychiatric conditions
4. Apply psychiatric nursing principles in managing patients suffering from mental illness
5. Explain how the family can be used as a primary resource in rehabilitating patients suffering from mental illnesses
6. Identify resources within the community for rehabilitation of patients suffering from mental illness
7. Describe how available resources can be utilized in rehabilitation of the mentally ill
8. Apply communication skills in identifying clients at risk within the family and community

COURSE CONTENT

This course has eight units/titles.

UNIT 1: Introduction to Mental Health-Psychiatric Nursing

In this unit, you will be introduced to mental health and psychiatric nursing concepts and approaches to create an understanding of this specialty. Psychiatric nursing as you may understand, is a branch of nursing concerned with identification, prevention and care of people suffering from mental illness (Townsend, 2010).Hence, from this brief description of psychiatric nursing, it is understood that you will be able to provide minimal specialised care to patients suffering from mental health and psychiatric illnesses in communities around you as well as at the health facility you will be working from after you qualify from your training in general nursing.

UNIT 2: Psychiatric Nursing Skills

You might acknowledge that psychiatric nursing skills comprise the foundation of a nurse-patient therapeutic relationship, which is key to intervention modality of psychiatric nursing and for a psychiatric nurse to be a good communicator; he/she should reinforce self-awareness before dealing with the concerns of a psychiatric patient (Corpel, 1996).Thus, you will learn numerous psychiatric nursing skills as organised in this unit 2.

UNIT 3: Classification and Management of Psychiatric Disorders

As for this unit, you will learn about classification of psychiatric disorders mainly from two mostly recognised classification criteria by World Health Organisation (WHO) despite that there are many other diagnostic criteria by the Chinese, Russians and Japanese. The International Classification of Diseases (ICD) of British origin has undergone numerous changes from ICD1 to the current ICD10; probably there should be even a newer version now which could be in the way out for publication. The other approach to classification of disease entities in mental health is through the American Diagnostic Statistical Manual (DSM) which also went through several reviews up to the current DSM V (2014) from DSM I, II, III and IV. The DSM uses Axes; Axis I, II, III, IV and V in providing a diagnosis while the ICD 10 uses a code F for instance F00-F99, where F20 implies schizophrenia, F30, F10, mean other disease entities, among others.

UNIT 4: Conditions not attributed to mental disorders that are a focus of attention and treatment

You may be aware that in psychiatry and psychiatric nursing, other conditions might be treated but they do not imply that they are psychiatric illnesses; nevertheless, because of behavioural disorders that arise due to a medical condition, psychiatric attention is and may be rendered/ provided. Epilepsy for example is a medical condition that receives awesome management in psychiatry.

UNIT 5: Management of a Client with Psychiatric Emergency

As you proceed in learning in this unit on psychiatric disorders, you will come across psychiatric disorders that jeopardise the lives of the patient him/herself, staff and people in the community and such conditions are treated as psychiatric emergencies hence special supervision has to be enhanced. You will examine and learn more about psychiatric emergencies in unit 5.

UNIT 6: Forensic Psychiatry

You should be aware that psychiatric patients may not have immunity to litigation once they commit an offence in society but there are legal aspects that apply in psychiatry which provide a platform for their cases to be heard in a court of law in a proficient approach compared to an ordinary court case. Therefore, you will have an explicit orientation particularly in this unit 6 on how such forensic patients receive care while in a detention centre and about special forensic care units in Zambia.

UNIT 7: Community Psychiatry

Community psychiatry is a subsidiary of the psychiatric specialty that is concerned with psychiatric issues that arise in the community. You will therefore be tasked to learn about how families cope with the pressures of looking after a relative diagnosed with a psychiatric illness. Besides, you will learn about patient's social networks as far as psychiatric treatment and support are concerned.

UNIT 8: Advocacy in Psychiatry

You may be aware that psychiatric patients are vulnerable people in society because of the nature of their disorders, hence, others should stand and speak on their behalf so that where need arises, they might have recognition in the communities they live. Non-governmental organisations (NGOs) in this view may provide such support for instance MHUNZA speaks for those suffering from mental illnesses in Zambia. This may not imply that individuals are excluded in providing support to psychiatric patients, for example MHAZ (Mental Health Association of Zambia comprises of many individuals who have taken up independent individual roles in promoting mental health in Zambia.

CLINICAL EXPERIENCE

Your practical experience in mental health-psychiatric nursing will last for four weeks and you are expected to do it in the following areas:

1. Psychiatric wards
2. Community health centres
3. Drop in centres
4. Orphanages
5. Skills training centres
6. Geriatrics
7. Support groups

DEMONSTRATIONS

During your clinical experience the following demonstrations will be done:

- Admission
- Interview (Simulation)
- Psychosocial counselling skills
- Group therapy

ASSESSMENTS

Your work in this course will be assessed in the following two ways:

1. **Tests and assignments will make up 40% of your continuous assessment results.**

    - Two written tests which will constitute 20% of your continuous assessment. One group assignment which will constitute 10% of your continuous assessment. One individual assignment in the form of a case study during your clinical placement which will constitute 10% of your continuous assessment.

2. **A written examination will take place at the end of the course. This exam is worth 60% of the final mark.**

LEARNING TIPS:

How long will it take?

It will probably take you a minimum 90 hours to work through this course. The time should be spent on studying the Course and the readings, doing the activities and self help questions and completing the assessment tasks. Note that units are not same length. Unit 3 is the longest and needs more hours to complete. You therefore need to plan and pace how you will cover your work.

PRESCRIBED READING

There is a list of further reading at the end of this course. This includes books and articles referred to in the Course in case you need to explore certain topics further. You are encouraged to read as widely as possible to get different viewpoints and approaches.

UNIT 1: INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRIC NURSING

1.1 Unit introduction

In this unit you will look at the definitions of common terminologies used in mental health and psychiatric nursing. You will also have a privilege to learn how mental health has evolved in Zambia from the colonial days up to date. The unit will also introduce you to legal aspects of psychiatric – mental health nursing, some of the mental health laws and mental health policies in Zambia

Mental illness has been with man since time immemorial (Stuart and Laraia, 2005). Over the years mental health and psychiatry have gone through a lot of changes. This has shifted from looking after psychiatric patient from prisons to hospital. In order to fully appreciate mental health nursing, It will be important to define key concepts used in psychiatry and mental health, look at the history of psychiatric nursing in Zambia, learn about psychiatric nursing principles and the guidelines that govern the care of the mentally ill,

1.2 Unit Objectives

By the end of the unit, you should be able to:

1. Define common terminologies in mental health and psychiatric nursing:
2. Discuss the history of mental health and psychiatric nursing in Zambia.
3. Outline the principles of psychiatric nursing.
4. Explain the legal aspects of psychiatric-mental health nursing
5. Explain mental health laws that apply in Zambia
6. Discuss the mental health policies in Zambia

1.3 Definition of common terminologies used in mental health and psychiatric nursing :

1. **Psychiatry**: A specialized or branch of medicine that deal in the diagnosis and management of mental disorders.
2. **Mental health**: 'Wright Taylor 1970' defines mental health as being happy, efficient, lack of anxiety, maturity, able to adjust, practicing autonomy and self-esteem is high.
3. **Health**: A state of well being, but not merely the absence of disease or infirmity
4. **Psychiatric nursing** is a branch of nursing concerned with identification, prevention and care of people suffering from mental illness
5. **Mental health nursing** is a specialized nursing involved in identification, diagnosis and management of psychiatric disorders. This definition is synonymous with psychiatric nursing (Townsend, 2011).

Other terminologies used in Psychiatry

- **Communication**: Interaction between people and their environment based on stimuli and responses.
- **Language:** This is a method by which thoughts and activities are made available to conscious awareness. It can be vocal, written or sign represented.
- **Agraphia**: An inability to write occurring in general dysphasia also called apraxia.

DISORDERS OF PERCEPTION
Illusion: miss-interpretation of stimuli.
Hallucinations: presence of perception without stimuli.

DISORDERS OF THINKING:

- Flight of ideas: Too much ideas flowing together.
- Retardation of thought : slowed thought process
- Circumstantial thinking : A talk that does not go directly to the topic but takes time for that individual to state the point or simply beating about the bush.
- Fragmented thinking: disjointed ideas.
- Delusion : false and fixed belief not based on founded fact(s) or evidence- based research and is not related to an individual's educational background, religion, race or culture.
- Obsession: These are repetitive ideas coming into your mind frequently
- Paranoid: Suspiciousness and a tendency to distort experience by misconstruing the natural or friendly actions of others as hostile or contemptuous

DISORDERS OF ORIENTATION

- Disorientation: inability to recognize place, time, date, year and person (all the spheres are forgotten).

DISORDERS OF SPEECH

- Incoherent speech: Senseless speech.
- Echolalia: Patient repeating what the interviewer says.
- Echopraxia : Patient repeating the movements made by the interviewer
- Neologism: Formation of own new words with meaning known by the patient him/herself.
- Word salads: Mixing of words that only make sense to the owner.
- Mutism: When someone can't talk, as seen in severe depression.

Disorders of motor activity

- Stereotyped activity: Copying what someone else is doing.
- Negativism: Doing exactly the opposite of what one is taught or told to do.
- Compulsion: An act due to a repeated ideas coming into your mind.
- Waxy flexibility: Maintaining of awkward or a sustained posture.

Disorders of mood or affect

- Euphoria/elation : Excessive happiness.
- Depression: Extreme feeling of sadness
- Incongruent affect: Expected mood not tallying with the current behaviour
- Flat affect : Severe reduction in expression of emotions
- Ambivalence: Existence of two conflicting feelings

Disorders of memory

- Amnesia: Forgetting things that happened.
- Retrograde amnesia: Loss of memory of events that happened after the accident or injury.

- Anterograde amnesia: Loss of memory of events that happened before the accident.
- Confabulation: Creating own ideas or feeling in blanks to cover up what you have forgotten.
- Erotomania: An individual normally un-married woman who has a false belief that she is loved by a person of high social status. She engages in writing letters, sending gifts, telephoning or attempt visits.
- Grandiose delusion: An individual believes he/she possess a recognized talent or in sight such as that of religious leader and seek for position of power. Or can simply be explained as an individual believing that he/she is a very important person in society
- Folie ŏ duex: Shared paranoid disorder which develops as a result of close relationship with a person who already experience persecutory delusion.
- Déjà vu: A patient seeing a strange person and believing that he/she has seen that person before, psychopathology familiarity.

1.4 History of mental health and psychiatry in Zambia

Northern Rhodesia had no psychiatric hospital and most of the patients where looked after in the general hospitals known as mental annexes. These buildings were very dirty and unfit for human habitation. The male patients were managed in prisons while the female where treated in General hospitals like Kasama, Ndola, Livingstone and Mansa.

Those who couldn't recover from mental illness were sent to Southern Rhodesia in Bulawayo at Ingutsheni hospital which had a bed capacity of 690 and yet it accommodated 1, 391 patients resulting into congestion and poor psychiatric care.

Not until 1957 when Sir Steward Gobrown the then MP of Shiwang'andu suggested in parliament that psychiatric patients could best be nursed at home, here in Zambia than at Ingutsheni. An inquiry was instituted and a bill was passed in parliament in 1957 with the following positive resolutions that:

a. Patients are looked after in Zambia not in Bulawayo.
b. A psychiatric hospital be built at Chainama
c. Qualified human resources to be recruited from England, these should be Roman Catholic Nuns and Brothers.

In 1962 three wards and student hostels were built together with the convent (A, B and C wards).

Mental attendants were employed to assist in the care. After six months the medical assistant training started, composed of 40 students out of which 10 qualified in **1965**. The same year the hospital was extended by three modern blocks for rehabilitation (E, F and D wards). In 1967 psychiatric enrolled nursing started and in **1968** Chainama East Forensic block was opened with 168 beds.

In **1970** children's day centre was built by Jaycees and the bus was provided by the Lion's club for the disabled children.

In **1989** enrolled psychiatric nursing was phased out. In September 1991 the first intake of registered mental health nurses was commenced with 20 students.

It was a post basic programme with eighteen month duration. All 20 students qualified and were sent in provincial annexes. Mrs Ikafa and Hellen Blackburn started the programme.

Mental Health Association of Zambia

Mental Health Association of Zambia (MHAZ) is a nongovernmental organization that looks into the welfare of the mentally challenged. The association collaborates with the government to ensure that mental health services are well provided to the community at large. MHAZ plays a key role in sensitizing the community on the prevention of mental illnesses. It also highlights the challenges that the mentally ill go through. The association has also been fighting stigma against the mentally ill. It was formed in 2010.

Membership is open to all that are interested in mental health issues.

1.5 Principles of psychiatric nursing

- Allow a client an opportunity to set own pace in working with problems.
- Nursing interventions should centre on the client as a person, not on control of symptoms. Symptoms are important, but not as important as the person having them.
- Recognize your own feelings towards clients and deal with them.
- Go to the client who needs help the most.
- Do not allow a situation to develop or continue in which a client becomes the focus of attention in a negative manner.
- If client's behaviour is bizarre, base your decision to intervene on whether the client is endangering self or others.
- Ask for help-do not try to be a hero when dealing with a client who is out of control.
- Avoid a highly competitive activity that is having one winner and a room full of losers.
- Make frequent contact with clients- it lets them know they are worth your time and effort.
- Remember to assess the physical needs of your client.
- Have patience, move at the client's pace and ability.
- Suggesting, requesting, or asking works better than commanding.
- Therapeutic thinking is not thinking about or for, but with the client.
- Be honest so the client can rely on you.
- Make reality interesting enough that the client prefers it to his or her fantasy.
- Compliment, reassure and model appropriate behaviour.

1.6 The legal aspects of psychiatric-mental health nursing

There are many legal aspects in psychiatry for instance a patient suspected of suffering from mental illness should be admitted to a mental unit under certain legal procedures for example a patient shall be admitted Under Detention orders endorsed by a magistrate or in the subordinate court. You are therefore referred to the Laws of Zambia Vol.17 of the Zambian Constitution.

This is a basic and brief illustration on the legal principles and sources of law which have enhanced the delivery of mental health and sound psychiatric nursing practice in Zambia and other common wealth countries internationally.

Sources of law affecting Psychiatric Nursing in Zambia:

1. The Zambian constitution

You may be aware that the Zambian constitution has outlined guidelines on. How psychiatric patients should be handled when they commit an offence that is deemed criminal. Such a patient should be admitted to a mental unit so that an evaluation could be made to ascertain whether the patient is or not fit to stand trial in a court of law. Patients' of such nature may get admitted to a prison station via His Excellence Pleasure, also called H.E.Ps.

2. Mental health policy of Zambia

The Mental Health Services Bill, (2006) provides clear guidelines for handling and care of psychiatric patients at any level of health care for instance the health centre, there should be at least two beds where such a patient may be admitted before transfer to a district hospital where five beds strictly are reserved for mental patients.

3. The Ministry of Health – Zambia

The ministry of health is the core custodian for mental health care implementation and employment of mental health staff. It keeps and facilitates all legal issues related to mental health care any information regarding legal implications for mental health care could be accessed through the ministry of health and currently the ministry of health is working on the draft document for mental health in Zambia which is only awaiting parliament approval.

1.7 Mental Health Laws in Zambia

Mental disorder in Zambia is defined by an act of parliament called the mental disorders Act Chapter 305 of the laws of Zambia (1951). The law was enacted by the federal government and contains terms that are deemed as derogatory to the mentally ill. Such terms refers to the mentally ill as idiots, imbecile. Mental health activists are fighting for this law to be repealed. The government has currently made tremendous progress in repealing this out dated law.

According to this law, a mentally disordered or defective person means any person who, in consequence of mental disorder or disease or permanent defect of reason of mind.

Congenital or acquired:

(a) is incapable of managing himself or his affairs; or

(b) is a danger to himself or others; or

(c) is unable to conform to the ordinary usages of the society in which he moves; or

(*d*) requires supervision, treatment or control; or

(*e*)(if a child) appears by reason of such defect to be incapable of receiving proper benefit from the instruction in ordinary schools;

1.8 Mental health policies in Zambia

The Government of Zambia has been trying to recognize the importance of mental health in the country. In order to provide coordinated and well structured mental health services, the government has offered policy

direction as regarding care of the mentally ill. The care is in different forms that is, institutional care, community care as well as prevention aspects. In the execution of mental health services in Zambia, particular attention is paid to special needs and expectations of vulnerable groups in the community. The role of traditional healers, who in many instances are the first contact for the people with mental health problems and mental disorders, shall be incorporated into the policy.

The role of non-governmental organizations in supporting people with mental health problems and mental disorders shall be addressed if the mental health policy will be acknowledged.

Culture is also very important, certain ways of life among the people of Zambia contribute to positive mental well-being, for instance, payment of dowry initiation ceremonies and respect for elders. However, certain cultural factors that are implicated in the causation of mental illness arise out of social punishment or witchcraft. For instance the issue of ritual cleansing following the death of a spouse may precipitate mental ill health. Certain cultural and social norms are responsible for problems like Gender Based Violence (GBV). These norms are transmitted through the process of socialization, teach girls to be submissive and have a low opinion of themselves.

Religion can have both positive and negative implications on the mental wellbeing of individuals. It plays a significant role in the management and care of the mentally ill by mitigating effects of stress on individuals and families. On the other hand, it may contribute to delays in seeking mental health services.

The issue of Gender is another important issue in mental health. Men and women are traditionally ascribed social roles. In the case of women, they are assigned domestic roles such as fetching water, providing food and caring for the sick. The stress arising from these roles may lead to emotional and mental disorders such as anxiety states and depression respectively. In a similar way, the men are traditionally considered to be breadwinners and therefore are expected to provide security for the family. Men are under pressure to provide almost all the necessities for the family. As a result most of the men may resort to alcohol and substance abuse (Mental health policy, 2005).

A complete document on mental health policies in Zambia's is available and can be obtained from Government printers. You are encouraged to access this document.

1.9 Summary

Mental illness is commonly manifested by observable behaviour and its exceptionality to individuals, its variation from time to time with even the same individual and its dependence on a host of other factors that have made it easier to draw a distinct line between mental health and mental illness. This means that no single characteristic or quality can be taken as evidence of positive mental health but lack of any of these characteristics or traits is evidence of mental illness. It is therefore easier to define mental health by use of mental illness observable actions that are quite exceptional.

1.10 Self Assessment Test

1. Define the following terminologies
    a. Psychiatry

b. Confabulation

c. Grandiose delusion

d. Mental Health

Answers

- Grandiose delusion: an individual believe he/she possess a recognized talent or in sight such as that of religious leader and seek for position of power. An individual simply believes he/she is an important person in society
- Echolalia: Repeating what the interviewer says.
- Mental health: 'Wright Taylor 1970' defines mental health as being happy, efficient, lack of anxiety, maturity, able to adjust, practicing.
- Confabulation: creating own ideas to cover up what you have forgotten.
- Psychiatry: a specialized or branch of medicine that deal in the diagnosis and management of mental disorders.

1.11 References

1. Elakkuvana, B.R. (2011) Mental Health Nursing. New Delhi: Jaypee Brothers Publishers
2. Keltner, N, Schwecke, L, Boston, C. (2007). Psychiatric Nursing. St Louis: Mosby

UNIT 2: PSYCHIATRIC NURSING SKILLS

2.1 Introduction

I welcome you to our second unit in which we will discuss the many different ways in which you as a nurse is able to use psychiatric nursing skills to help people with mental disorders recover. In unit 1, Introduction to mental health and psychiatric nursing**,** we defined certain terms such as mental illness/disorder, psychiatry, mental health to mention but a few. In this lesson we will be repeating some of these new terms and be sure to refer to unit 1 and the glossary at the end of this unit for any terms you have difficulties understanding.

In this unit (2) on psychiatric nursing skills, we will cover the skills that we need to use when caring for clients with psychiatric illness. Psychiatric nursing skills are interventions a nurse uses to give care to a person with a mental disorder or illness. These interventions are given to change the wrong thoughts and abnormal behaviours that characterize people with mental illnesses.
A skill is an ability to do an activity or job well, especially because you have practiced it.
A nurse needs special skills in order to assist a patient with disorders of the mind and abnormal behaviours. They are special because people with mental illness can be the most challenging group of individuals to work with, as you shall discover when you reach Unit three which deals with both minor and major mental disorders.

2.2 Objectives

By the end of this unit you should be able to:

1. Apply communication skills
2. Demonstrate self awareness skills
3. Exhibit assertiveness training skills
4. Apply counselling skills
5. Demonstrate social skills
6. Demonstrate interactive skills
7. Demonstrate observation skills
8. Describe stress management skills
9. Demonstrate behaviour modification skills
10. Utilize therapeutic nursing intervention skills
11. Conduct physical assessment of a psychiatric patient
12. Describe the admission of a psychiatric patient

Activity
Using your own words, write down the meaning of the word ‘skill’ in your notebook

Okay, so you have come up with your answer? Now you can compare it with the definition below.

A skill is an ability to do an activity or job well, especially because you have practiced it.

2.3 Communication skills

From your lessons in psychology and fundamentals, what would you say communication skills are? Start by doing the following activity.

Activity Using your own words, write down the meaning of the term communication in your notebook

Well done! I hope in your definition you mentioned that communication is the reciprocal exchange of information, ideas, beliefs, feelings and attitudes between 2 people or among groups of people. It is a skill that is practiced when making the different nursing interventions in nursing practice.

Methods of communication

There are various methods used for communicating with clients in mental health. These include:

- verbal
- non verbal
- written communication skills

Now look at each method of communication in turn:

1. Verbal communication or the spoken word

Verbal communication occurs through words that are spoken or written. As a nurse you need to be prepared to communicate effectively with patients that speak a different language from your own. You may therefore also need to learn or adapt to your client's language because certain phrases or ways of expression are better done in the mother tongue or local dialect.

As a nurse you start communicating with a patient with opening remarks that build rapport and encourage clients to open up. Then when the patient opens up, as a nurse you need to listen. Don't 'interrogate patients' or shower them with questions all at one instant, thereby making them feel judged.

2. Non verbal communication or body language

These are messages received via facial expression, voice tone, pitch, physical postures and gestures. Body language is always present during communication, without which we cannot communicate. The body language of both the patient and ourselves as nurses (the patient also sees our body language). For instance, if you are quick and sharp as a nurse the patient may view such body language as rudeness and an 'I don't care' attitude. On the other hand if you as a nurse is unhurried, smiles, warm and friendly, it conveys acceptance and patients may turn to you for help, or disclose personal feelings to you.

Tips for understanding non-verbal communication

Recognise that people communicate on many levels. Watch their facial expressions, eye contact, posture, hand and feet movements, and their appearance. When interviewing people, watch how they sit and wait. As you watch clients, take note of negative gestures and personal space.

1. **Negative Gestures**

- Feet dragging: lethargic, don't care
- Head down: timidity, shyness
- Shoulders Drooped: weariness, lethargy
- Shifty eyes: nervousness
- Hands in pockets: something to hide
- Weak handshake: meek, ineffectual

2. **Personal space**

- 'proper' space 2-4 feet
- Violation of personal space is seen as a threat and an aggressive gesture by both the client and yourself as a nurse alike.

The Importance of Listening to Clients

The first rule of a therapeutic relationship is to listen to the patient. It is the foundation on which all other therapeutic skills (assertiveness, counselling, social, and nurse patient therapeutic relationship) are built. Real listening is difficult. It is an active, not a passive, process. As nurses, we should suspend thinking of personal experiences and problems and making personal judgments of the patient.

This can be demonstrated by behaviours which are summarized by the acronym known as 'SOLER'.

What does SOLER stand for?

Before you read on, do the following activity.

Activity
? In your notebook, write the acronymic SOLER. Then next to each letter indicate the behaviour that demonstrates that you are listening actively to a patient.

Now compare your answer with the following letters (SOLER). It stands for:
S – Sit squarely
O – Open posture
L – Lean forward
E – Eye contact
R – Relax as you listen
Now that you know the meaning of SOLER, practice it with a fellow student. Imagine yourself in a room with a client who is confiding his or her feelings to you. Place 2 chairs, and sit on one and adopt the SOLER behaviour as the client talks to you.

We hope you now understand the meaning of communications, SOLER and the methods used to pass on ideas from one person to another. In the next section we shall look at another psychiatric nursing skill known as self awareness.

2.4 Self awareness skills

To be able to relate effectively with clients that have mental illness you as a nurse must know and understand yourself very well, that is, your weaknesses, strengths, biases, attitudes and so on. When you know yourself well, you will avoid imposing your personal values on patients. It will also keep you from being judgmental to patients especially when they exhibit abnormal behaviours.

Self awareness involves looking inward to understand oneself and objectively (without bias) examine one's beliefs, values, attitudes, motivations, strengths and limitations. It is like looking inside the mirror and seeing your image

This means that you must be able to examine your personal feelings, actions, and reactions. However, no one ever completely knows their inner self, as shown in the Johari window in Figure 2.1.

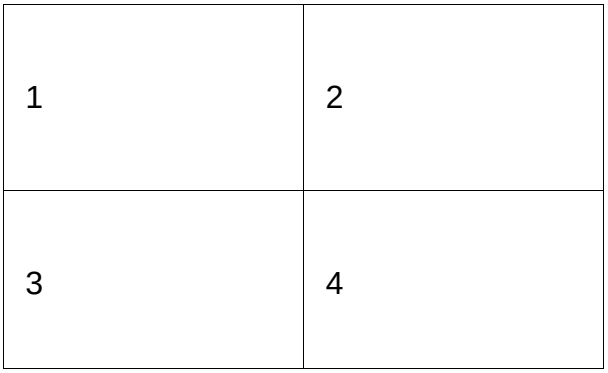

Figure 1:The Johari Window

The Johari Window consists of four quadrants that represent the total self as follows:

- Quadrant 1 – Known to self and others. It includes the behaviours, feelings, and thoughts known to the individual and others.
- Quadrant 2 – Known only to others. (It is an open secret!). It includes all the things that others know but the individual does not know.it is also known as a blind spot
- Quadrant 3 – Known only to self. This quadrant includes the things about self that only the individual knows. It is also called a façade (mask)
- Quadrant 4 – Known neither to self nor to others.

The goal of increasing self awareness is to enlarge the area of quadrant 1 while reducing the size of the other quadrants.

Why is Self Awareness important in Psychiatric Nursing

To ensure the most effective use of self, it is important to be aware of personal stress that can interferes with your ability to communicate therapeutically with patients. If you are tired, anxious, angry or apathetic, it will be very difficult to convey an interest in the concerns and fears of the patient.

As a student nurse, what are your social biases? Remember that they can influence the way you interact with patients.

The messages you communicate verbally and none verbally to patients can only be clear when you as a nurse acknowledge your own feelings even when they are negative.

A good understanding and acceptance of yourself will allow you to acknowledge a patient's differences and uniqueness. By so doing, we will not be judgemental in our dealings with patients. It is also teaching the patient to be aware about themselves.

We hope you now understand the importance of self awareness. When you are aware about yourself you are motivated because you know what makes you tick you avoid biases in nursing care of patients. Next, we shall learn how you can use assertiveness skills to help patients with mental conditions.

Self assessment Test

Explain the four (4) quadrants by matching column A to column B

Column A Column B

Quadrant 3- known to self and others,

Quadrant 2- Only known to others

Quadrant 4- Only known to self

Quadrant 2- Neither known to self nor others

ANSWERS

Quadrant 3 - Only known to self

Quadrant 2 – Only known to others

Quadrant 4- Neither known to self nor others

Quadrant 1 – Known to self and others

2.5 Assertiveness training skills

What is assertiveness?

Assertiveness means communicating directly with another person to express yourself. It means:

- Saying no to unreasonable requests
- Being able to state complaints without being aggressive
- Expressing appreciation as appropriate

Training patients to be Assertive

Lack of assertiveness is common in psychiatric patients because of their mental illnesses. Patients who lack assertiveness skills easily get frustrated when dealing with other people. This can cause them to have aggressive behaviours. Such patients are easily taken advantage of when they lack assertiveness. To enable a patient develop assertive behaviours, nurses can carry out assertiveness training. This is done in groups so that the patient learns to relate to other people within the group in an assertive way, before generalizing the behaviour to another setting.

Methods of training patients to be Assertive

Patients can learn assertiveness by participating in groups. Patients watch the staff demonstrate specific skills in a role play, (such as, saying please when asking for something; thank you when they are given something, or seeking redress when treated unfairly, without insults or violence).

They then engage in a role play and demonstrate the skills they have learnt. Staff can then provide feedback to the patients on the appropriateness and effectiveness of their responses in the role play. They can also assign homework to the patients to help them generalize these skills outside the group. As the patient learns new and more effective assertiveness skills, their aggressive behaviour diminishes.

Activity

Practice assertive behaviours with your peers. Say no to unreasonable requests, state your complaints without being aggressive and express appreciation as appropriate).

Self assessment questions

Explain how assertiveness skills can help patients

The following are probable answers – write True or False

1**.** Assertiveness means communicating directly with another person to express yourself. T/F

2. Patients can learn assertiveness by doing individual assignments T/F.

3. Lack of assertiveness is common in psychiatric patients because of their mental illnesses. T/F 4. Patients who lack assertiveness skills easily get frustrated when dealing with other people because they are able to express themselves - T/F

ANSWERS

1. True

2. False

3. True

4. False

2.6 Counselling skills

What is counselling?

Counselling is a method of relieving distress undertaken by means of a dialogue between 2 people. The aim is to help the client find their own solutions to problems, while being supported and being guided by appropriate advice.

Nurses who care for clients with mental problems must be ready at all times to take on the role of a counsellor. A counsellor must have certain qualities if clients are to confide in him or her. Now look at that next.

Qualities of a counsellor

The most important qualities in a counsellor are being genuine, accepting, and empathic. What do these mean?

- Being genuine means that a counsellor cares for the client and behave toward the client as they really feel. It is similar to congruence.
- Being accepting means that counsellor should appreciate clients for who they are, despite the things that they may have done counsellor does not have to agree with clients, but they must accept them. It is the same as unconditional positive regard.
- Being empathic means that the counsellor understands the client's feelings and experiences and conveys this understanding back to the client. Empathetic understanding can be demonstrated through reflection of feelings, and clarification.

ROLE PLAY (GROUP WORK) As a group, go through the following paragraph on empathy and then practice the following dialogue that demonstrates how a counsellor shows empathy to a client.

To show empathy, a counsellor restates what the client has said and seeks clarification of the client's feelings. The counsellor may use such phrases as 'What I hear you saying is…' and 'You're feeling like…' The counsellor seeks mainly to reflect the client's statements back to the client accurately, and does not try to analyse, judge, or lead the direction of discussion. For example:

Client: I always felt my husband loved me. I just don't understand why this happened.
Counsellor: You feel surprised by the fact that he left you, because you thought he loved you. It comes as a real surprise.

Client: M-hm. I guess I haven't really accepted that he could do this to me. A big part of me still loves him.

Counsellor: You seem to still be hurting from what he did. The love you have for him is so strong.

Basic Counselling Skills

There are (eight) 8 basic skills of counselling that a nurse needs to learn. These skills are used by the nurse when counselling and are necessary for forming a working relationship with the patient.

The skills are:

- Attending
- Listening
- Clarifying
- Reflecting
- Paraphrasing
- Asking questions / probing
- Summarizing
- Challenging

Now consider each skill at a time.

Attending

Patients in distress are acutely aware of the attention/inattention of the attending nurse, and are sensitive to both verbal/non-verbal cues. A nurse or counsellor must show through their body position and facial expression that they are paying attention—for example, by directly facing the client and making good eye contact. Attending involves 'SOLER' behaviours which we discussed earlier in this unit. Attending skills also means the way you receive a client, being polite, kind and friendly

Listening

Listening includes hearing what the patient has to say, gathering and processing information, and observation of non-verbal cues. It requires more than a physical relationship, but should involve personal contact during consultation. Active listening demonstrates empathy—letting clients know that they are being fully listened to and understood.

Clarifying

Clarifying is an attempt to understand a client's statements. Asking clients to give examples to clarify what they mean can help you understand better. Other strategies used to clarify something the client has said include summarizing, at the beginning, during and at the end of a session.

Reflecting

Reflecting involves the nurse acting as a sounding board for the patient by reflecting back what she or he is saying or feeling. The nurse does this by repeating the client's verbal and nonverbal message. Reflection conveys back to the speaker their thoughts and feelings.

Paraphrasing

The nurse determines the basic message in a patient's statement, and then rephrases it, or restates the sentence in similar words used by the patient. It gives an opportunity to test your understanding of what is being communicated.

Asking questions / Probing

Probing is a counsellor's use of a question or statement to direct the client's attention inward to explore his/her situation in more depth. A probing question, sometimes called an 'open-ended question', requires more than a one word (yes, no) answer from the client. When phrased as a statement, the probe contains a strong element of direction by the counsellor; for example, "Tell me more about your relationship with your parents," or "Suppose we explore a little bit more your ideas about what an alcoholic is.'

Summarizing

To summarize is to select the key points or basic meanings from the client's verbal content and feelings and tie them together. This should not include the assumption of the counsellor. Summarizing then, is a review of the main points already discussed in the session to ensure continuity in a focused direction.

Challenging

The counsellor invites the client to examine thoughts and observable behaviour that is self defeating and change such thoughts and behaviour for the better. For example, she / he might ask this question to challenge a belief: 'What is your evidence for this belief?' or challenge clients to explore behavioural consequences.

- Self Assessment True or Force
- 1. Being **genuine** means that a counsellor cares for the client and behave toward the client as they really feel. It is similar to congruence. T/F
- 2. Being **accepting** means that counsellor should appreciate clients for who they are, despite the things that they may have done. counsellor does not have to agree with clients, but they must accept them. It is the same as unconditional positive regard. T/F
- 3. Being **honest** means that the counsellor understands the client's feelings and experiences and conveys this understanding back to the client T/F. **Empathetic** understanding can be

demonstrated through reflection of feelings, and clarification.

Answers

- 1. True
- 2. True
- 3. Force

2.7 Social skills

What are social skills?

It is the knowledge and skills people need to have to live in the community. Examples of social skills include:

- Holding conversations
- Establishing and maintaining friendships
- Dating
- Managing medications
- Grooming
- Numerous other activities that are a part of leading a happy, successful life

How to conduct social skills training

In social skills training we teach the patient a structured (step by step) way of examining and modifying their own thoughts and behaviour. The clinician or nurses teaching involvement is reduced as the patient becomes more skilful at managing difficult situations.

Like assertive training, social skills training is conducted in a group setting so that clients can learn to interact with both the staff training them and other clients within the same group. From this group they develop confidence to generalize behaviour learned to other settings such as home when they get discharged or shops when they go shopping.
? Do you remember assertiveness training? Well, social skills' training is conducted in a similar manner. In fact assertiveness is a social behaviour.

Why is Social Skills Training important?

Social skills' training is important for the following reasons:

- People with abnormal behaviours; do not interact with others because their social skills are poor.
- Other people may avoid people with mental disorders because of their self absorption, pessimism or elation.

- When someone has had mental illness for a long time, they tend to lose their social skills.

Clients with mental illness lose their social skills due to chronic or long illnesses or admissions. As nurses we have to train them so that they can regain the lost social skills, to avoid social isolation and stigmatization.

Explain when social skills can be constituted – the following are the probable answers, write True or False

1. People with abnormal behaviours; do not interact with others because their social skills are poor.- T/F

2. Other people may avoid people with mental disorders because of their self absorption, pessimism or elation.- T/F

3. When someone has had mental illness for a long time, they tend to lose their social skills.- T/F

ANSWERS

1. True

2. True

3. True

2.8 Observation skills

Observations are an integral part of nursing as a whole, as you can recall from your lessons in Fundamentals of Nursing. In mental health, Observations are cardinal to the safety of all, and when carried out correctly, they ensure a safe environment for clients and staff alike. This is because many patients lack insight into their illness and may pose a danger to themselves and others when measures are not put in place to watch them carefully.

What does the word 'Observe' mean?

To observe is to watch carefully the way something happens or the way someone does something. To notice or see something Patients with mental disorders can be unpredictable, for example, violent, risk to self and others, suicidal, homicidal, arsonists, destructive to property.

As a nurse, you should therefore use all your senses to observe the patient by using your ears, touch, taste, smell and instincts. Observations are therefore carried out continuously around the clock by nurses on duty because a nurse is the only staff who is with the patient on a 24hour continuous basis.

Why are observations important in Psychiatric Nursing?

Observations are important for the following reasons:

- Physical condition of patient is affected by mental disorder
- People with mental disorder are not able to tell you what is wrong with them physically
- Observations include general condition, mental state examination, appearance, vital signs, fluid balance, sleep patterns, nutritional status, side effects of psycho tropics, look out for absconding among others.

When nursing patients, we should always record all our observations using the correct charts, sheets and case notes.

Importance of record keeping

Record keeping is very important for the following reasons:

- When your observations are in writing they will facilitate treatment and interventions by other professionals (psychiatrists, psychologists, sociologists, courts of law) that may not be present with the patient on a 24 hour basis.
- It may protect you in courts of law.
- It helps you to report abnormal findings to psychiatrist.

NURSES' NOTES

The nurses' notes of observations of their patients are a large part of their value as long as they are accurate and complete records of their findings are kept. Nursing notes are already in use in many psychiatric hospitals and provide information of great value without in any way interfering with the nurses' other duties.

The following are the purposes of such notes:

1. To give the psychiatrist information about the 24hour behaviour of the patient.
2. To indicate the patient's relationships with other significant people.
3. To pass on useful information to other nurses.
4. To serve as part of the official record of the patient, nurses' notes may be of great importance in planning current treatment, in subsequent research and may in some circumstances be a significant legal document.
5. To assist the trainee nurse by stimulating her interest in the particular problem under consideration and to provoke her/his additional reading.
6. To provide psychiatrists and senior nursing staff with a basis for teaching, the notes may be used in group discussions to help trainees to evaluate situations in an objective way and to analyse the factors which affect the nurse patient relationship.

The following 10 principles should be observed in the preparation of nursing notes

1. Care must be taken to convey accurate meaning intended; description of behaviour and conversation must be accurate.
2. Statements should be as objective as possible.
3. Notes should be brief – the quality not the quantity is important
4. Information should be concrete – generalizations are usually valueless
5. Simple descriptive English should always be used in preference to technical terms.
6. Direct quotation can be most valuable, especially in reporting delusions and hallucinations
7. The form of the notes should be flexible, depending on the type of patient being studied. Depending on hospital policy, some places use the SOAPIER format to write nurses' notes.
8. Notes should be written at least once a week, with special incidents being described as they occur.
9. Notes must be dated and signed, they are valueless if they lack a proper time sequence and if the writer cannot be identified
10. Any relevant material produced by the patient himself should be included – for example, writings, sketches, and paintings.

Things to note on the patient when writing a progress report

Activities of daily living such as the sleeping pattern, resting, eating habits/ appetite, interaction among fellow patients and members of staff, personal hygiene, speech, mood, participation in ward activities, such as sweeping, bed making, washing plates, insight of the illness, hallucinations or delusions, weight, vital signs, elimination and toilet habits, hobbies.

Observations are necessary when caring for clients with mental illness because may not always tell you what is troubling them. It is always important to keep a record of your observations in patients' charts and notes

Self Assessment Questions

Why are Observations Important in Psychiatric Nursing? Write True or False

Observations are important for the following reasons:

1. Physical condition of patient is affected by mental disorder
2. People with mental disorder are not able to tell you what is wrong with them physically
3. Observations will include general condition, mental state examination, and appearance
4. Observations will also help to observe sleep patterns, nutritional status, side effects of psycho tropics, look out for absconding among others.

Answers

1. True
2. True
3. True
4. True

2.9 Stress management skills

You will recall from your Psychology in Nursing that Stress Management skills are means and ways of dealing with, or solving problems that we daily encounter in everyday living. In mental health we are going to use the stress management skills that we learnt in Psychology to train patients with mental health problems so that they can be able to cope up with stress thereby preventing relapse.

What is Stress?

Stress may be viewed as an individual's reaction to any change that requires an adjustment or response.

What is Stress management?

Stress management involves the use of coping strategies, ways or methods that protect the individual from harm in response to stressful situations or stressors.

Importance of Stress Management for People with Mental Disorders

To prevent people with vulnerability to mental illness falling sick, they can be taught how to manage the stress. Stress is a precipitating factor in a person with an already existing vulnerability (such as, genetic inheritance, early childhood traumatic experiences).

Coping Strategies

There are various coping strategies that we can teach our patients to help them manage stress. These include:

- Awareness of stressors– Become aware of stressors, then omit, avoid, or accept them.
- Relaxation – Through physical exercises, breathing exercises and muscle relaxation.
- Meditation.
- Seeking support and talking to others if anxiety is too much.
- Problem solving technique of counselling can be used, during which catharsis (ventilation of feelings) is allowed to take place.

- Good social support networks that are able to offer material, informational and emotional support.
- Prayer
- Music
- Pets
- Good nutrition
- Balance your life. Avoid too much of one thing.

Self Assessment Questions - True /False

1. Stress management prevents vulnerable people from getting sick

2. Stress is not a precipitating factor in a person with an already existing vulnerability

3. Seeking support and talking to others is helpful in stress management

4. Nutrition does not help in stress management

ANSWERS

1. True

2. False

3. True

4 – false

2.10 Behaviour modification skills

Behaviour modification is to change behaviour. If you remember at the beginning of this unit we discussed that people with mental health problems have disordered thinking that leads to abnormal behaviours. These abnormal behaviours can be changed into good or acceptable behaviour using behaviour modification skills.

As a nurse, you have to make interventions to change behaviour during the implementation phase of the nursing process. Behaviour modification skills utilize the principles of classical and operant conditioning, and social learning which you have already covered in Psychology in Nursing. Kindly read up these topics so that you can easily follow and understand this lesson.

What is behaviour modification?

Behaviour modification is a practice that treats behavioural problems. It is based on operant, classical conditioning and social learning.

It is based on the premise that all behaviours are learned and can therefore also be unlearned. In this approach, bad behaviours are unlearned while good behaviours are learned using the principles of classical and operant conditioning and social learning.

DIFFERENT WAYS OF CHANGING ABNORMAL BEHAVIOUR

Classical conditioning

Many of our feelings for example, violent emotions, are probably conditioned responses to a face, or voice that we associate with previous childhood bad experiences, such as being scolded, beaten, or mistreatment.

Since such emotional responses (fear, anger, and low self esteem) are learned, perhaps they can be unlearned.

This change (to unlearn) of disturbing emotional responses by classical conditioning is called behaviour modification.

For example patients with aggressive behaviour can be trained in anger management skills which include assertiveness that we earlier looked at, relaxation and deep breathing technique, all which are behavioural methods.

In operant conditioning, if a response to a stimulus produces positive consequences for the individual it will tend to be repeated, while if it is followed by negative consequences it will tend not to be repeated. For instance patients who manipulate others by for instance by making fun of them should not have such behaviour reinforced.

This means that the bad behaviour should be ignored and good things that they like should be withdrawn from them. For instance, when it is time to go out for a social outing, explain to them that they cannot go out because they are unpleasant to other people. They will only be able to go out when they stop treating other people unkindly.

Positive reinforcement – It means adding a rewarding stimulus as a consequence of behaviour, thus increasing the probability that it will occur again. When patients display good behaviour like being helpful, being good to others, they can be positively reinforced by giving them something they like in the form of food, makeup, a social outing and so on.

Extinction – When positive reinforcement for a particular response (behaviour) is withdrawn, the behaviour usually stops. This means that when you ignore and do not laugh at a patient's unkind jokes that targets vulnerable patients, the unkind jesting will soon stop.

Social learning / observation (for example, assertive skills and social skills) Is a strategy used to form new behaviour patterns, increase existing skills, or reduce avoidance behaviour (such as phobias and panic attacks (systemic desensitisation) The behaviour to be learned is broken down into a series of separate stages that are ranked in order of difficulty or distress, with the first stage being the least anxiety provoking.

The person then acquires the new behaviour by observing a person modelling the behaviour in a controlled environment. The person then imitates the model's behaviour.

Social learning or modelling can be displayed by nurses as they interact with patients in the ward environment. As a nurse you can model behaviours like greeting, politeness to say 'thank you' and 'please'. You can also model grooming, holding conversation, maintaining personal space and good table manners, through involving themselves in the activities of daily leaving in the unit. The nurse is a role model for clients. They watch and imitate your behaviour. So remember your self awareness skills while in the unit with your patients.

Self assessment questions - True or False

1. Extinction - Is a strategy used to form new behaviour patterns, increase existing skills, or reduce avoidance behaviour

2. Social skills - When positive reinforcement for a particular response (behaviour) is withdrawn, the behaviour usually stops.

3. Positive Reinforcement - Adding a rewarding stimulus as a consequence of behaviour, thus increasing the probability that it will occur again.

4. Classical Conditioning - Since such emotional responses (fear, anger, and low self esteem) are learned, perhaps they can be unlearned.

ANSWERS

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

2.11 Therapeutic nursing intervention skills

You may remember that we defined the terms 'therapeutic' and 'interventions' in one of our earlier lessons.

What did we say the terms 'therapeutic' and 'interventions' are?

Therapeutic nursing interventions are actions that nurses take to help, treat or deliver nursing care to clients so that they may recover or get well. Giving nursing care or therapeutic nurse interventions to clients with abnormal behaviours and disordered thought patterns is more effective when clients' trust has been built up within a nurse patient therapeutic relationship. In fact, the psychiatric nursing skills are nursing interventions and therefore delivered within a nurse patient therapeutic relationship.

The nurse patient therapeutic relationship

The nurse patient therapeutic relationship can be defined as an interaction between two people (usually a caregiver and a care receiver) in which input from both parties contributes to a climate of healing, growth promotion, and illness prevention.

The importance of a nurse patient therapeutic relationship

The nurse-client relationship is the foundation upon which psychiatric nursing is established. This means all nursing interventions are most effective within a nurse patient relationship. It is a relationship in which both participants learn from one another (Peplau 1991). Like other areas of nursing practice, psychiatric mental health nursing works within nursing models such as Hildegard Peplau and Dorothea Orem utilizing nursing care plans, and seeks to care for the whole person.

The emphasis of mental health nursing is on the development of a therapeutic relationship (healing or beneficial to patient) or alliance. In practice this means the nurse seeks to engage with the client in a positive collaborative manner that empowers them to draw on their inner resources in addition to other treatment they may be receiving.

A therapeutic or 'helping' relationship is established through use of basic counselling skills as seen earlier during our lesson on counselling skills.

Activity

In your GROUP list the basic counselling skills. Write them in your note books and discuss each one of them.

Advantages of a nurse patient relationship

1. Through establishment of a nurse-patient relationship, clients learn to transfer their relationship with the nurse to relationships with significant others because the nurse acts as a role model.

2. Therapeutic relationships are goal oriented. The nurse and client decide together what the goal of the relationship will be.

3. The goal of a therapeutic relationship may be based on a problem solving model.

4. Therapeutic use of self is whereby the nurse uses her personal qualities to establish the relation and to give care to the patient. To use oneself in a therapeutic way one needs to have a great deal of self awareness skills. For example, don't use the patient to direct your feelings for someone in your life.

5. The relationship is the means by which the nursing process is implemented. Through the relationship problems are identified and resolution is sought.

Phases of a nurse patient relationship

The relationship is divided into 4 phases:

1. Pre interaction

The nurse and patient first meet during this phase.

The nurse's primary concern is to find out **why the patient sought help,** and together with patient formulate objectives on what should be achieved in the relationship

Tasks:

- Establish a climate of trust, understanding, acceptance, and open communication.
- Formulate a contract with the patient

2. Orientation (Introduction)

Elements of a Nurse-Patient Contract:

- Names of individuals
- Roles of nurse and patient
- Responsibilities of nurse and patient
- Expectations of nurse and patients
- Purpose of the relationship
- Meeting location and time
- Conditions for termination
- Confidentiality

3. Working

Most of the therapeutic work is carried out in this phase.

Problems (reasons patient sought for help) are dealt with using problem solving approach.

Actual behavioural change is the focus of this phase.

The psychiatric nursing skills are used to bring about this behavioural change.

4. Termination

Prepare the patient for termination by decreasing visits, incorporating others into meetings, or changing location of meetings.

Clarify reason for such changes so patient does not interpret it as rejection by the nurse.

Mutually explore feelings of rejection, loss sadness and anger among others.

Review progress of therapy and attainment of goals.

Therapeutic Nursing Interventions are composed of nursing care directed towards the patient with the aim of helping him or her recover. Such interventions are best made within the nurse patient relationship utilizing the nursing process.

Self Assessment questions

Therapeutic nurse patient relationship has four (4) phases; can you match phase A to the right phase in B

Phase A

1. Pre orientation

2. Introduction

3 Working phase

4. Termination phase

Phase B

A. Clarify reason for such changes so patient does not interpret it as rejection by the nurse

B. The psychiatric nursing skills are used to bring about this behavioural change.

C. Roles of nurse and patient

D. The nurse and patient first meet during this phase.

ANSWERS

1 - A

2. – B

3.- C

4.- D

2.12 Physical assessment of a psychiatric patient

A physical assessment is an examination that is conducted the first time a patient comes to the health facility with a complaint. It may also be conducted upon admission. Psychiatric patients may not tell you what physical problems they are having, so you have to be very observant and skilful in the way that you conduct your examination.

You can also refer to your Procedure and Evaluation manuals for a step by step procedure of physical assessment of a psychiatric patient. It starts with history taking, is followed by vital signs, and then a physical examination. A variety of techniques and medical equipment is used when performing a physical assessment. Examination may either be head to toe or may be system by system. After the physical

examination, laboratory, x-ray and other investigations may be carried out and will depend on findings of the physical examination and any complaints from the patient.

Timing of physical assessment – ideally carried out as part of the admission procedure. If there is a delay in examining due to an unstable mental state reasons of delay should be recorded clearly. A physical assessment contains 2 kinds of information: Subjective and objective. A patients' feedback is subjective information. A nurse's observation is considered objective information.

When conducting a physical examination it is advisable to have a chaperone in attendance, to guard against accusations of sexual harassment when examining a member of the opposite sex. Also guards against risk of violence by patients who may be aggressive.

Purpose of physical examination in psychiatric patients

- To identify physical illnesses that may have been overlooked and then refer the patient to appropriate specialists.
- To assess impact of mental illness on the physical wellbeing of the patient such as nutritional status and symptoms of dehydration in conditions like major depression, anorexia nervosa and mania.
- To identify side effects of neuroleptic (drugs used to treat mental illness) drugs.
- To assess for signs of neglect and ill treatment such as dishevelled hair, unkempt appearance; injuries due to use of non-recommended methods of restraint that lead to skin abrasions on the wrists and ankles and swellings on the body due to being beaten.

Benefits of physical examination in psychiatric patients

1. Physical disease is more prevalent in people with mental disorder than in the general population. It is important for psychiatrists to maintain skills in physical examination to ensure that physical illnesses are diagnosed and treated appropriately. Annual death rates from all causes among psychiatric patients are 2-4 times higher than in the general population with higher rates of physical disorder across the entire range of mental disorder.
2. Patients who are mentally disturbed may be unable to give a clear account of their symptoms, even in the presence of a life threatening disorder. Studies have also shown that in many cases, physical diseases will not be diagnosed and treated when a patient is admitted to a psychiatric unit.
3. An important aspect of psychiatric evaluation is differentiating organic disease from 'functional' psychiatric disorders.
4. A competent assessment of patient's physical health also helps to tailor drug use and reduce the risk of side effects.
5. Physical assessment gives a clear baseline for comparison, should a patient's physical state change, thus informing the clinician of the severity of the effect of a drug and of the need for action.

Remember that when you are examining a patient with mental illness you should not be alone with him or her in the room for safety reasons. In addition, psychiatric patients may not tell you what physical problems they are having, so you have to be very observant and skilful in the way that you conduct your examination.

Self Test Questions

Encircle the correct answer

Benefits of physical examination in psychiatric patients

1. Physical disease is more prevalent in people with mental disorder than in the general population. TRUE / FALSE

2. Patients who are mentally disturbed are able to give a clear account of their symptoms, even in the presence of a life threatening disorder. TRUE / FALSE

3. An important aspect of psychiatric evaluation is differentiating organic disease from 'functional' psychiatric disorders. TRUE / FALSE

4. A competent assessment of patient's physical health does not help tailor drug use and reduce the risk of side effects. TRUE /FALSE

ANSWERS TO SELF TEST

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

2.13 Admission of psychiatric patients

In psychiatry, patients are admitted for care when they become a danger to themselves and others. There are three types of admission that govern admission to a psychiatric or other medical facility. It is to be remembered that whilst admitting a patient to protect the general public, care must be taken to avoid infringing upon the patient's rights as a person and as a patient with a mental disorder.

What is psychiatric admission?

It is when a patient is accepted to stay in hospital for inpatient services.

Types of admissions

There are several types of admissions: Voluntary, emergency, involuntary or compulsory, medical board and court adjudication.

1. Voluntary Admission

This is where a patient is willing to be admitted and knows that he/she has a problem, and the medical officer in charge of the mental hospital sees that the patient really needs admission. The Mental Health Services Bill, (2006) states that:

'Patients aged 18 years and above must be encouraged to opt for voluntary admission into a psychiatric institution, facility or ward.

Patient with mental health problems may seek help from any health institution including primary health care clinics, as first contact before being transferred to a psychiatric facility.

If any patient is admitted to a psychiatric facility as a voluntary patient, the person in-charge of the hospital or ward must notify the patient's parents, guardians or relatives as soon as possible. In the absence of the relatives, community leaders from the same locality must be notified.

Where a patient is already admitted to a mental health facility as a voluntary patient but wishes to discharge himself contrary to the considered opinion of the person in-charge, the patient may be held at the institution or ward as an involuntary admission upon recommendation of the attending mental health practitioner.

A mental health practitioner should physically and mentally examine any voluntary patient within 24 hours of admission to a mental health facility.'

2. Emergency admission

A family member, friend, community health worker or any responsible citizen may request orally or in writing that health institution admits a suspected mentally disordered person as an emergency admission under the following conditions:

If a person in a community begins to act in a manner inconsistent with the norms of society because of suspected mental illness;

If a person in the community is believed to be mentally ill and because of mental illness lacks proper care in terms of food, clothing and shelter or is neglected or cruelly treated.

If any person believed to be suffering from mental disorder is dangerous to himself, others and property.

3. Involuntary or Compulsory Admission

This is where the patient is not willing to be admitted and does not accept treatment, or is unable to give consent for treatment, but he or she has a problem, illness or he is a potential absconder. A detention order will permit a compulsory emergency admission under the legislation or law in place. According to human rights you are not supposed to force the patient to be admitted or to force the patient to take medication, hence you get detention orders, a form that is signed by the magistrate, which will allow medical personnel to enforce an admission and administer medication. Without detention orders you can be sued, Detention orders are obtained from the police station or magistrate's court.

The Mental Health Services Bill, (2006) stipulates that:

'Involuntary admissions to be are initiated by a family member, a friend or a community health worker who takes a person suspected of suffering from mental illness to the nearest health centre where such a person is examined by an approved health worker who then certifies in writing that the person required to be detained suffers from a mental illness.

An approved health worker, if satisfied that a person is mentally disordered and is dangerous to himself and others shall refer such a person to a psychiatric facility or ward within five days of such certification, where the person so certified to be suffering from a mental illness shall be admitted.

Upon receipt of the patient the person in-charge of the said psychiatric facility shall ensure that the patient is examined physically and mentally.

The patient must not be admitted to or detained in a psychiatric institution unless the person in-charge of the psychiatric institution is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available to the patient.

Where it is not possible for a family member, friend or social worker to convey a person suspected of suffering from mental disorder to a psychiatric institution a family member, friend or social worker may seek the assistance of the nearest health centre or police station which wherever possible shall provide transport with which to convey a suspected mental patient to the psychiatric institution. The in-charge of the health facility or police station must provide transport within 24 hours.

A person in-charge of the health centre or police station should provide transport for conveyance of a patient to a specialist psychiatric institution.

The in-charge of the health centre or police station may enter premises of the mentally disordered person if need be in order to facilitate conveyance of the patient to the health centre.

Where the patient is of the opinion that his admission or continued detention is unjustified he may appeal to a mental health review board for review of his detention. The review must be carried out within fourteen (14) days of the receipt of the application.

Any patient involuntarily admitted shall not be detained for more than fourteen (14) days without review by a mental health practitioner.'

Request for compulsory admission may be made by any family member or relative who are above 18 years. Other people like friends, employers among others who have good knowledge of the person and have been with the individual for at least 15 days may request for compulsory admission.

Medical Practitioners may also certify a patient for admission for as long as they have identified reasonable grounds for compulsory treatment after a medical examination. Police officers, judges, local or traditional rulers in whose jurisdiction the individual resides are also empowered to request for compulsory admission. In other words it's an admission where by the patient is not willing to be admitted but he's a danger to himself, society as well as to property.

4. Admission under medical board

This is when the employers writes a letter to the hospital requesting the medical officers who in turn consult the psychiatrist where applicable, to examine the patient thoroughly and come up with a report to say whether that person can continue working or be retired on medical grounds.

5. Admission by Court Adjudication

The client is admitted into a psychiatric forensic unit by the court's decision, whilst his/her case is being reviewed by the courts of law. In the psychiatric hospital courts request for assessments, treatment and psychiatrists are required to submit periodical reports to the courts.

In these reports the following examinations should be included: Previous psychiatric history, past medical, surgical, obstetric, early childhood and adolescent developmental history, social histories, alcohol and drug history, family history of any mental history or any offences in the family, marital status, educational and employment record, prognosis of disorder and outcome if treated.

The important issues on which opinion may be required in the psychiatric report are:

Mental state at time of interview and of the alleged offence: – It must be established whether the person was mentally ill at the time of the offence.

Competence to attend court and make a defence

Criminal responsibility – does the patient understand the difference between pleading guilty and not guilty. Does the patient understand the nature of the charge?

The admission procedure

The admission procedure consists of history taking, mental state examination, physical examination, investigations and a diagnosis is arrived at. The clinician or psychiatrist will come up with a psychiatric diagnosis after which the patient is commenced on appropriate medication to stabilize him or her and reduce symptoms. You as a nurse have to conduct your own assessment which should include demographic details, chief complaint, various histories and mental state examination.

As you learned in the last psychiatric nursing skill of physical examination, you conduct a systemic examination and obtain the vital signs. In addition, you will ensure recommended investigations are carried out and prescribed treatments given. The information derived from the above assessment is used to identify needs and problems of the patient thereby coming up with a nursing diagnosis. At the same time you also identify strengths of the patient. You will work with the patient assisting him or her to solve problems noted by utilizing the strengths, or resources that you have identified to solve his or her problems.

The actual admission procedure involves receiving the patient into an inpatient psychiatric or medical ward in which there are restrictions that will prevent him or her absconding if he or she has come on an involuntary or emergency basis. For indications, principles and actual procedure refer to your Procedure Manual, Learning Guide and Evaluation Manuals for admission of a psychiatric patient.

SELF TEST

Complete the following sentences:

Voluntary admission is the entry of a patient into a psychiatric hospital……..

Emergency admission is ……..of a patient into hospital due to a sudden health crisis.

Involuntary admission is the entry and detention of a patient within an institution……..

Answers to self test

With his/her agreement.

Unexpected and sudden entry.

Without his consent.

The Discharge of a Psychiatric Patient

We have discussed how a psychiatric patient is admitted. It therefore goes without saying that when a patient is admitted, a day will come when upon his recovery, he will get discharged. A process to prepare the patient for discharge begins as soon as the patient is admitted to hospital. This process is known as discharge planning.

Discharge of a Psychiatric Patient from Hospital

The leaving of the hospital by a patient is officially termed discharge, and involves a corresponding discharge note.

Discharge Planning

Discharge Planning begins as soon as the patient enters hospital. It is most effective when the patient and his or her family are active in the discharge planning process. In addition to the family or friends, a variety of hospital staff (also known as the multi-disciplinary team - MDT) can be involved in the discharge planning process. Discharge planning involves working through phases:

Introduction or admission phase

Introduction or admission phase in which the admitting nurse and multi disciplinary team holds a meeting with the client and relatives on admission in which they together begin to plan for the patient's eventual discharge upon recovery.

In this meeting clients and relatives are given Information Education Communication (IEC) on the condition of the patient, signs and symptoms, treatment, hospital stay, visiting of patient whilst in hospital, preparation of home environment and family resources for discharge, and prognosis of illness. In addition, relatives are involved in the goal formation of the patient so that upon discharge they will continue care, in line with goals.

Working (treatment phase)

After the patient has stabilized the nurse meets with relatives and the rest of the MDT (mental health nurse, psychologist, psychiatrist, clinical officer, community health nurse / team to review / evaluate patient's progress, ascertain his/her suitability for discharge, and to further prepare patient for discharge. At this time the community mental health team may be called upon to make a home visit to assess the home environment for any psychosocial stressors before a patient goes there.

Termination phase

Termination phase (this is when the patient goes into the community): this is a transition (passing from mental hospital to the community) in which the patient is discharged and given a review date for continuity of care. If the patient is in need of other services such as a physician, surgeon, counselling services, rehabilitation services among others, he/she is discharged via those services.

Advantages of discharge planning

Discharge planning reduces relapses or hospitalization by identifying clients who are at risk for experiencing problems when discharged, so that they can be referred to appropriate places or people who can be of good help to prevent relapses and admissions.

- To help patients re-socialize or reintegrate in to community:
- Those with chronic enduring psychiatric illness,
- Those with special education needs, or elderly living alone, homeless among others.

Preparation for Discharge

Assess the readiness of patient to leave the treatment setting.

Assess the level of functioning with regard to activities of daily living.

Financial resources – Ask the family about financial resources and that they should identify anticipated problems associated with discharge as soon as possible after admission from hospital. Let them suggest possible solutions for their problems.

Conduct home visit for home exploration prior to client's discharge.

Provide client and family with verbal and written information about available medical, social, vocational and support resources in the community (services)

Actual Discharge Procedure

For the actual practical discharge procedure you can refer to your procedure and Evaluation manuals.

Throughout hospitalization, and indeed, upon discharge, Information, Education and Communication (IEC) are given to the patient, relatives and significant others on the following:

Patient's Condition

The client's symptoms- Train relatives on how to handle and respond to the patient when he/she becomes violent

Educate family on emotionally supporting client (importance of preventing High Expressed Emotion)

Importance of compliance to medication – it can take as long as 6 months for antipsychotic drugs to be excreted from the system during which time a patient might think they no longer need the drug. However, once the drug has all been excreted, the patient will relapse.

Prevention of relapse (how to recognize early signs of relapse)

Medication

Clear information about medication (dosage, frequency, route – if i/m which place and days it will be administered from), who will keep medication, who will assist/support/ensure patient takes medication.

Duration of drugs

Side effects of drugs

Review dates that should be open appointments

Nutrition, that some foods cannot interact with certain drugs that is, alcohol or patient has to eat something before taking drugs.

Give the patient medication that will be taken at home and the discharge slip.

When a patient's behaviour and thoughts become normal, they are ready to go home. Various measures are undertaken to successfully prepare the patient for discharge. The community, that's the patient's neighbourhood, workplace and church, must undergo sensitization for successful integration of the patient upon discharge.

We have finally come to the end of UNIT 2. I hope you thoroughly enjoyed our time together and understood the psychiatric nursing skills that we covered. You will be able to put these skills into practice when you come to our next unit which is UNIT 3. It consists of Mental Disorders. So you will practice the psychiatric nursing skills you have just learned.

Self test

Fill in the blanks:-

Discharge planning involves working through phases:

Introduction (thus admission phase) the admitting nurse and multi disciplinary team holds a meeting with the client and relatives in which ……..for the patient's eventual discharge upon recovery.

Working (treatment phase)**:** At this time the community mental health team may be called upon ……..before a patient goes there.

Termination phase (this is when the patient goes into the community) this is a transition (that is, passing

from mental hospital to the community) ……..……..……..……..……..……..……..……..……..……..……..……..……..

Answers to Self Test

They together begin to plan

To make a home visit to assess the home environment.

In which the patient is discharged.

2.14 Summary

We have together discussed the nursing skills used to care for patients with mental disorders. Mental disorders consist of abnormal behaviours and wrong, negative or abnormal thinking patterns. Psychiatric nursing skills covered in this unit are directed towards putting a stop to these abnormal behaviours and wrong thinking patterns.

We also saw that these psychiatric nursing skills are delivered to the patient within the framework or context of the nursing process to ensure systematic individualized nursing care. In addition, it was highlighted to you that in order for any nursing interventions to be successful the nurse has to create rapport and engage the patient in a therapeutic relationship. The reason is simply that patients will only cooperate with nursing interventions when they have learned to trust their care giver, in this case the nurse. Our next UNIT three (3) will be on the different mental illnesses that affect patients. Remember that psychiatric nursing skills that you have just completed are for the purpose of implementing nursing care targeted at ending or minimizing abnormal behaviours of these same mental disorders.

Glossary

Jurisdiction – The authority to enforce laws or pronounce legal judgments.

Mental Health Review Board - means an autonomous body appointed to inquire into a specific matter relating to the rights of mental patients.

2.15 Self Assessment Test

Encircle letter that corresponds with correct answer

1. The psychiatric assessment consists of the following:
 a. The mental state examination, history taking and psychiatric interview.
 b. The psychiatric interview, investigations, physical examination.
 c. The mental state examination, investigations, and physical examination.
 d. History taking, the psychiatric interview and investigations.

2. Which of the following is a priority assessment for the patient with major depression?
 a. Nutritional status

b. Fluid and electrolyte balance
c. Suicidal ideation
d. Mood and affect

Match the following psychiatric nursing skills with their corresponding definition by writing the number of the correct skill on the dotted line.

1. Communication skills ……Teach patient step by step way of changing bad behaviour and learn good manners.

2. Self awareness skills …….. To watch carefully the way something happens or the way someone does something.

3. Assertiveness training skills ……..Inspect oneself inwardly

4. Counselling skills ……..Help patients change abnormal behaviour

5. Self awareness skills ……..Train patients to express themselves in an appropriate way

6. Social training skills ……..Train patients not to be aggressive

7. Observation skills ……..Solve a problem successfully

8. Stress management skills ……..The reciprocal exchange of information, ideas and feelings

9. Behaviour modification skills ……..Acting to bring about a desired treatment outcome.

10. Therapeutic intervention skills …….. The leaving of the hospital by a patient which involves a corresponding discharge note.

11. Physical assessment of psychiatric patient….. actions nurses take to help, treat or deliver nursing care to clients so that they may recover or get well.

12. Admission of psychiatric patients …….. An examination that is conducted the first time a patient comes to the health facility with a complaint. It may also be conducted upon admission.

13. Discharge of psychiatric patients ……..When a patient makes up his mind and leaves minus psychiatric consent.

2.16 References

UNIT 3: CLASSIFICATION AND MANAGEMENT OF PSYCHIATRIC DISORDERS

3.1 Introduction

Welcome to Unit 3 in which we will discuss the classification and management of psychiatric disorders. Classification or taxonomy is a process by which complex trends are organized into groups, classes or ranks, in order to put together things that must be similar to each other and to isolate those that are different. You will discover in this unit that mental disorder can be broadly classified into two. The disorder can either be minor (neurotic) or major (psychosis). Major mental disorders (psychoses) are further divided into functional psychoses and organic psychoses. Functional psychoses are major mental disorders with no demonstrable physical cause. Organic psychoses are major mental disorders with demonstrable physical cause.

3.2 Objectives

By the end of the unit you should be able to:

1. Define key terms
2. Describe neurosis/ anxiety disorders
3. Discuss mental health and child birth
4. Describe psychosis

3.3 Definition of terms

In this section you will review the definition of anxiety and anxiety disorders

Anxiety

Anxiety is an emotional response (for example, apprehension, tension, uneasiness) to anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety may be regarded as pathological when it interferes with effectiveness in living, achievement of desired goals or satisfaction, or reasonable emotional comfort (Shahrokh and Hales, 2003) in (Townsend 2011).

Anxiety disorders

Anxiety disorders or (anxiety states) are abnormal states in which the most striking features are mental and physical symptoms of anxiety, occurring in the absence of organic brain disease or another psychiatric disorder.

Anxiety disorders comprise a group of conditions that share a key feature of excessive anxiety with ensuing behavioural, emotional, cognitive, and physiologic responses. Clients suffering from anxiety disorders can demonstrate unusual behaviours such as panic without reason, Unwarranted fear of objects or life conditions, uncontrollable repetitive actions, re-experiencing of traumatic events, or unexplainable or

overwhelming worry. They experience significant distress over time, and the disorder significantly impairs their daily routines, social lives, and occupational functioning.

Generalized anxiety disorder

Generalised anxiety disorder is characterized by chronic, unrealistic, and excessive anxiety and worry. The symptoms have existed for 6 months or longer and cannot be attributed to specific organic factors, such as caffeine intoxication or hyperthyroidism.

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Disorders of perception

Illusion: misinterpretation of stimuli.
Hallucinations: presence of perception without stimuli.

3.4 Neurosis/ Anxiety Disorders

Under this section of Unit 3, we will cover neurotic or anxiety disorders. To start with we are going to examine what anxiety consists of and the different levels it is made up of. Then we will learn about the various types of anxiety disorders. These are generalized anxiety, obsessive compulsive, somatoform disorders and reactive depression. We will outline the causes of neurotic or anxiety disorders and the psychiatric treatment, and describe nursing management.

The term anxiety is often used interchangeably with the word stress; however, they are not the same. Stress, or more properly, a stressor, is an external pressure that an individual has to shoulder or bear. Anxiety is the individual's emotional response to that stressor. Anxiety disorders are characterized by exaggerated and often disabling anxiety reactions. Anxiety is distinguished from fear, which is feeling afraid or threatened by a clearly identifiable external stimulus that represents danger to the person.

Anxiety is usually considered a normal reaction to a realistic danger or threat to biological integrity or self-concept. Normal anxiety dissolves when the danger or threat is no longer present.

It is difficult to draw a precise line between normal and abnormal anxiety because it occurs on a continuum from mild, to moderate, severe, and then panic levels. So what criteria can be used to determine if an individual's anxious response is normal? Anxiety can be considered abnormal or pathological if:

1. It is out of proportion to the situation that is creating it.

Example:

Mrs K witnessed a serious automobile accident 4 weeks ago when she was out driving in her car, and since that time refuses to drive even to the grocery store a few miles from her house. When he is available, her husband must take her wherever she needs to go.

2. The anxiety interferes with social, occupational, or other important areas of functioning.

Example:

Because of the anxiety associated with driving her car, Mrs K has been forced to quit her job in a downtown bank for lack of transportation.

Anxiety is a response to stress and if it occurs at the severe or panic levels results into the anxiety disorders, which are generalized anxiety disorder, phobias, OCD, PTSD and panic disorder. Furthermore, a considerable amount of anxiety that is repressed or ignored can lead to somatoform disorders in which emotional distress is expressed as physical symptoms that have no organic evidence.

Activity

Now pause here for at least five minutes and consider what anxiety is.
Reflect upon the times that you have been filled with anxiety, such as before an exam, interview, or before receiving results for an examination you undertook at secondary or primary school.
Then in your note book list the feelings and changes that come in different parts of your body just before these anxiety provoking situations.
Now compare the list in your notebook with the signs and symptoms below this activity box.

Signs and symptoms of anxiety

Psychological arousal

- Fearful anticipation
- Irritability
- Sensitivity to noise
- Poor concentration
- Worrying thoughts

Autonomic arousal

- Gastrointestinal
- Dry mouth
- Difficulty in swallowing
- Epigastric discomfort
- Excessive wind
- Frequent or loose motions

Respiratory

- Constriction in the chest
- Difficulty inhaling

Cardiovascular

- Palpitations
- Discomfort in the chest

- Awareness of missed heartbeats

Genitourinary
- Frequent or urgent micturition
- Failure of erection
- Menstrual discomfort
- Amenorrhoea

Muscle tension
- Tremor
- Headache
- Aching muscles

Hyperventilation
- Dizziness
- Tingling in the extremities
- Feeling of breathlessness

Sleep disturbance
- Insomnia
- Night terror

Anxiety presents in the following ways:

Generalized anxiety disorders – anxiety is continuous
Phobic disorders – anxiety intermittent, comes up in particular circumstances
Panic disorder – anxiety intermittent but its occurrence is unrelated to any particular circumstances.

Causes of anxiety

Anxiety occurs when a person has difficulty dealing with life situations, problems, and goals. Each person handles stress differently. One person can thrive in a situation that creates great distress for another. For example, many people view public speaking as scary, but for teachers and actors, it is an everyday, enjoyable experience. Marriage, children, airplanes, snakes, a new job, a new school, and leaving home are examples of stress-causing events.

Aetiological factors of anxiety can be classified as biopsychosocial, or biological (related to physiological processes in the body), psychological (early childhood experiences) and social (relating to interaction with other people and one's rank in society).

Biological factors

Genetic / Heritability: The tendency to anxiety may be inherited from one's parents.
Biochemical: Imbalance of serotonin and Gamma-amino Butyric Acid (GABA). These are neurotransmitters which regulate emotions.

Psychological factors

- Stressful events and early childhood and current experiences.
- Result of abnormal cognitions – focus on worrying thought, anxious-avoidant personality disorders.

Sociological factors

Poverty such as lack or absence of money to provide for, accommodation, food, essential services like clean running water, electricity, expensive transport, clothing; low ranking in society, belonging to the vulnerable groups of society among others.

Levels of Anxiety

Anxiety has both healthy and harmful aspects depending on its degree and duration as well as on how well the person copes with it. Anxiety has four levels: mild, moderate, severe, and panic (Figure 1). Each level causes both physiologic and emotional changes in the person.

Figure 2: Levels of anxiety

Mild anxiety is a sensation that something is different and warrants special attention. Sensory stimulation increases and helps the person focus attention to learn, solve problems, think, act, feel, and protect himself

or herself. Mild anxiety often motivates people to make changes or to engage in goal-directed activity. For example, it helps students to focus on studying for an examination.

Moderate anxiety is the disturbing feeling that something is definitely wrong; the person becomes nervous or agitated. In moderate anxiety, the person can still process information, solve problems, and learn new things with assistance from others. He or she has difficulty concentrating independently but can be redirected to the topic. For example, the nurse might be giving preoperative instructions to a client who is anxious about the upcoming surgical procedure. As the nurse is teaching, the client's attention wanders but the nurse can regain the client's attention and direct him or her back to the task at hand.

As the person progresses to severe anxiety and panic, more primitive survival skills take over, defensive responses ensue, and cognitive skills decrease significantly. A person with severe anxiety has trouble thinking and reasoning. Muscles tighten and vital signs increase. The person paces; is restless, irritable, and angry; or uses other similar emotional–psychomotor means to release tension.

In panic, the emotional–psychomotor realm predominates with accompanying fight, flight, or freeze responses. Adrenaline surge greatly increases vital signs. Pupils enlarge to let in more light, and the only cognitive process focuses on the person's defence.

Working with Anxious Clients

Nurses encounter anxious clients and families in a wide variety of situations such as before surgery and in emergency departments, intensive care units, offices, and clinics.

First and foremost, the nurse must assess the person's anxiety level because that determines what interventions are likely to be effective.

Mild anxiety is an asset to the client and requires no direct intervention. People with mild anxiety can learn and solve problems and are even eager for information. Teaching can be very effective when the client is mildly anxious.

In moderate anxiety, the nurse must be certain that the client is following what the nurse is saying. The client's attention can wander, and he or she may have some difficulty concentrating over time. Speaking in short, simple, and easy to-understand sentences is effective; the nurse must stop to ensure that the client is still taking in information correctly.

The nurse may need to redirect the client back to the topic if the client goes off on an unrelated tangent.

When anxiety becomes severe, the client no longer can pay attention or take in information. The nurse's goal must be to lower the person's anxiety level to moderate or mild before proceeding with anything else. It is also essential to remain with the person because anxiety is likely to worsen if he or she is left alone. Talking to the client in a low, calm, and soothing voice can help. If the person cannot sit still, walking with him or her while talking can be effective. What the nurse talks about matters less than how he or she says the words. Helping the person to take deep even breaths can help lower anxiety.

During panic-level anxiety, the person's safety is the primary concern. He or she cannot perceive potential harm and may have no capacity for rational thought. The nurse must keep talking to the person in a comforting manner, even though the client cannot process what the nurse is saying. Going to a small, quiet, and non-stimulating environment may help to reduce anxiety. The nurse can reassure the person that this

is anxiety, that it will pass, and that he or she is in a safe place. The nurse should remain with the client until the panic recedes. Panic-level anxiety is not sustained indefinitely but can last from 5–30 minutes.

Generalized Anxiety Disorder (GAD)

Symptoms of GAD

The symptoms must have occurred for many days for at least 6 months and must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- Excessive anxiety and worry about a number of events that the individual finds difficult to control.
- Restlessness or feeling keyed up or on edge.
- Being easily fatigued.
- Difficulty concentrating or mind 'going blank'.
- Irritability.
- Muscle tension.
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).

The disorder may begin in childhood or adolescence, but onset is not uncommon after age 20. Depressive symptoms are common, and numerous somatic complaints may also be a part of the clinical picture. Generalized anxiety disorder tends to be chronic, with frequent stress-related exacerbations and fluctuations in the course of the illness.

Nursing Management of a Patient with Generalized Anxiety Disorder (GAD)

You recall that in Unit two which is on Psychiatric nursing skills we discussed and revised the Nursing Process which you first covered in the first year in Fundamentals of Nursing. The Nursing Process is the tool of delivery of care to the individual with a psychiatric disorder. In psychiatric nursing, care is planned, implemented and evaluated in collaboration with the patient and his family. This can be noticed by the wording of the goals that state an action which a patient should be able to perform after a specific time frame during which care is delivered by the nurse in conjunction with the patient. This team work ensures continuity by the patient and relatives even after nurse leaves the picture upon discharge, or when the patient returns home if the treatment is on outpatient basis.

In addition, in unit two we discovered that the other psychiatric nursing skills such as communication, counselling, therapeutic nurse patient relationship, assertiveness training and social skills training skills, behaviour modification, stress management, and physical assessment and observation skills can be utilized to assess, implement and evaluate care of patients. As we discuss the nursing care of patients with anxiety disorders, therefore, now remember to assess, plan, implement and evaluate our patients, so that we will deliver individualized, evidence-based care that will yield expected outcomes. In this unit we will use the nursing process to deliver nursing care of patients suffering from neurotic and psychotic disorders.

Goals of Care

Data obtained from assessment (psychiatric interview, physical examination, and investigations) is formulated into nursing diagnoses, which are then used to come up with objectives or goals of care. Nurses work hand-in-hand with patient in their own care, which includes what the client needs to achieve within a certain time span, nursing interventions in which the client takes an active role, and evaluation in which what has been achieved is measured against what was planned. Hence the following are the goals that will be put in place to successfully deliver nursing care to the patient.

- The patient will be protected from harm.
- The patient will engage in a daily schedule of activities.
- The patient will experience relief from the symptoms of severe anxiety.

By the time of discharge from treatment, the client will be able to recognize symptoms of onset of anxiety and intervene before panicking stage.

Nursing Interventions

Accept and support the patient's defences. Severe and panic levels of anxiety can be reduced by initially allowing the patient to determine the amount of stress that can be handled.

If the patient is unable to release anxiety it can lead to mounting tension and panic levels. However if the patient is supported he will experience relief from the symptoms of severe anxiety, thereby avoiding loss of control and panic levels of anxiety.

Assume a calm manner with the patient. Decrease environmental stimulation. Identify and modify anxiety provoking situations for the pt. Administer supportive physical measures such as warm baths, and massages. The patient's behaviour may be modified by altering the environment and the patient's interaction with it.

Initially share an activity with the patient to provide support and reinforce socially productive behaviour. Provide for physical exercise of some sort. Plan a schedule or list of activities that can be carried out daily. Involve family members and other support systems as much as possible. By encouraging outside activities, the nurse limits the time the pt. has available for destructive coping mechanisms while increasing participation in and enjoyment of other aspects of life.

Administer medications that help reduce the patient's discomfort. Observe the medication side effects and initiate relevant health teaching. The effect of a therapeutic relationship may be enhanced if the chemical control of symptoms allows the patient to direct attention to underlying conflicts.

When level of anxiety has been reduced, explore possible reasons for occurrence.

Teach signs and symptoms of escalating anxiety, and ways to interrupt its progression (relaxation techniques, such as deep-breathing exercises and meditation, or physical exercise, such as brisk walks and jogging). Recognition of precipitating factor(s) is the first step in teaching client to interrupt escalation of anxiety.

Relaxation techniques result in a physiological response opposite that of the anxiety response.

Physical activities discharge excess energy in a healthful manner. (Townsend, 2011). Recognition of precipitating factor(s) is the first step in teaching client to interrupt escalation of anxiety.

Teach strategies that she may employ to interrupt the escalation of the anxiety. She could choose which is best for her: relaxation exercises, physical exercise, meditation.

Obsessive Compulsive Disorder (OCD)

Obsessions are recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses that cause marked anxiety and interfere with interpersonal, social, or occupational function. The person knows these thoughts are excessive or unreasonable but believes he or she has no control over them. Compulsions are ritualistic or repetitive behaviours or mental acts that a person carries out continuously in an attempt to neutralize anxiety. Usually, the theme of the ritual is associated with that of the obsession, such as repetitive hand-washing when someone is obsessed with contamination or repeated prayers or confession for someone obsessed with blasphemous thoughts.

Common compulsions include the following:

i. Checking rituals (repeatedly making sure the door is locked or the coffee pot is turned off)
ii. Counting rituals (each step taken, ceiling tiles, concrete blocks, or desks in a classroom)
iii. Washing and scrubbing until the skin is raw
iv. Praying or chanting
v. Touching, rubbing, or tapping (feeling the texture of each material in a clothing store; touching people, doors, walls, or oneself)
vi. Hoarding items (for fear of throwing away something important)
vii. Ordering (arranging and rearranging furniture or items on a desk or shelf into perfect order; vacuuming the rug pile in one direction)
viii. Exhibiting rigid performance (getting dressed in an unvarying pattern)
ix. Having aggressive urges (for instance, to throw one's child against a wall).

The DSM-IV-TR describes obsessive–compulsive disorder (OCD) as recurrent obsessions or compulsions that are severe enough to be time consuming or to cause marked distress or significant impairment (APA, 2000).

The individual recognizes that the behaviour is excessive or unreasonable but, because of the feeling of relief from discomfort that it promotes, is compelled to continue the act.

The most common compulsions involve washing and cleaning, counting, checking, requesting or demanding assurances, repeating actions, and ordering.

The disorder is equally common among men and women. It may begin in childhood, but more often begins in adolescence or early adulthood. The course is usually chronic, and may be complicated by depression or substance abuse. Single people are affected by OCD more often than are married people (Sadock and Sadock, 2007 in Townsend, 2009).

Nursing Interventions for Obsessive Compulsive Disorder (OCD)

Offer encouragement, support, and compassion through therapeutic communication. Offering support and encouragement to the client is important to help him or her manage anxiety responses. The nurse can

acknowledge the overwhelming feelings the client experiences while indicating the belief that the client can make needed changes and regain a sense of control. The nurse encourages the client to talk about the feelings and to describe them in as much detail as the client can tolerate.

Because many clients try to hide their rituals and to keep obsessions secret, discussing these thoughts, behaviours, and resulting feelings with the nurse is an important step. Doing so can begin to relieve some of the 'burden' the client has been keeping to himself or herself.

Be clear with the client that you believe he or she can change. Encourage the client to talk about feelings, obsessions, and rituals in detail. Gradually decrease time for the client to carry out ritualistic behaviours. Assist client to use exposure and response prevention behavioural techniques. Encourage client to use techniques to manage and tolerate anxiety responses.

To manage anxiety and ritualistic behaviours, a baseline of frequency and duration is necessary. The client can keep a diary to chronicle situations that trigger obsessions, the intensity of the anxiety the time spent performing rituals, and the avoidance behaviours. This record provides a clear picture for both client and nurse. The client then can begin to use exposure and response prevention behavioural techniques. Initially, the client can decrease the time he or she spends performing the ritual or delay performing the ritual while experiencing anxiety. Eventually, the client can eliminate the ritualistic response or decrease it significantly to the point that interference with daily life is minimal. Clients can use relaxation techniques to assist them in managing and tolerating the anxiety they are experiencing. It is important to note that the client must be willing to engage in exposure and response prevention. These are not techniques that can be forced on the client.

Teaching Relaxation and Behavioural Techniques

The nurse can teach the client about relaxation techniques such as deep breathing, progressive muscle relaxation, and guided imagery. This intervention should take place when the client's anxiety is low so he or she can learn more effectively. Initially, the nurse can demonstrate and practice the techniques with the client. Then, the nurse encourages the client to practice these techniques until he or she is comfortable doing them alone. When the client has mastered relaxation techniques, he or she can begin to use them when anxiety increases. In addition to decreasing anxiety, the client gains an increased sense of control that can lead to improved self-esteem.

Completing a Daily Routine

Assist client to complete daily routine and activities within agreed-on time limits. Encourage the client to develop and follow a written schedule with specified times and activities.

To accomplish tasks efficiently, the client initially may need additional time to allow for rituals. For example, if breakfast is at 8:00 AM and the client has a 45-minute ritual before eating, the nurse must plan that time into the client's schedule. It is important for the nurse not to interrupt or to attempt to stop the ritual because doing so will escalate the client's anxiety dramatically. Again, the client must be willing to make changes in his or her behaviour. The nurse and client can agree on a plan to limit the time spent performing rituals. They may decide to limit the morning ritual to 40 minutes, then to 35 minutes, and so forth, taking care to decrease this time gradually at a rate the client can tolerate. When the client has completed the ritual or the time allotted has passed, the client then must engage in the expected activity. This may cause anxiety and is a time when the client can use relaxation and stress reduction techniques. At home, the client can

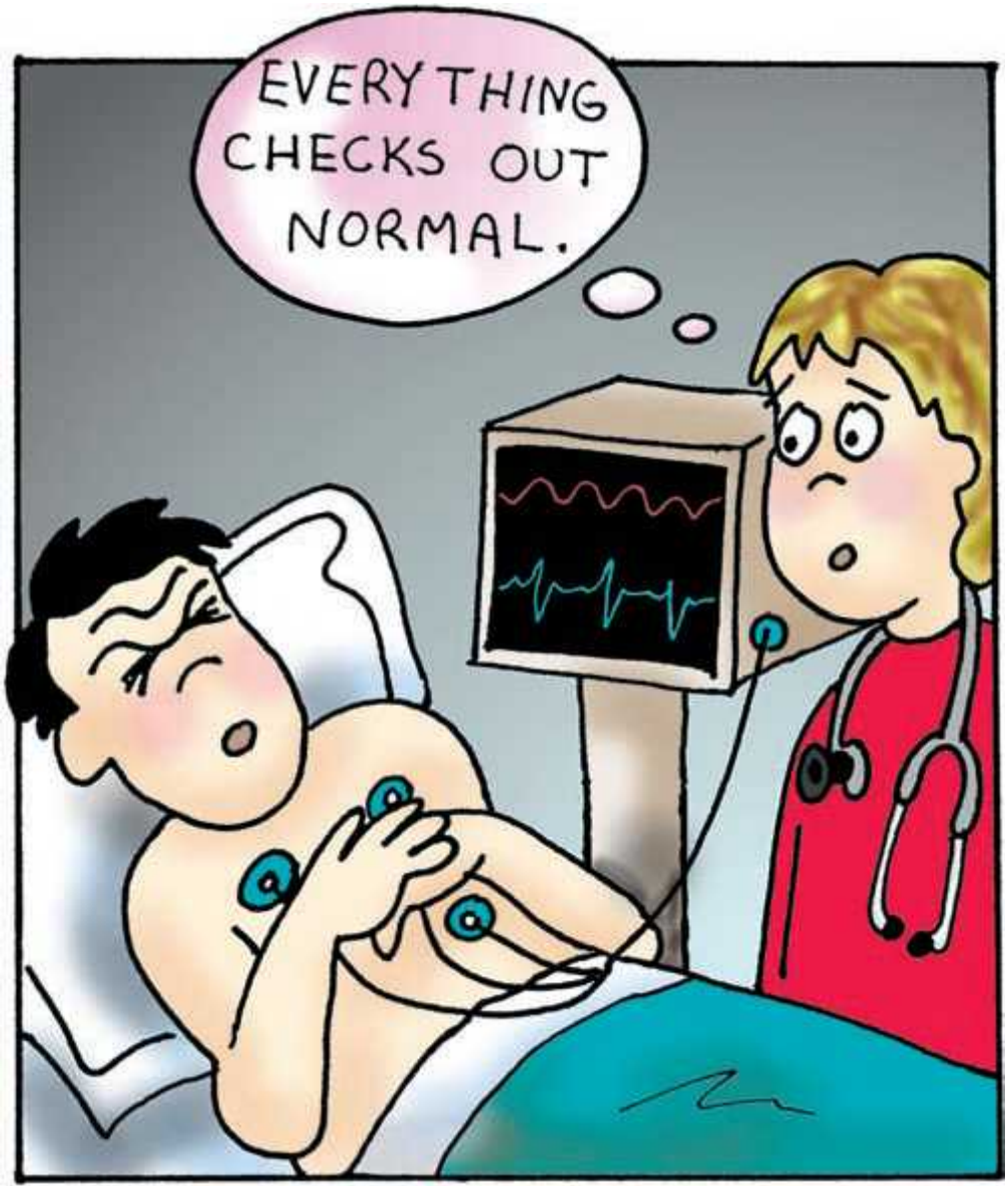
continue to follow a daily routine or written schedule that helps him or her to stay on tasks and accomplish activities and responsibilities.

Providing Client and Family Education

It is important for both the client and the family to learn about OCD. They often are relieved to find the client is not 'going crazy' and that the obsessions are unwanted, rather than a reflection of any 'dark side' to the client's personality. Helping the client and family to talk openly about the obsessions, anxiety, and rituals eliminates the client's need to keep these things secret and to carry the guilty burden alone. Family members also can better give the client needed emotional support when they are fully informed.

Teaching about the importance of medication compliance

The client may need to try different medications until his or her response is satisfactory. The chances for improved OCD symptoms are enhanced when the client takes medication and uses behavioural techniques.



Conversion disorder clinical example

Mulenga, 13 years of age, has just been transferred from a medical ward to a psychiatric unit. He had been on the medical unit for 3 days, undergoing extensive tests to determine the cause of a sudden onset of blindness. No organic pathology was discovered, and Mulenga was diagnosed with a conversion disorder.

As the nurse interviews Mulenga, she notices that he is calm and speaks of his inability to see in a matter-of-fact manner, demonstrating no distress at his blindness. Mulenga seems to have the usual interests of a 13-year-old, describing his activities at school and with his friends. However, the nurse finds that Mulenga has little to say about his parents, his younger brother, or activities at home.

Later, the nurse has a chance to talk with Mulenga mother when she comes to the unit after work. Soon,

Mulenga mother is crying, telling the nurse that her husband has a drinking problem and has been increasingly violent at home. She admitted that two days before Mulenga symptoms developed, Mulenga witnessed one of his father's rages, which included breaking furniture and hitting her.

When Mulenga tried to help his mother, his father called him spineless and worthless and told him to go to the basement and stay there. The nurse understands that the violence Mulenga has witnessed and his inability to change the situation may be the triggering event for his conversion disorder.

Reactive Depression

From a historical point of view, depressive disorders were sometimes classified according to two types. Endogenous depression in which the symptoms were caused by factors within the individual, and reactive depression in which symptoms came about in response to external stressors. However, this approach to classifying depression is not without limitations. This way of classifying depression recognizes only one factor – either external (environmental) or internal (genetic, personality) to the exclusion of different factors interacting with one another to cause depression.

Furthermore, neither the DSM-4-TR nor ICD-10 contains categories of reactive or endogenous depression (Gelder, et. al. 2006)

ACTIVITY- Read more and find the difference between this type of depression and psychotic Depression

3.5 Child birth and Mental Health

The time of childbirth is a period when many women are at risk to mental illness because it can sometimes be a stressful time. Added responsibility of having a young infant that needs a lot of care, can sometimes be overwhelming to a new mother.
Postpartum onset mood symptoms are divided into 3 depending on severity:

Postpartum Blues
This occurs within 1-5 days of delivery. Emotional lability and tearfulness is present. However, this is a normal response that occurs due to hormonal level changes taking place upon delivery and is treated by assurance and given time to resolve. Nevertheless, social support such as a considerate husband or other close relatives to help with the baby and house chores reduces the severity of the postpartum blues. The nurse can also explain to the patient the physiological processes that lead to the blues. Other postnatal difficulties which could worsen postpartum blues like a broken episiotomy, sore nipples, engorged breasts and a persistently crying baby can be prevented by adequate prenatal preparation and education by midwives and nurses.

Post Partum Depression (PPD)

Postpartum depression – occurs 2wks to 12m after delivery. The risk is higher for people with psychiatric disorders and in individuals who have psychosocial problems as well as chronic physical illnesses.

A. Symptoms of PPD

Can occur anytime in the first year after delivery and include, but are not limited to, the following:

- Sadness, hopelessness, low self-esteem.
- Guilt, sleep and eating disturbances.
- Inability to be comforted, exhaustion, emptiness, inability to feel pleasure.
- Social withdrawal
- Low or no energy
- Becoming easily frustrated
- Feeling inadequate in taking care of the baby
- Impaired speech and writing
- Spells of anger towards others
- Increased anxiety or panic attacks
- If a new mother scores more than 13, on the Edinburgh PND Scale, she's likely to develop depression.

B. Risk factors

While not all causes are known, a number of factors have been identified as predictors of PPD

- Formula feeding rather breast feeding
- A history of depression
- Cigarette smoking
- Low self esteem
- Childcare stress
- Prenatal depression during pregnancy
- Prenatal anxiety
- Life stress
- Low social support
- Poor marital relationship
- Infant temperament problems/colic
- Maternity blues
- Single parent
- Low socio-economic status
- Unplanned/unwanted pregnancy
- Hormonal changes
- Life style changes
- Pre existing mental illness

C. Four coping strategies

1. **Avoidance coping:** Denial, behavioural disengagement.

Mothers who use avoidance coping and don't respond to their infants' needs may make the infant feel insecure.
Insecurity can lead to infant stress and infant avoidance, where the infant may become so subdued that it will not interact with the mother or any other adult.
This is a concern because months 2 through 6 in an infant's life are very important; it is in these months that the infant develops some interaction and cognitive skills and bonding.
Parent-infant interaction is most essential during this time because it builds the connection not only with the mother, but others as well (Long-term).

2. **Problem-focused coping:** Active coping, planning, positive reframing.
3. **Support seeking coping:** Emotional support, instrumental support.
4. **Venting coping:** Venting, self-blame.

D. Prevention

- Early identification and intervention improves long term prognoses.
- Knowledge of risk factors and dealing with them.
- Women should be screened by their physician to determine their risk for acquiring PND.
- Proper exercise and nutrition appears to play a role in preventing postpartum, and general depression.

Nutrition

The following information may be beneficial in achieving a well balanced diet during and after pregnancy.

Omega-3 Fatty Acids

Some experts believe that PPD can be attributed to depletion of omega 3 fatty acids from the mother's brain to support development of the brain of the breast fed infant.
This can be prevented by ensuring that sufficient omega 3 fatty acids are provided in the mother's diet. Good natural sources of omega 3 fatty acids include edible linseed oil, certain fish, grass fed rather than grain fed meat and eggs from chicken fed on flax seed or other feed high in omega 3 fats.
Omega 3 can also be purchased in capsule form as a dietary supplement.

Protein

Protein can be found in a wide variety of foods which include:

3 ounces of most meat contain 25gm of protein.
3 large eggs have approx. 19gm
3 ounces of Swiss cheese have 15gm

Hydration

One of the most important roles in any diet (especially for pregnant and nursing mothers) is that of hydration. Physicians may recommend that mothers who are nursing drink a tall glass of water, milk or juice before sitting down to breastfeed their child.
Women should consult with their doctor about caffeine and alcohol consumption after delivery.

Vitamins

A woman who has delivered should speak with her physician for information about, and a recommendation for a daily prenatal/postnatal vitamin B.

Some limited research recommends that intake of B vitamins; specifically Riboflavin can help reduce the chance of PND. (Vitamin B is water soluble and has to be replenished each day.

Appetite
If a woman finds herself with a loss of appetite or other eating disturbances it may be a sign of PND and she should discuss this with her doctor**.**

E. Treatment
Post natal depression is treatable using a variety of methods.
If the cause can be identified, treatment is aimed at mitigating the root cause of the problem, including increased partner support, additional help with childcare, cognitive therapy, among others.
Women need to be taken seriously when symptoms occur, in the following 2 ways:

- First the woman who has delivered will want to trust her intuition about how she is feeling and believe that her symptoms are real enough to tell her significant other, a close friend, and/or her doctor, erring on the side of caution will go a long way in the treatment of PND.
- Second, the people in whom she confides must take her symptoms seriously as well, aiding her with treatment and support. Partners, friends and physicians may notice changes in a postpartum (a woman who delivered recently) mother that she may not. Knowing that that PND is treatable with a variety of methods can make persistence in seeking treatment easier.

Treatment options

Various treatment options include:

- Medical evaluation to rule out physiological problems.
- Cognitive behavioural therapy (Counselling).
- Possible medication.
- Support groups, home visits.
- Healthy diet.
- Consistent/healthy sleep patterns.

An experienced medical professional will work with a postpartum mother to develop a treatment plan that is right for her.
The plan may include any combination of the above options, and might include some discussion or feedback from/with a partner.
If a woman suffering from PND does not feel she is being taken seriously or is being recommended a treatment plan she does not feel comfortable with, she will want to seek a second opinion.

The choice of treatment: Counselling versus Medication

Symptoms of mothers with PPD improve at similar rates when treated with CBT (Cognitive Behaviour Therapy/counselling) or the antidepressant Fluoxetine. It can be concluded that counselling is equally as effective a treatment for PND as medication.
The choice of treatment may be made by the women themselves. Treatment can reduce the length of suffering and its severity.
Approximately 15% of all women will experience postpartum depression following the birth of a child.

The childbearing years are when a woman is most likely to experience depression in her lifetime.

Postpartum psychosis is divided into depression and manic types and is rare. The period of risk is within the first month of delivery. It constitutes a psychiatric emergency because the life of the baby is in danger. In such a case the child must be taken away from the mother until she is stable. Admission of the mother is necessary, with administration of anti-psychotic drugs, close observations and nursing interventions according to the nursing diagnoses.

Self Assessment questions

The real cause for post partum depression is not known, but the following could be predictors or not. Indicate against the sentence whether True or False

1 -Formula feeding rather breast feeding

2 -A history of depression

3 -Cigarette smoking

4 -High self esteem

5 -Childcare stress

6 -Prenatal depression during pregnancy

ANSWERS

1 – True

2 – True

3 – True

4 – False

5 – True

6 - True

3.6 Psychosis

A psychotic disorder is one which is major in nature. This means the mental illness is one in which a patient experiences delusions and hallucinations. Furthermore, the patient is out of touch with reality. Due to the misperceptions (delusions and hallucinations) he/she experiences they imagine themselves to be somebody else in another world, place or situation of life. Psychotic symptoms can be found in

schizophrenia, mania, depression and bi-polar affective disorders as we shall soon see in the content below.

Affective Disorders

Welcome to this section where you are going to learn about mood disorders also known as affective disorders.

Definitions of mood

- Mood, is a prolonged emotional state that influences the person's whole personality and life functioning.

- Mood is a pervasive and sustained feeling tone that is experienced internally and that significantly influences a person's behaviour and perception of the world. Affect is the external expression of mood. Mood can be normal, elevated, or depressed. Healthy persons experience a wide range of moods and have an equally large repertoire of affective expressions; they feel in control of their moods and affects.

Definitions of mood disorder

- Mood disorders are a range of conditions in which the most prominent symptom is elevation or depression of mood. It is also termed affective disorder.
- A disturbance in mood is predominant feature of mood disorders.
- Mood disorders are a group of common psychiatric disorders characterized by dysregulation of emotion.

Symptoms of mood disorders

Persons exhibiting mood disorders demonstrate a range of emotions, from intense elation to severe depression.

- Impaired cognition
- Sleep disorders
- Appetite problems
- Lowered self esteem in depression

Effects of Mood Disorders

- Personal suffering

- Family suffering
- Interpersonal impairment
- Occupational impairment

Mania

Mania is characterized by an elevated, expansive or irritable mood. There is psychomotor acceleration.

Symptoms

i. Elevation of mood and/or increased irritability
ii. Inflated self regard (grandiosity)
iii. Increased energy and activity
iv. Increased talkativeness (pressure of speech)
v. Flight of ideas
vi. Decreased need for sleep
vii. Decreased attention
viii. Loss of inhibitions
ix. Psychotic symptoms
- Delusions – Grandiose / persecutory
- Hallucinations – Auditory most common, often reflecting prevailing delusional beliefs

Etiology
There is no specific known cause for mania. However, the predisposing factors that are biopsychosocial in nature and includes the following:

Biological factors
Genetics: Mania and Major depression are hereditary in nature. First degree relatives or children of people with these disorders are more likely to develop the mood disorder than people in the general population.
Biochemistry: Research has shown that people with depression have less of the neurotransmitter serotonin, whilst those with mania have too much of serotonin and epinephrine.

Psychological factors
According to the Cognitive Theory of Beck et al, (1979) sited in Stuart and Laraia, (2005), people experience depression because their thinking is disturbed.
Freud's Psychoanalysis states that early adverse childhood experiences buried in the subconscious could lead to depression until they are brought into the conscious through psychotherapy and dealt with.

Social factors
Stressful life events, lack of social support, and environmental stress and poverty can predispose a person to mood disorders.

Nursing Diagnosis for Mania

- Risk for injury, to self and others, related to extreme hyperactivity, destructive behaviour, anger directed at the environment, increased agitation among others., evidenced by hitting head, hand or foot against the wall, among others

- Risk for violence, self directed or directed at others, related to manic excitement, suspiciousness, paranoid ideation, hallucination among others., evidenced by body language, clenching of fists and jaws, hyperactivity, pacing, repetition of verbalization among others.

- Altered nutrition less than body requirement related to, refusal or inability to sit still long enough to eat, lack of appetite,., evidenced by loss of weight, pale conjunctiva, among others.

- Risk for exhaustion, related to hyper activity, pacing, repetition of verbalization, evidenced by …

- Altered thought process, related to heredity among others., evidenced by delusions, among others.
- Sensory perceptual alteration, related to hereditary factors, biochemical imbalance among others., evidenced by hallucinations, talking and laughing to self, listening pose among others.
- Impaired social interaction…
- Sleep pattern disturbance…

Nursing management for a patient with mania

Admission to hospital

Admit the patient to a closed ward in a psychiatric hospital or annex, because he poses a risk of harm to himself by his psychomotor acceleration and expansive concept of himself. For example, delusional thoughts that he is very strong or super man might lead him to perform dangerous feats such as jumping from a three storey building or walking in fast moving traffic without giving way to the vehicles. In addition, he poses a danger to others if he has persecutory delusions or hallucinations, because he might end up injuring someone, as he acts upon these psychotic symptoms.

Create a nurse patient relationship

This is so as to reduce suspicion and build trust in the patient which will in turn make it possible to carry out collaborative nursing interventions; meaning that the patient will cooperate with the nurse. The nurse must use a matter of fact tone when interacting with or talking to the patient to avoid arguments, since he/she tends to be irritable. This also entails firmness and calmness when dealing with the patient.The nurse must use clear concise directions and comments, keep remarks brief and simple because the patient tends to be hyper active and has no time for lengthy discourse. Also, the patient's delusions /hallucinations may preoccupy him.

Maintain a safe environment:

A risk assessment (Assess whether patient is a danger to himself as well as to others patients and staff as well) and monitoring to promote safety of client and others by observing patient closely. Limit setting in which boundaries are set, of behaviour that is not expected and consequences, both positive and negative (behaviour therapy), on manipulative and violent behaviours.

For instance, if a nurse is conducting a group therapy there's need for limit setting because a talkative patient can be disruptive because of the following tendencies:

- Manipulation of the self-esteem of others
- Ability to find vulnerability of others
- Ability to shift responsibility to others

To counteract the above tendencies, the following interventions are made:

a. Nurse protects vulnerable clients and keep them from being drawn into anger that manic patient feels.
b. Nurse must remain calm
c. State unit policy and move on because debating / arguing reinforce the tendencies mentioned earlier.

Consistency among staff is necessary because manic patients tend to create conflict, to pick on vulnerable individuals (staff and patients) blame others, test limits and shift responsibilities. The nurse must diffuse conflict and clarify communication. This means that staff must agree amongst themselves to follow the same agreed upon consequences for forbidden behaviour when dealing with the patient. For instance, the patient could have a limit set in which he is informed that if he threatens other patients or staff with violence, then he will be given time out, in which he has to spend time alone in a room by himself.

Reduce environmental stimuli such as noise, television, radio or crowded rooms because patients are hyperactive, talkative, irritable and angry. Patients are distractible and respond to all sorts of environmental cues. Some more modifications which can be made to the environment include a quiet room, limited activities with others, gross motor activities.

Since patients with mania tend to be hostile and aggressive take heed not to worsen the situation. Deal with this behaviour in a calm, confident manner. Have a strong show of strength by having enough well trained staff on the unit to handle and control the patient in case his behaviour worsens.

In the case of violent or unruly behaviour start by talking to the patient in a calm and matter of fact way, reminding him of any limits he has broken and that if he continues with violent behaviour you will have no choice but to physically restrain him and administer a drug that will help him calm down. If the patient does not comply then staff, at least 6 or more of them must advance in a planned way and physically restrain the patient whilst another nurse gives the prescribed medication by injection.

If the patient is escalating (getting worse) administer haloperidol / chlorpromazine as per prescription to calm him down. Depending on the policy of that particular hospital, to keep patient safe from injury and staff and other patients safe from violent outbursts the patient may be put in restraints, or in a seclusion room for an agreed period of time. Necessary observations and care to prevent complications should be carried out on the patient while he or she is in restraints or under seclusion.

Rest and sleep

Provide opportunities for rest, relaxation and ventilation of impulsive feelings to calm the patient and reduce the risk of acting out.

When talking with patients use clear concrete statements and avoid abstract general statements to enable the patient understand what you are saying, and thereby prevent worsening of hallucinations and delusions. For instance if you want a patient to have his meal, you would say, ' Mutale, come to the tap and wash your hands. Now go together to the dining hall. We are now in the dining hall, sit on that chair over there and I will sit on this one….'

Frequently reality orientation of the client and discourage false beliefs without challenging or threatening client.

Provide nutritious finger meals that are easy to eat 'on the run' because the patient is unable to sit or stay for long enough in one place to eat a meal. Weigh patient daily.

Accompany patient to group activities beginning with the more structured, less threatening ones and gradually incorporate more formal, spontaneous activities to increase patient's socialization skills.

Assist in personal hygiene, appropriate dress and grooming until client is able to function independently to prevent physical complications and preserve self-esteem.

Establish routine times for self-care. Routine and structure tend to organize and promote reality in client's world.

Spend intervals of time each day with client engaging in non-challenging inter actions, to develop trust and to avoid upsetting patient. For instance you could play a game in which no one wins or you could allow him to win.

Praise the patient for reality based perception, reduction/cessation in aggressive behaviours and appropriate social interaction and group interaction. Praise reinforces repetition of functional behaviours when given at appropriate time.

Reinforce or emphasize reality since patient with mania experience disturbances in perception (hallucinations). This means you bring his/her attention to what is happening now or what needs to be done now, such as, 'it is time for lunch, let us go and eat some food.'

Respond to legitimate complaints to diffuse irritability and develop trust.

Redirect patients into more 'healthy' activities. When engaged in unproductive behaviour the patient's distractibility serves as an intervention tool. For instance, if the patient is continuously pacing up and about, you could re-direct that excessive energy into a ball game or physical activity.

Safe Environment

Prevent patients with mania from self and other injury.

Information Education and Communication (IEC) to the patient and family is done upon admission as part of discharge planning. It involves teaching about the patient's diagnosis, signs and symptoms, course, prognosis, medications, side effects, prevention of relapse, and psycho social support whilst he is in hospital and upon discharge. IEC also involves teaching relatives and community or neighbours correct and safe ways of handling and restraining or dealing with the patient when he relapses and becomes violent whilst at home.

Self Assessment Questions

The following statements could be True or False about Mood disorders

Indicate whether true or false against the sentence

Effects of mood disorders

1 -Personal suffering –T/F

2 -Family suffering- T/F

3 –Interpersonal not impairment- T/F

4 -Occupational impairment T/F

Answers

1 –True

2 –True

3 – False

4 -True

Major Depressive Disorder

Major depressive disorder is described as disturbance of mood involving depression or loss of interest or pleasure in the usual activities with evidence of interference in social and occupational functioning for at least 2 weeks. There is psychomotor retardation.

There is no history of manic behaviour.

The symptoms cannot be attributed to use of substances or general medical condition.

Clinical Features

Symptoms

- Depressed mood
- Loss of interest and enjoyment (Anhedonia)
- Reduced energy and increased fatigability
- Reduced concentration and attention
- Reduced self esteem and self confident
- Ideas or acts of self harm or suicide
- Disturbed sleep

Biological, melancholic symptom or somatic signs

- Early morning waking
- Low appetite
- Decreased enjoyment
- Decreased libido
- Decreased concentration
- Feeling worse in morning
- Constipation and psychomotor retardation

- Early morning wakening (2hrs or more b4 usual time)
- Diurnal variation of mood
- Psychomotor retardation or agitation
- Loss of appetite
- Loss of weight (5% or more body weight in past month)
- Loss of libido

Symptomatology (set of symptoms)

1. Affect – sad, dejection, helplessness and hopelessness. A feeling of worthlessness prevails.

2. Thoughts – slowed, difficult concentrating, Obsessive ideas and rumination of negative thoughts. In severe depression (Major Depressive Disorder) psychotic features like hallucinations and delusions may be present.

3. Physically – weakness and fatigue – very little energy to carry on activities of daily living (ADLs).

    - An individual may express an exaggerated concern over bodily functioning
    - Some individuals may be inclined towards excessive eating and drinking, while others may experience loss of appetite and weight loss
    - In response to general slowdown of body, digestion often sluggish, constipation common and urinary retention possible.
    - Sleep disturbance common, either insomnia or hypersomnia

4. A general slowdown of motor activities (psychomotor retardation)

    - Energy level depleted movements lethargic and performance of ADLs extremely difficult.
    - Regression (reversal to a less developed condition or way of behaving) common, evidenced by withdrawal into self and retreat to fetal position.
    - Verbalizations are limited – content of speech may be ruminations regarding their life regrets or if psychotic reflection of delusional thinking

5. Diminished social participation – in depression people have an intense focus on self, discouraging others from pursuing relationship with the person, which increases their feelings of worthlessness – isolation.

Psychotic symptoms

- Delusions taking the form of poverty, personal inadequacy, guilt over presumed misdeeds, deserving of punishment, nihilistic delusions

- Hallucinations: auditory defamatory or accusatory voices, cries for help, or screaming, olfactory, bad smells such as rotting food, faeces, decomposing flesh. Visual: tormentors, demons, the devil, dead bodies, scenes of death or torture. These examples are mood congruent (they match the patient's low mood).

- Catatonic symptoms or marked psychomotor retardation (depressive stupor).

Epidemiology

Prevalence – 2-5% in the general population

Sex ratio – male female ratio 1:2

Risk Factors to Developing Depression

Biological

Genetic risk factors such as heritability: There are 40 -70% chances of developing depression when an individual is from a family with anxiety disorders and neuroses.

Neurotransmitters: In balance of neurotransmitters especially serotonin, endocrine changes resulting into hormonal in balance such as in postnatal depression, and sleep pattern changes.

Physical illness especially chronic, severe, or painful.

Psychological

Early childhood experiences such as loss of a parent, lack of parental care, parental alcoholism, antisocial traits, childhood sexual abuse; personality traits such as anxiety, impulsivity, obsessional; and negative cognitions.

Social

Social circumstances such as marital status affect mental health status. Men have low rates of depression when married whereas women show high rates of depression when married due to marital disharmony, separation or divorce. Research shows that women having 3 or more children under age 11, lack of paid employment, and lack of a confiding relationship, adverse life events and particularly loss events lead to increased chances of developing depression in vulnerable individuals.

Comorbidity

Depression may exist alongside another mental illness in about two thirds of patients. Such illnesses include anxiety disorders, substance abuse, alcohol dependency, personality disorders.

Nursing Diagnosis

- Risk for suicide related to depressed mood, feelings of worthlessness, punitive superego, irrational feelings of guilt, numerous failures, hopelessness, delusional thinking, hallucinations among others
- Dysfunctional grieving related to real or perceived loss, bereavement overload, among others. Evidenced by denial of loss, difficulties in expressing loss, labile affect, among others.
- Self esteem disturbance related to lack of positive feedback, feelings of abandonment by significant others among others, evidenced by difficulty accepting positive reinforcement, being highly critical and judgmental of self and others.

- Social isolation / impaired social interaction related to fear of rejection or failure to interact, evidenced by, sad, dull affect, seeking to be alone among others.
- Altered nutrition less than body requirements, related to depressed mood, loss of appetite, ideas of self destruction among others, evidenced by, loss of weight, pallor, amenorrhea among others.
- Sleep pattern disturbance, related to repressed fears among others, evidenced by verbal complaints of difficulty falling asleep among others.
- Self care deficit related to
- Hopelessness

Activity

Complete the last two Nursing Diagnoses

- Self-care deficit related to ….
- Hopelessness….

Nursing Management

Patients with moderate to severe depression must be admitted in a closed ward due to risk of self-harm.

Assess for risk of suicide and self-harm. This is done during the psychiatric interview when conducting the mental state examination upon discharge and throughout hospitalization. Thoughts of deliberate self-harm are likely to occur at some stage in patients with illness of any severity. Therefore always inquire about them. Ask for thoughts and behaviours that suggest increased suicide risk, their frequency, and their severity. This can be done in a tactful manner as follows:

- How do you feel about the future? When a patient describes the future as hopeless, and feels things will never get better it is worrying.
- Have you ever thought that life is not worth the living? When a patient describes the future as hopeless then they are likely to feel that nothingness would be better.
- Have you had thoughts of ending your life? If yes inquire how often the patient has had such thoughts. Are they just passing thoughts or are they commonly occurring?
- Have you thought about how you would do it? Enquire about methods of suicide the patient has considered. It is worrying if the patient has considered particularly violent methods which are likely to succeed like shooting, hanging, or jumping from a height.
- Have you made any preparations? The aim of asking this question is to find out how far the patient's plans to commit suicide have progressed from ideation (thoughts) to actual action such as actual place, time, buying pills, obtaining a gun. Have they carried out a final act such as a (suicide note, or began to put their affairs in order).
- Have you tried to take your own life? Try to find out if there has been any recent concealed attempt to commit suicide.

Closely monitor the patient on a one to one (1:1) basis, to promote safety of client. One to one basis means that a primary nurse is assigned to the patient throughout the time that the risk for suicide lasts. The patient should never be left on his or her own at any time, both day and night. Ensure the patient's environment free of harmful objects such as sharp objects, ropes, drugs among others. Explain to patient that if thoughts of suicide or self-harm come into their mind they should let a nurse on the unit know immediately.
Cultivate a nurse patient therapeutic relationship so that you can closely observe patient in the unit. Develop rapport, show respect to patient and this will enable them trust you and in turn make it possible to ease client out into community. This can be done by just sitting with them and spending intervals of time with client each day and then accompanying them to group gatherings afterwards.

In dysfunctional grieving assess the stage of grieving the patient is in and then assist them work through the grieving process, systematically with the patient. For instance if the patient is fixed at the anger phase of the grieving process, they may blame themselves for something that happened to a beloved one such as death, and they will be angry with what they perceive to have been their part in that death. The nurse will have to come in with her counselling skills and assist the patient to change these dysfunctional thoughts / cognitions that the patient could not necessarily control the life course, illness and death of a loved one. Help patients accept their feelings of loss and support them as they work through these feelings by allowing them to verbalize their anger (listening, empathetic understanding, non-judgmental attitude).

Give the patient positive feedback concerning anything they do well to increase their self concept and esteem. For instance if they greeted you or attended a group meeting acknowledge this with words of affirmation.

In severe depression where there's loss of weight and dehydration give patient a nutritious diet and monitor fluid intake and record all intake and output. Weigh the patient weekly. Be present at meal times and serve meals in small attractive portions. Give preferred but nutritious foods. The patient may need assistance with feeding if very depressed.

Since sleep is disturbed with patient waking at least two hours before usual time, he or she needs to be closely observed for number of hours they actually sleep, and this information recorded on a sleep chart. Sleep is promoted by the following measures: Discourage day time naps, encourage patient to participate in day time activities, avoid caffeinated fluids, assist patient to have a warm bath at bedtime. If the patient still can't sleep there may be a need for a sedative but be careful of addiction.

Encourage and assist patient with self-care activities using Orem's self care model. Establish routine times for self-care such as washing of face and brushing teeth in the morning, taking a bath after breakfast, among others., and add more complex tasks as client improves.

Ensure the patient takes all prescribed drugs such as antidepressants. It takes 4 to 6 weeks for the effects to be seen such as lifting of the mood. Observe to ensure he/she swallows and does not keep or hoard medications, due to the risk that they may attempt suicide by taking the same medications. The risk to commit suicide is highest just when the antidepressants improve psychomotor activity. This is when the patient has the strength to carry out any suicide that they may not have had the strength when very depressed.

Suicide

Suicide is a deliberate act of self-harm which results into death. The potential for suicide should always be assessed in those with severe mood disturbances. Approximately 15% of severely depressed patients commit suicide, and between 25% and 50% of patients with bipolar disorder attempt suicide at least once (Stuart and Laraia, 2005).

It can be prevented through early detection of thoughts, verbalizations and plans of committing suicide and urgent intervening which includes hospitalization with one to one nursing in a safe environment, medication and counselling.

In the community nurses must be observant of those people who are prone to committing suicide such as the following:

Risk factors for completed suicide

Social demographic factors

- Male sex
- Elderly
- Single, divorced or widowed
- Living alone, poor social support
- Unemployed or low-socio-economic situation

Personal/mental health factors

- Previous para suicide (attempted suicide).
- Any mental disorder (greatest risk in major depression, and anorexia nervosa, then psychosis, then neurotic and personality disorders)
- Dependence on drugs or alcoholic
- Recent in-patient psychiatric treatment
- Chronic physical disorder
- Recent bereavement

Attempted suicide
Attempted suicide (Para-suicide) is a deliberately undertaken act of self-harm with the intention to commit suicide, but does not result in death. This is a psychiatric emergency.

Bipolar Affective Disorders (BAD)

BAD are periods of prolonged and profound depression alternate with periods of excessively elevated and/or irritable mood, known as mania.

Bipolar I disorder is one or more manic episodes with/without a history of one or more depressive episodes.

Bipolar II disorder is one or more depressive episodes accompanied by at least one hypomanic episode.

A hypo manic episode is clearly different from a 'normal' mood, but is not severe enough to interfere with social or occupational functioning, require admission to hospital, or include psychotic features. Its features are similar to those of mania but in a milder form.

Cyclothymic

This is a chronic mood disturbance of at least 2-year duration, involving numerous episodes of hypomania and depressed mood of insufficient severity or duration to meet the criteria for bipolar mood disorders.

Self Assessment Questions

The following could be signs and symptoms of depression. Indicate True or False on the following statements concerning depression:

1 - Low appetite

2 -Decreased enjoyment

3 –Increased libido

4 -Decreased concentration

5 -Feeling worse in morning

ANSWERS TO THE TEST

1 –True

2 – True

3 – False

4 –True

5 – True

Schizophrenia

This is the most common psychotic disorder and yet the most difficult to define and describe. The reason for this difficulty being that over many years, to date, many divergent concepts of schizophrenia have been held in many countries and by different psychiatrists.

Schizophrenia is a psychiatric syndrome in which specific psychological symptoms lead, in most cases, to disintegration of personality. The symptoms interfere with thinking, emotion, motor behaviour, and volition (will power). The abnormal thinking leads to misinterpretation of reality with development of fantasy thinking, delusions and hallucinations. Insight is always lost to a variable degree.

Subtypes of schizophrenia

Schizophrenia is divided into different types which have varying characteristics that distinguish one subtype from another.

1. Simple schizophrenia

The onset is in adolescence. Condition characterized by insidious development of eccentric behaviour, apathy, a shallow affect, social withdrawal, a lack of drive and initiative, and declining performance at work. Delusions and hallucinations are uncommon. Prognosis is very poor since clear schizophrenic symptoms are absent, simple schizophrenia is difficult to identify reliably.

2. Hebephrenic schizophrenia
Onset in adolescence or early 20s. Patients often appear silly and childish in their behaviour. Affective symptoms (flattened affect and incongruity) and thought disorder are prominent. Delusion is common and not highly organized. Hallucinations also are common, and are not elaborate. Though onset is usually insidious, some cases begin suddenly, with marked depression and anxiety.

3. Catatonic schizophrenia
Onset later than in hebephrenia and is usually acute. Characterized by motor symptoms and by changes in activity between excitement and stupor. Patient many have one (or a combination) of several forms of the following catatonic symptoms described below:-

Catatonic stupor or mutism: Patient does not appreciably respond to the environment or to the people in it. Despite appearances, these patients are often thoroughly aware of what is going on around them.
Catatonic negativism: Patient resists all directions of physical attempts to move him or her.
Catatonic rigidity: Patient is physically rigid.
Catatonic posturing: Patient assumes bizarre or unusual postures.
Catatonic excitement: Patient is extremely active and excited.

Delusions, hallucinations and affective symptoms occur, but are usually less obvious

4. Paranoid schizophrenia
Develops later (in the 30s or 40s) than other forms of schizophrenia. This is the most stable and common subtype. Paranoid delusions are predominant. Patients are often uncooperative and difficult to deal with and may be aggressive, angry, or fearful. Thought disorder and affective change are usually inconspicuous.

Hallucinations (auditory) are often present. Personality is well integrated.

5. Residual schizophrenia

After many years and repeat episodes, the active symptoms of schizophrenia 'burn out' and the patient displays symptoms of residual phase (for example,for example, dullness, social with drawl, flat or inappropriate affect, eccentric behaviour, loosening of association, illogical thinking, lacking in interest, volition or imagination).

Symptoms of Schizophrenia

Symptoms of schizophrenia are commonly described as positive or negative. Positive symptoms are an exaggeration of normal functions, whereas negative symptoms are a loss of normal functions (APA, 2000). Most clients exhibit a mixture of both types of symptoms. Positive symptoms respond well to treatment whereas negative symptoms are difficult to treat and respond less well to neuroleptics. Negative symptoms are also the most destructive because they render the patient passive and apathetic.

Behavioural disorders are classified as positive or negative and are considered under eight areas of functioning: content of thought, form of thought, perception, affect, sense of self, volition, impaired interpersonal functioning and relationship to the external world, and psychomotor behaviour. Additional impairments outside these eight areas are also considered.

Positive and negative symptoms of schizophrenia

Positive symptoms	**Negative symptoms**
Content of Thought Delusions Inappropriate affect Religiosity Bland or flat affect Paranoia Apathy Magical thinking **Form of Thought** Associative looseness Neologisms activity Concrete thinking Clang associations Word salad Circumstantiality Tangentiality Mutism Perseveration **Perception** Hallucinations Illusions **Sense of Self** Echolalia Echopraxia Identification and Imitation Depersonalization	**Affect** Inappropriate affect Bland or flat affect Apathy **Volition** Inability to initiate goal-directed activity Emotional ambivalence Impaired Interpersonal functioning and Relationship to the External World Autism Deteriorated appearance **Psychomotor Behaviour** Anergia Waxy flexibility Posturing Pacing and rocking **Associated Features** Anhedonia Regression

Aetiology

Biopsychosocial

Biological

1. Genetic theories – Schizophrenia may be genetic (about 1 in 3 cases). Twin and family studies show that schizophrenia is inheritable. The closer one's relative is, the higher the possibility of inheritance. People with a 'lighter' genetic load may require environmental triggers, for instance, Perinatal trauma, family stresses, whilst those with greater genetic predisposition may develop schizophrenia on a genetic basis alone or with minimal environmental triggering.

2. Biochemical theories – The dopamine hypothesis states that there is over activity in the mesolimbic pathways.

3. Obstetric complications and injuries
4. Left or mixed handedness
5. Lower birth order if from large family
6. Head injury
7. Epilepsy, Mental retardation

Psychosocial

Psychological life events are emotionally arousing or threatening experiences, (Brown and Birley 1968), For example:

1. Moving house
2. Having visitors to stay
3. Witnessing an accident
4. Separation – from close friend or relative
5. Promotion at work

Social factors such as family factors and high expressed emotion.
High Expressed Emotion (EE) – is critical comments hostility over – involvement. Living with a high EE relative, the relapse rate usually is high at 50%. Whereas low EE homes appear protective with relapse rates lower (21%) when patients have been assessed 9 months later.

Diagnosis
Schneider's first rank symptoms in the diagnosis of schizophrenia (provided there is no evidence of organic disease) are as follows:

- Thought with drawal (belief that thought are being taken out of one's mind)
- Thought insertion (belief that thoughts are being put into one's mind)
- Thought broadcasting (belief that thoughts become known to others)
- Echoing thoughts (hearing thoughts spoken aloud)
- Hearing hallucinatory voice discussing one's thoughts and behaviour in the third person, or passing a se Running commentary (for example, 'he is doing in now')
- Passivity feelings (belief that thoughts and behaviour are being influenced or controlled by external forces.

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Psychiatric Management

Hospitalization is needed for both first episodes of schizophrenia and acute relapses and various neuroleptics can be used.

There are advantages in a few days of observation without drugs, although some acutely disturbed patients may require immediate treatment.

For acutely disturbed patients the sedative effects of chlorpromazine are useful. An alternative approach is to use a modest dose of a high potency agent with additional benzodiazepine treatment (for example, diazepam 5-20mg.

Oral medication usually given at this stage, although occasional IM doses may be needed for patients who exhibit acutely disturbed behaviour and are unwilling to comply with oral treatment.

After the first few days medication is continued at a constant daily amount for several weeks, gradually changing to twice daily dosage or a single dose at night.
Antiparkinsonian drugs (for example, artane) are prescribed if side effects are troublesome, but they need not be given routinely.

Electro Convulsive Therapy is indicated mainly in catatonic stupor and severe depressive symptoms. Also in patients whose symptoms have not responded to adequate antipsychotic drug therapy.

Activity –
Before you continue, can you remember the different types of schizophrenia

Other Management

When the patient is very ill, that is, in the acute phase of the disease, they are hospitalized and commenced on antipsychotics. Once stable, psychotherapeutic interventions are made depending on the assessed needs of the patient.

Psychotherapy

- Psychoanalytic psychotherapy: Suitable for patients with good motivation and productivity.
- Group therapy: But of little benefit in the acute stage of the disorder.
- Supportive therapy: for patients who are resettling after the resolution of an acute illness.
- Behavioural treatment: Methods include social skills training, using positive and negative reinforcement to change behaviour. Behaviour therapy is based on learning theory which postulates that problem behaviours (that is, almost any of the manifestations of psychiatric conditions) are involuntarily acquired due to inappropriate learning. Therapy concentrates on changing behaviour.
- Cognitive therapy: Attributes emotional difficulties to faulty thinking or beliefs (cognition**)** that lead to counterproductive behaviour. Psychiatric conditions presumably improve when the patient's thinking is more accurate and when the behaviour is more appropriate. Thus the therapist works with the patient to identify and correct misperceptions (one by one) and (mis) behaviours.

Dosage of some antipsychotic drugs

Drug (oral – mg)	Relative dose (mg)	Maximum dose (mg)
Chlorpromazine	100	1000
Thioridazine	100	800
Trifluoperazine	5	20
Fluphenazine	2	20

Haloperidol 2 100
Fluphenthixol 1 18
Sulpiride 200 2400
Clozapine 60 900

Nursing Management of Schizophrenia

Nursing diagnoses

- Risk for violence; directed to self or others
- Social isolation related to lack of trust, delusional thinking among others evidenced by sad, dull affect, staying alone in a room, uncommunicative, no eye contact.
- Sensory perceptual alteration (Auditory/Visual)
- Impaired verbal communication
- Self-care deficit
- Sleep pattern disturbance

Specific nursing interventions

- Risk assessment and monitoring to promote safety of client and others.
- Reduce environment stimulation to lessen client's impulsivity, agitation and prevent injury.
- Provide opportunities to pt to rest, relax and ventilate to calm pt and reduce risk of acting out.
- To deal with isolation, spend intervals of time with client each day, engaging in non-challenging interactions, to ease clients out in community by first developing trust, rapport and respect.
- To continue dealing with social isolation – accompany client to group activities, beginning with less threatening ones and gradually incorporate more informal spontaneous activities to preserve self-esteem. Role model appropriate social behaviours such as good eye contact, appropriate social distance, and a calm demeanor.
- To deal with hallucinations/delusions carry out frequent reality orientation and discourage clients false beliefs without challenging or threatening the client. For example if a patient says he sees a snake, you can say to him, 'It must be frightening to see a snake. However, I cannot see any snake in this room.'
- Distract patient from delusions that tend to exacerbate aggression and violence by engaging him/her in more functional and less anxiety provoking activities.
- For self-care – establish routine times for self-care and add more complex tasks as client improves. Routine and structure tends to organize and promote reality in clients world.
- Assist in personal hygiene, appropriate dress and grooming until client is able to function independently to prevent physical complications and preserve self-esteem.
- IEC to client and family / significant others about:

- The client's symptoms
- Educate family on emotionally supporting client (importance of preventing high expressed emotion)
- Importance of compliance to medication
- Prevention of relapse

- Support and monitor prescribed medical and psychosocial interventions to encourage client and family in the treatment plan and prevent client's behaviour from escalating.

Rehabilitation of patients with schizophrenia and other mental illnesses

Tertiary prevention is carried out through activities identified as rehabilitation in which disabilities are limited through emphasizing strengths of the patient. Psychiatric rehabilitation involves making interventions to improve performance of people with serious and persistence mental illness and enhance their recovery in the following areas:

- Social (through social skills training)
- Educational
- Occupational (through Vocational skills training and supported employment)
- Behavioural (Behavioural therapy)
- Cognitive (Cognitive behaviour therapy)

The interventions are done in the patient's chosen environment which may be home (activities of daily living), work and school. Different professionals may be involved such as occupational therapists, rehabilitation assistants, social workers, psychologists, counsellors and nurses. Interventions focus on emphasizing strengths. Strengths may be related to:

- Recreational and leisure activities for example sports, outings, to mention but a few.
- Work skills in vocational trade institutes.
- Educational accomplishments
- Self-care skills
- Special interests
- Talents and abilities
- Positive interpersonal relationships

People with serious mental illness often need help with defining their skills, abilities, and interests as strengths. Low self-esteem may lead them to believe that they have only problems, not strengths.

Self Assessment Test

The following statements explain types of Schizophrenia – you are requested o write whether True or False

1 -Simple Schizophrenia – Hallucinations are very common – T/F

2 -Hebephrenic Schizophrenia – Hallucinations are not common – T/F

3 -Paranoid Schizophrenia – Patients are very suscipicious – T/F

4 -Catatonic Schizophrenia – There is apathy with good appetite and patient interacts well with others – T/F

Answers

1 – False

2. –False

3 – True

4 – False

Dementia

Poor memory and disorientation were once considered a normal part of aging. It was believed that if one lived long enough, such impairments were unavoidable. Currently, dementia is considered an abnormal state with many causes that can often be identified. Dementia is an important concern in the field of psychiatry and in Zambia dementia is a condition that has not been understood quite well. The Zambian culture strongly believes in magic and witchcraft and most people with dementia have become victims of torture and even death.

Definition of dementia: Dementia is defined as global or total intellectual decline of sufficient severity to impair social and/or occupational functioning that occurs in normal consciousness, (Steele, 2010 :3).The term dementia describes symptoms of a large group of illnesses that cause a progressive decline in a person's functioning such as loss of memory, intellect, rationality and social skills.

There are four key elements to the definition of dementia (Steele,2010)

1. Global impairment. Dementia is a syndrome characterized by progressive, usually irreversible, global cognitive deficits (Semple et al, 2005). The impairments occur in more than just memory. Most dementia patients experience impairments in reasoning, using and understanding language, recognizing what one perceives through the senses, coordinating learned motor movements, planning and decision-making.
2. Decline. The impairments represent a decrease from a previous level of functioning. To recognize a reduction, it is crucial for the nurse to know the patient's previous level of functioning unless members of the family or significant others give correlated information.
3. Severity. Impairments are severe enough to interfere with normal functioning in everyday life. Examples are a person who was living independently and begins to make poor financial decisions or forgets how to cook a meal, although the person could previously perform those tasks. Getting lost while walking from a nearby church, neighbourhood and driving can also indicate severe impairment.

4. Normal consciousness. These impairments occur in a normal state of consciousness; patients are awake and alert. This is distinguished from an abnormal state of consciousness, such as drowsiness, stupor or coma, seen in delirium.

Causes of Dementia

There are many brain disorders that cause dementia. The currently recognized causes of dementia are represented in the pie chart shown in the Figure below and each type has a distinctive profile of symptoms and course (Steele, 2010).

In the box below are the Four A's of Alzheimer Disease

Table 1: Four A's of Alzheimer Disease

• Amnesia	Memory impairment
• Aphasia	Communication impairment
• Apraxia	Impairment in performing movements
• Agnosia	Impairment in recognition of what is taken in through the senxes

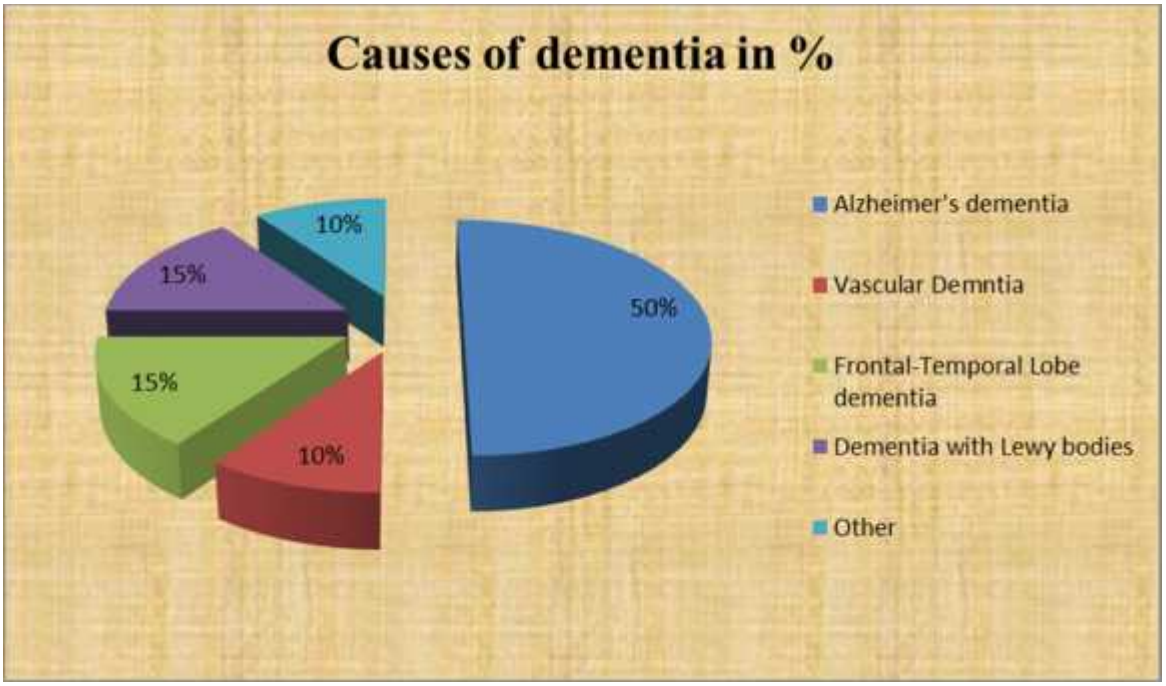

Figure 3: Causes of dementia

- Alzheimer's dementia 50%
- Vascular dementia 10%
- Frontal-Temporal Lobe 15%
- Dementia with Lewy bodies 15%
- Other 10%

Alzheimer's Disease

Alzheimer disease (AD) is the most common cause of dementia and thus the most common type that nurses encounter in clinical practice. AD is an incurable neuro- degenerative disease. The hallmark pathology of AD includes amyloid plaques and neurofibrillary tangles in the brain. One also sees general shrinkage of the brain and a decrease in the number of functioning neurons.

Signs and symptoms of dementia

In the early stages of dementia, people function relatively normal with minimum support. As dementia progresses, more specific symptoms occur (such as difficulty with speech and language, poor judgement and lack of insight). Difficulty with personal care tasks (such as bathing) and other everyday tasks (such as cooking, shopping and managing money) may become evident, (Stuart and Laraia, 2005).

Often there are enduring changes in personality and behaviour as well. People with dementia can be perceived to be aggressive, uncooperative and unpredictable. They may also present with hallucinations and delusions. These 'behaviours of concern' and others can best be classified as 'behavioural and psychological symptoms of dementia'.

All signs and symptoms are due to progressive damage to the brain for example, damage to the limbic system is associated with memory dysfunction, unstable mood and personality changes (Steele, 2010). The behaviours are not the result of deliberate attempts to be difficult or to upset carers.

Types of dementia

Dementia can be caused by a number of disease processes. Approximately 60 per cent of people with dementia have

(i)**Alzheimer's disease**, a consequence of degenerative brain changes as an individual age.(ii) **Vascular dementia** result from small brain infarcts; small brain haemorrahges. Dementia related to (iii) **Parkinson's disease** is also common and (iv**) excessive alcohol consumption** is another prevalent cause. Other illnesses (such as (v**) multiple sclerosis**, (vi) **HIV/AIDS**, (vii) **Huntington's disease** and (viii) **Creutzfeldt-Jacob disease**) are less common.

Onset and course of dementia

In Alzheimer's disease, the onset is insidious, generally occurring after the age of 55 and increasing in frequency of occurrence with advancing age (Steele, 2010). Dementia is an incurable illness with failing brain functioning and increasing physical disability leading to total dependence on others for all care.

Difficulties with diagnosis

It is important to understand the difference between dementia, delirium and depression. Depression and delirium are treatable conditions that present similar to dementia. Remember that all three conditions can be present and that dementia increases the risk for delirium. Common precipitating factors for delirium include infection, medication interactions and surgery.

Differentiating between **D**ementia, **D**elirium and **D**epression and (**three Ds**) requires skilled assessment. The differences and similarities are outlined in the Table below. Be alert to co-morbid substance misuse as complex co-morbidities may mask substance misuse and the impact of co-occurring problems.

Delirium, Dementia and Depression (Stuart and Laraia, 2005)

Table 2: Delirium, Dementia and Depression

The three Ds	**Dementia**	**Delirium**	**Depression**
Thoughts	• Repetitiveness of thought • Reduced interests • Difficulty making logical connections • Slow processing of thoughts	• Bizarre and vivid thoughts • Frightening thoughts and ideas • Often paranoid thoughts	• Often slowed thought processes • May be preoccupied by sadness and hopelessness • Negative thoughts about self • Reduced interest
Sleep	• Often a disturbed 24 hour clock mechanism (later in the disease process)	• Confusion disturbs sleep (may have a reverse sleep-wake cycle) • Nocturnal confusion • Vivid and disturbing nightmares	• Early morning waking or intermittent sleeping patterns (in atypical cases, too much sleep)
Orientation	• Increasingly impaired sense of time and place	• Fluctuating impairment of sense of time, place and person	• Usually normal
Onset	• Usually gradual, over several years • Insidious in nature	• Acute or sub acute (hours or days)	• Usually over days or weeks • May coincide with life changes
Memory and cognition	• Impaired recent memory • As disease progresses, long term memory also affected • Other cognitive deficits such as in word finding, judgement	• Immediate memory impaired • Attention and concentration impaired	• Recent memory sometimes impaired • Long-term memory generally intact • Patchy memory loss

	and abstract thinking		• Poor attention
Duration	• Months or years and progressive degeneration	• Usually brief — hours to days (but can last months in some cases)	• At least two weeks (but can be several months to years
Course throughout the Day	• May be variable depending on type of dementia	• Fluctuates — usually worse at night in the dark • May have lucid periods	• Commonly worse in the morning with improvement as the day continues.
Alertness	• Usually normal	• Fluctuates — lethargic or hypervigilant	• Normal
Other	• May be able to conceal or compensate for deficits (early)	• May occur as a consequence of a drug interaction or reaction, physical disease, psychological issue or environmental changes	• Often masked • May or may not have past history.

Treatment for dementia

In general, non-pharmacological approaches are first-line treatment for behavioural and psychological symptoms of dementia. If symptoms are moderate to severe and impact on the person's (or the carer's) quality of life or functioning, medication may be needed, often in conjunction with non-pharmacological interventions.

The person with dementia, the family and carers will need much support, education and counselling to help them understand and cope with what can be a distressing illness. A **problem-solving approach** that is preventative rather than reactive may help to identify situations that trigger a particular behaviour, which can then be avoided or modified.

Non-pharmacological strategies

Non-pharmacological strategies need to be based on an understanding of the individual's strengths and deficits. A 'catastrophic reaction' may result when the person's ability to cope is exceeded by the demands of the caregiver. This may be in the form of aggression or other distressed behaviour.

Communication strategies should include using clear, plain language and short sentences that convey one idea at a time. Use of gestures, pictures and body language can enhance the effectiveness of the message.

It is helpful to use the '**ABC**' model. This looks at the:

Activating event: what happens before the client reacts?

Behaviour: how does the client reacts to the stimulus?

Consequences: what happens after the behaviour?

Documenting these can provide clues to patterns and the triggers of behaviour.

Pharmacological strategies

Currently there is no cure for dementia, but drugs such as cholinesterase inhibitors (for example, donepezil, galantamine and/or rivastigmine) may help to slow the progress of the disease in the early stages. Memantine, which inhibits the release of glutamate (a neurotransmitter), is indicated for more advanced disease and may be used in conjunction with a cholinesterase inhibitor. Antipsychotic medication is most effective in the treatment of psychotic symptoms (such as hallucinations and delusions) and behavioural symptoms (such as physical aggression). Newer antipsychotic medications appear to be at least as effective as conventional neuroleptics, but have fewer side effects. Those with strong extrapyramidal effects (such as muscle rigidity, tremour and Parkinsonism) may be avoided in favour of those with sedating qualities, (Stuart and Laraia,2005).

When the person is severely agitated and as a result, distressed or representing a danger to himself, herself or others, sedation (a waking calm) is indicated. However, care needs to be taken to avoid oversedation (drowsiness), which ironically increases confusion and exposes the person to other risks such as falls, immobility, hypotension and reduced engagement.

Benzodiazepines with lower toxicity and shorter half-life (for example, temazepam, and/or oxazepam) are preferred to longer-acting agents (for example, diazepam, and/or nitrazepam).

Antidepressant medications are underused in people with dementia, despite the common occurrence of depression in dementia and the documented therapeutic value of these drugs. Some people may present as agitated when suffering a depressive disorder.

Research in the United States of America shows that giving a client suffering from dementia a cocktail of vitamins, such as Folic acid, B12 and B6 improves memory. This treatment has to be given simultaneously once daily (OD) for one month and then the client to be observed for signs of improvement.

Goals for nursing a person with dementia

Appropriate goals for caring for a person with dementia in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Provide an environment that supports flexible but anticipated routines.
- Maintain a safe environment for the person, yourself and other staff.
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person with dementia.

Guidelines for Responding to a Person with Dementia

The following guidelines will assist in nursing a person with dementia.

- Arrange for a review of the person's medication and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A mental health assessment may be

appropriate to undertake — see the mind Essentials resource 'What is a mental health assessment?'.

- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans.
- Explain to the person who you are, what you want to do and why.
- Smile — the person is likely to take cues from you, and will mirror your relaxed and positive body language and tone of voice.
- Move slowly, you may have a lot to do and be in a hurry, but the person is not. Imagine how you would feel if someone came into your bedroom, pulled back your blankets and started pulling you out of bed without even giving you time to wake up properly.
- If the person is resistant or aggressive but is not causing harm, leave him or her alone. Give the person time to settle down and approach the task later.
- Distract the person by talking about things he or she enjoyed in the past and by giving him or her a face washer or something to hold while you are providing care.
- Do not argue with the person. The brain of a person with dementia tells the person that he or she cannot be wrong.
- If the person is agitated, maintain a quiet environment. Check noise levels regularly and reduce them if necessary y by turning off the radio and television.
- Provide orientating cues such as a clock and calendar.
- Give the person a comfortable space. Any activity that involves invasion of personal space increases the risk of assault and aggression.
- Always provide care from the side (not the front) of the person. If you stand in front, you are easily hit or kicked if the person becomes aggressive.
- Be vigilant if the person is climbing out of bed. Refer to your workplace policy on restraint. If you cannot work out a reason for this behaviour, you might walk with the person or engage him or her in an activity. This helps to maintain his or her mobility, and eventually he or she may tire and go back to bed. Encourage family or volunteers to help with this.
- Monitor compliance with medication and general physical health (including nutrition, weight, blood pressure, among others).
- Monitor food and fluid intake and elimination — dehydration or constipation can exacerbate confusion.
- People with dementia are at increased risk of developing delirium, so be aware of risk factors for delirium (such as medication interactions, infection and the postoperative period).
- Provide family members and carers with information about the illness if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- Be aware of your own feelings when nursing a patient with dementia. Arrange for debriefing for yourself or any colleague who may need support or assistance — this may occur with a clinical super visor or an Employee Assistance Service counsellor (Steele, 2010).

Self test questions -

The following signs and symptoms are seen in Dementia

Write True or False

- 1- Amnesia: Memory impairment – T/F
- 2 -Aphasia: Communication is not impaired – T/F
- 3 -Apraxia: Impairment in performing motor movements –T/F
- 4 -Agnosia: Impairment in recognition of what is taken in through the senses –T/F

Answers

1 –True

2 – False

3 – True

4 –True

HIV/AIDS Related Psychosis

The HIV/AIDS epidemic means that, increasingly, psychiatrists are encountering individuals with psychological and neuropsychiatric complications of HIV infection. For Holistic care to be given to such individuals, a biopsychosocial approach with special attention to the emotional, economic, social and spiritual and ethical challenges are taken into account.

HIV infection affects the brain at an early stage and the disease has a chronic progressive course associated with a wide range of psychiatric consequences.

Psychosis is more common among people with HIV infection than the general population whereas factors contributing may include direct effect of HIV on CNS, opportunistic infection, CNS neoplasm, medications, substance use disorder and other psychological stresses (McDaniel et al., 2000).

New-onset psychosis can occur in the setting of HIV infection for instance as an opportunistic infection (like CNS lymphoma), with AIDS-related dementia, as medication side-effect, or with asymptomatic HIV infection (Perry and Jacobsen, 1986).

Generally such psychosis occurs in the later stages of HIV infection, usually in the context of AIDS. Less often it occurs with positive past psychiatric history, no antiretroviral therapy and lower global cognitive performance compared to non-psychotic HIV-positive subjects (De Ronchi et al., 2000).

Management of Psychosis in HIV Infected Individuals

Evaluation: The clinical evaluation of HIV-AIDS patients with psychotic symptoms requires broad history taking and physical examination, to rule out other known causes of psychosis. A careful history should include information about the onset and course of the patient's symptoms. Signs of medical illness, drug

intoxication, or medication toxicity should be considered during the examination (Nebhinani and Mattoo, 2013).

Treatment: Medication side-effects and drug–drug interactions are important considerations when patients are prescribed antipsychotic agents for the treatment of new-onset psychosis while concomitantly receiving HAART. For example, the enzymatic inhibition seen with protease inhibitors may lead to increased serum levels of antipsychotic agents and a greater potential for side-effects. Similarly, the ability of protease inhibitors and some atypical antipsychotic agents to cause weight gain and dyslipidaemia may lead to negative long-term outcomes such as diabetes, hypercholesterolemia, and cardiovascular events. The ability of some antiretroviral agents (for example, zidovudine, efavirenz) to cause CNS effects (for example, nightmares, hallucinations) may also complicate the treatment of psychiatric disorders. Caution should thus be exercised when deciding on the pharmacological treatment of psychosis in HIV-infected individuals, (Nebhinani and Mattoo, 2013).

As patients with HIV-associated psychosis are more sensitive to extrapyramidal side effects, so they require lower doses than other patients with psychosis. The use of atypical antipsychotics in the treatment of new-onset psychosis in HIV positive persons has proven helpful in reducing cases of extrapyramidal symptoms. For example the use of risperidone (1mg-3.3 mg), Olanzapine (10 mg) and Clozapine (mean 27 mg) given in smaller dosages minimize extrapyramidal symptoms. These antipsychotics fall in the Atypical(new generation antipsychotics) while the old generation antipsychotics also called Typical antipsychotics follow the same trend of smaller dosages(that is, chlorpromazine, haloperidol, trifluoperazine, thioridazine and fluphenazine depot).

Thus, since patients with HIV-associated psychosis are more sensitive to extrapyramidal side effects, consequently they need lower doses of antipsychotic drugs than other patients' with psychosis.

Emotional distress in people with HIV/AIDS

Emotional distress is common in people with HIV/AIDS for the following reasons:

- The nature of the AIDS physical symptoms
- Their progressive course
- The reactions of other people
- Some people at high risk for HIV (for example, Drug abusers) have other psychological problems

Psychiatric problems may occur to people with:

- Previous psychological problems
- Long standing social difficulties
- Lack of social support

Such problems include:

- Adjustment disorders
- Depressive disorders
- Anxiety disorders
- Suicide and deliberate self harm
- Neuropsychiatric disorders
- Social consequences

- Problems in relation to illicit drug use
- Ethical problems

Neurophysiological Disorders

These are common due to immune suppression and the direct effects of HIV on the brain. This results into:

- Minor cognitive disorders common
- HIV associated dementia (AIDS-dementia complex) is the most common and goes undiagnosed. Patients given ARVs because it is AIDS defining condition. Because it mostly occurs with a CD4 less than 200.
- HIV encephalopathy – It is caused by the HIV 'virus' itself. The virus attaches itself to the neurons in the brain which leads to the encephalitis. Managed with appropriate ARVs. In most cases these patients are taken to psychiatrists because of these symptoms. Hence appropriate diagnosis must be made to rule out HIV.
- Sub acute encephalitis occurs in 1/3 of patients. Late in the illness
- Delirium may occur when there is an opportunistic infection or cerebral malignancy

Psychosis is present in most of the above neuropsychological disorders. This may include psychiatric symptoms such as visual hallucinations, delusions.

Contexts in which psychiatric problems may arise

1. The 'worried well', eg. HIV –ve people may be concerned about being infected due to contact with HIV +ve sources/individuals.

2. Pre-test anxiety.

3. Post-test stress may precipitate a psychiatric illness such as adjustment disorder, major depressive disorder, and suicidality.

4. Living with AIDS often results in stressful life events (losing a job, becoming economically disadvantaged, and experiencing social alienation).

5. In some cases individuals with psychiatric needs (victims of abuse, LD persons) may be more vulnerable to becoming infected with the virus.

6. HIV directly infects neurons in the brain causing neuropsychiatric symptoms.

7. HIV+ve people are susceptible to secondary opportunistic infections and/or tumours of the CNS which may manifest as neuropsychiatric symptoms.

8. Anti-viral medications may cause psychiatric symptoms, eg. AZT may precipitate a major depressive episode.

Self assessment test

The following could be emotional distress in people with HIV/AIDS write true or False for the following statements

- 1 - The nature of the AIDS physical symptoms – T/F
- 2 - Their progressive course -T/F
- 3 -The reactions of other people is not important –T/F
- 4 -Some people at high risk for HIV (for example, drug abusers) may have other psychological problems – T/F

Answers

1 –True

2 – True

3 – False

4 - True

Continual seeking for excitement, appreciation by others and activities in which the person is centre of attention, over concern with physical attractiveness. The disorder is more common in females. The defence mechanism used most often are acting out and dissociation.

3.7 Summary

Neurosis is a mild psychiatric disorder characterized by anxiety. When anxiety is such that it reaches a level in which a person's functioning in the areas of activities of daily living, occupational functioning, and social interaction is disrupted then it is said to have become an anxiety disorder or a neurosis. There are four levels of anxiety namely, mild, moderate, severe and panic level. Anxiety disorders result from severe and panic level anxiety. They include generalized anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder, and somatoform disorders. The somatoform disorders are composed of five disorders which are somatization, conversion, pain, and hypochondriasis and body dysmorphic disorder.

Psychoses are major mental illnesses comprising of schizophrenia, mood disorders and dementia. Schizophrenia has several subtypes which are paranoid, catatonic, and simple. Mood disorders consist of major depression, mania and post-partum onset depression.

Nursing management of these disorders is done using the nursing process which is a tool that enables individualized care to be delivered to patients with mental health problems. In addition, nurses involve patients in their own care and relatives and the community at large also participate.

3.8 Self Assessment Test

Multiple Choice Questions

1. During the assessment, the client tells the nurse that she cannot stop worrying about her appearance and that she often removes 'old' makeup and applies fresh makeup every hour or two throughout the day. The nurse identifies this behaviour as indicative of a(n)
a. Acute stress disorder
b. Generalized anxiety disorder
c. Panic disorder
d. Obsessive–compulsive disorder

2. The best goal for a client learning a relaxation technique is that the client will
a. Confront the source of anxiety directly
b. Experience anxiety without feeling overwhelmed
c. Report no episodes of anxiety
d. Suppress anxious feelings

3. Which of the four classes of medications used for panic disorder is considered the safest because of low incidence of side effects and lack of physiologic dependence?
a. Benzodiazepines
b. Tricyclics
c. Monoamine oxidase inhibitors
d. Selective serotonin reuptake inhibitors

4. Which of the following would be the best intervention for a client having a panic attack?
a. Involve the client in a physical activity.
b. Offer a distraction such as music.
c. Remain with the client.
d. Teach the client a relaxation technique.

5. A client with generalized anxiety disorder states, 'I have learned that the best thing I can do is to forget my worries.' How would the nurse evaluate this statement?
a. The client is developing insight.
b. The client's coping skills have improved.
c. The client needs encouragement to verbalize feelings.
d. The client's treatment has been successful.

6. A client with anxiety is beginning treatment with lorazepam,(Ativan). It is most important for the nurse to assess the client's
a. Motivation for treatment
b. Family and social support
c. Use of coping mechanisms
d. Use of alcohol

7. Tony, age 21, has been diagnosed with Paranoid Schizophrenia. He has been socially isolated and hearing voices telling him to kill his parents. He has been admitted to the psychiatric unit from the emergency department. The *initial* nursing intervention for Tony is to:
a. give him an injection of chlorpromazine (Thorazine).
b. ensure a safe environment for him and others.
c. place him in restraints.
d. order him a nutritious diet.

8. The primary goal in working with an actively psychotic, suspicious client would be to:
a. promote interaction with others.
b. decrease his anxiety and increase trust.
c. improve his relationship with his parents.
d. encourage participation in therapy activities.

9. The nurse is caring for a client diagnosed with Paranoid Schizophrenia. Orders from the physician include 100 mg chlorpromazine (Thorazine) STAT and then 50 mg bid; 2 mg benztropine (Cogentin) bid prn. Why is chlorpromazine ordered?
a. To reduce extrapyramidal symptoms
b. To prevent neuroleptic malignant syndrome
c. To decrease psychotic symptoms
d. To induce sleep

10. The nurse is caring for a client diagnosed with Paranoid Schizophrenia. Orders from the physician include 100 mg chlorpromazine (Thorazine) STAT and then 50 mg bid; 2 mg benztropine (Cogentin) bid prn. Because benztropine was ordered on a prn basis, which of the following assessments by the nurse would convey a need for this medication?
a. The client's level of agitation increases.
b. The client complains of a sore throat.
c. The client's skin has a yellowish cast.
d. The client develops tremors and a shuffling gait.

11. Clint, a client on the psychiatric unit, has been diagnosed with Paranoid Schizophrenia. He begins to tell the nurse about how the CIA is looking for him and will kill him if they find him. Clint's belief is an example of a:
a. delusion of persecution.
b. delusion of reference.
c. delusion of control or influence.
d. delusion of grandeur.

12. The nurse is interviewing a client on the psychiatric unit. The client tilts his head to the side, stops talking midsentence, and listens intently. The nurse recognizes from these signs that the client is likely experiencing:
a. somatic delusions.
b. catatonic stupor.
c. auditory hallucinations.
d. pseudoparkinsonism.

13. The nurse is interviewing a client on the psychiatric unit. The client tilts his head to the side, stops talking midsentence, and listens intently. The nurse recognizes these behaviours as a symptom of the client's illness. The most appropriate nursing intervention for this symptom is to:
a. ask the client to describe his physical symptoms.
b. ask the client to describe what he is hearing.
c. administer a dose of benztropine.
d. call the physician for additional orders.

14. When a client suddenly becomes aggressive and violent on the unit, which of the following approaches would be best for the nurse to use *first*?
a. Provide large motor activities to relieve the client's pent-up tension.
b. Administer a dose of prn Thorazine to keep the client calm.
c. Call for sufficient help to control the situation safely.
d. Convey to the client that his behaviour is unacceptable and will not be permitted.

15. Margaret, age 68, is a widow of 6 months. Since her husband died, her sister reports that Margaret has become socially withdrawn, has lost weight, and does little more each day than visit the cemetery where her husband was buried. She told her sister today that she 'didn't have anything more to live for.' She has been hospitalized with Major Depression. The *priority* nursing diagnosis for Margaret would be:
a. imbalanced nutrition: less than body requirements.
b. complicated grieving.
c. risk for suicide.
d. social isolation.

16. The goal of cognitive therapy with depressed clients is to:
a. identify and change dysfunctional patterns of thinking.
b. resolve the symptoms and initiate or restore adaptive family functioning.
c. alter the neurotransmitters that are creating the depressed mood.
d. provide feedback from peers who are having similar experiences.

Answers

1. D
2. B
3. D
4. C
5. C
6. D
7. B

8. B
9. C
10. D
11. A
12. C
13. B
14. C
15. C
16. A

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UNIT 4: CONDITIONS NOT ATTRIBUTED TO MENTAL DISORDERS BUT ARE A FOCUS OF ATTENTION AND TREATMENT

4.1 Introduction

You are most welcome to the fourth unit in mental health and Psychiatric Nursing. In this unit we are going to discuss two topics. The topics are management of children with special education needs and management of epilepsy. In UNIT, three (3) we covered major and minor mental illnesses. Children with mental retardation and giftedness are not mentally ill. In addition, epilepsy is not a mental illness either.

Epilepsy and mental retardation are neurological conditions. These disorders result from abnormalities in the structure (anatomy) and functioning (physiology) of various parts of the nervous system. This can in turn result in a range of symptoms. Individuals with special learning needs or epilepsy are more likely to develop mental illness than the general population.

Activity

Read your Psychology in Nursing notes on intellectual disability and Giftedness.

Read Anatomy and Physiology notes on the Central Nervous System.

Children with intellectual disability and giftedness have special education needs because of their extremes of intelligence issues No matter how we choose to define and assess intelligence; it is true that there will be a wide range of individual differences. For example, intelligence tests compare people's scores to averages of others of the same chronological age, so most people by definition show average intelligence scores. But what about those whose Intelligence Quotient (IQ) scores are significantly below (intellectual disability) or above average (gifted)? What outcomes are common for these individuals? This is what we will discuss in this lesson today.

In Psychology in Nursing you covered intellectual disability and gifted child from a physical point of view, that is, the definitions, degree of disability and giftedness and management; I hope you have read through your past course content in Psychology so that you may easily understand what we are going do to today.

In this unit we will review some details that you covered in Psychology in Nursing. In the review we will define intellectual disability, state incidence, explain degrees of severity and outline causes of intellectual disability. We will then proceed to discuss the management of children with intellectual disability and those with giftedness. Finally, we will cover epilepsy from a physical point of view and then from a mental health point of view.

4.2 Objectives

By the end of the unit, you should be able to:

Describe the management of children with special needs

Before you proceed, attempt the following activity;

Activity

What do you know about intellectual disability?

Now compare your response with the following,

4.3 Children with special education needs

Children with special needs will be discussed in the unit. You will start by making some definitions.

Intellectual disability (Mental Retardation) is a disorder in which a person's overall intellectual functioning is well below average, with an intelligence quotient (IQ) around 70 or less. Individuals with intellectual disability also have a significantly impaired ability to cope with common life demands and lack some daily living skills expected of people in their age group and culture. The American Diagnostic Manual Five (V) (DSMV, 2014) has substituted mental retardation with the term Intellectual disability

The impairment may interfere with learning, communication, self-care, independent living, social interaction, play, work, and safety. Intellectual disability appears in childhood, before age 18. In the United Kingdom the term mental retardation is interchangeable with the term 'learning disability'.

Incidence: - About 1% of the general population has intellectual disability (DSM V,(2014) although some estimates range as high as 3% ICD 10,(2010). Intellectual Disability is slightly more common in males than in females. It occurs in people of all racial, ethnic, education, and economic backgrounds.

Degrees of severity

There are four degrees of severity of Intellectual disability based on IQ score:

1. Mild disability (retardation) (IQ range 50-55 to about 70).
2. Moderate (IQ range 35-40 to 50-55).
3. Severe (IQ range 20-25 to 35-40).
4. Profound (IQ level below 20-25).

People of average intelligence, score from about 90 to 110 on IQ tests.

Now go into a little bit of details about each of the above types

1. Mild

Mildly affected individuals often cannot be distinguished from normal children until they attend school. They may be labelled as slow learners by their teachers. Although they learn more slowly, people with mild disability usually can develop academic skills equivalent to the sixth-grade level. As adults, they can work and live in the community if helped when they experience unusual social or economic stress. Some may marry and have children.

2. Moderate

People with moderate disability can progress to about the second-grade level in academic skills. By adolescence, they usually have good self-care skills—such as eating, dressing, and going to the bathroom—and can perform simple tasks. As adults, most can work at unskilled or semiskilled jobs with supervision.

3. Severe

Severe disability affects 3 to 4% of individuals intellectually disabled. Severely disability individuals may learn to talk during childhood and develop basic self-care skills. In adulthood they can perform simple tasks with close supervision. They often live in group homes or with their families.

4. Profound

About 1 to 2% of disabled people have profound intellectual disability and requires constant care. Profoundly disabled individuals can understand some language, but they have little ability to talk. They often have a neurological condition that accounts for their disability.

Having looked at the different types of intellectual disabilities, what could be some of the causes of intellectual disability?

Here are some of the causes

Causes

1. Genetic conditions
2. Disorders that occur as a fetus develops during pregnancy
3. Problems during or after birth.

Genetic causes

Chromosomal disorders such as Down syndrome. Down syndrome occurs when people inherit all or part of an extra copy of a pair of chromosomes known together as chromosome 21. Although regarded as genetic disorders, chromosomal disorders are not necessarily inherited. Both parents may have normal genes, with the defect resulting from a random error when chromosomes reproduce.

Disorders that occur as a fetus develops during pregnancy

A variety of problems during a woman's pregnancy can cause mental retardation in her child.

a. Malnutrition;
b. Mother use alcohol or drugs;
c. Environmental toxins such as lead and mercury;
d. Viral infections, including rubella (see German Measles) and cytomegalovirus;
e. Untreated diseases such as diabetes mellitus.
f. Fetal alcohol syndrome results from excessive consumption of alcohol during pregnancy, including premature birth, very low birth weight, and stresses to the fetus such as deprivation of oxygen.

Problems that occur during or after birth

a. Infectious diseases during childhood, which are easily preventable through immunization, also can cause mental retardation when they result in complications. For example, measles, chicken pox, and whooping cough may lead to encephalitis and meningitis, which can damage the brain.
b. Physical trauma to the brain can also cause intellectual disability.
c. Brain damage may result from accidental blows to the head,
d. Near drowning,
e. Severe child abuse, and
f. Childhood exposure to such toxins as lead and mercury.
g. Experts believe that poverty and a lack of stimulation during infancy and early childhood can be factors for intellectual disability.
h. Children raised in poor environments are more likely to experience malnutrition, lack of routine medical care, and environmental health hazards.

Management of Children with Intellectual Disabilities (L D) or Intellectual Disability (Mental Retardation)

Provision of care and support should always be within a therapeutic environment or an appropriate setting. Support may be general or specific.

General support

Care is provided by usual care givers who are parents, relatives and sometimes even maids that remain with these children when parents are at work. Other health workers such as physiotherapists and community nurses promote a normal environment by encouraging care to take place at home, integration in cases where the degree of disability is only mild or moderate into mainstream schools; use of local community resources in for instance whatever assets are available in that community that could be used to care for these children such as physiotherapy, meeting in a central accessible point once per week for two hours.

Specific support

Special support addresses particular needs. These needs include Special Education, parental support groups, and maladaptive (abnormal) behaviours. Often, more specialized environments are necessary, if disabilities are too severe to manage with standard community resources. Such disabilities include severe and profound learning disability (LD), severe treatment resistant epilepsy, aggressiveness, co morbid psychiatric disorder, respite placements.

Epilepsy and intellectual disabilities

Epilepsy may occur in people with intellectual Disabilities. It may begin at any age, and multiple forms may occur in the same individual. Frequent epileptic seizures may lead to (or worsen) permanent loss of intellectual functioning (acquired epileptic aphasia), progressive partial seizures.

Treatment

- The neurologist deals with this area and therefore the psychiatrist needs to work with other specialists. Choice of treatment will depend on:
- Accurate classification of the type of seizures or epilepsy
- Possible drug interactions
- Minimizing side effects (esp. cognitive impairment)

Prevention of Intellectual Disability (ID)

- Screening programs for at risk infants and children during under five clinics, ANC and other children's clinic for example in paediatrics, neonatal clinics by nurses and other health workers.
- Adult screening tests can identify carriers of other conditions before couples conceive a child.
- Individuals and couples with a family history of mental retardation can seek genetic counselling to evaluate their own risks and need for screening.
- Specialized laboratory tests, including amniocentesis, can detect down syndrome and other genetic disorders in the early stages of pregnancy.
- Proper prenatal care, avoidance of alcohol and drugs during pregnancy, and routine immunization against measles and other childhood diseases can prevent some forms of retardation. This can be done by nurses working in such settings when these children are brought to ANC and under five clinics.

Now discuss the treatment and care of a child with mental retardation

Treatment and Care

- Some individuals diagnosed with mild mental retardation as children may gradually develop new skills through early intervention and educational services.
- As adults, they may function in everyday life at a level that no longer warrants a diagnosis of retardation.
- All but the most profoundly disability people usually can best develop their full potential by living in the community.
- Most people with mental retardation have the capacity to learn, advance intellectually, develop job and social skills, and become full participants in society. They may marry, have families, and be indistinguishable from other people.
- In order to achieve their potential, mentally retarded children need special education and training, which ideally begins in infancy and continues until they establish an adult role.

What do you think is the role of a nurse in managing a child with intellectual disability?

The role of a nurse in managing children with learning disabilities / mental retardation

Psychological care

When parents realize that their child is not like other children, that is, developing normally, it takes some time to register this in their minds and lives. They go through The Grieving Process. The length of this grieving process may vary depending on the psychological, social and medical support and expertise availed to them.

Absence or lack of inadequate medical expertise, psychological and social support will without any doubt lead to poor care of the child by its caregivers or parents. The child might even be abused, sometimes unknowingly because of the denial, anger and depression that many parents experience. The mentally disabled child will be at risk of being harmed, since it is so vulnerable.

Early identification and intervention

To avoid all these complications the nurse must be alert to quickly identify children with intellectual disability so that they can receive the needed care from a very young age, since the brain has been known to grasp and learn skills better, at a tender age. As a nurse you then need to counsel the mother or care givers and facilitate for available services such as physiotherapy, medical and surgical interventions if needed, special education, and psychosocial support.

A nurse also facilitates any medical and surgical interventions, and provide primary, secondary and tertiary health services to improve the quality of life of children with learning disabilities.

Prevention of intellectual disability

The role of the nurse starts prenatally (before pregnancy) by counselling and giving Information, Education and Communication to would be mothers and fathers to prevent the disorder.

It continues during the antenatal period with measures that foster a healthy pregnancy and normal growth and development of the fetus such as a good diet, treatment of any existing diseases in the mother and avoiding environmental hazards.

In labour, good care such as frequent observations to quickly identify anything that could go wrong thereby causing harm to the fetus.

During delivery the midwife must avoid birth asphyxia and trauma by continued alertness for any delays in labour.

In the postnatal period and during the early years of a child's life nurses and midwifes must ensure that the child receives immunizations from childhood diseases that may lead to brain damage in good time and completes them. Nurses must ensure that other diseases like malaria are prevented and if they occur prompt treatment must be given.

In the period of adolescence we as nurses must ensure that we advise parents and support them in caring for their children because this is the time when they sometimes try to experiment with behaviours that are risky such as substance abuse, use of fire arms, driving their parent's car when they have no license, and wrong sexual practices. These behaviours could put them at risk of accidents and diseases that might damage their brain thereby leading to intellectual disability.

Now let's look at the Psychiatric co morbidity in the learning disability population. You might wonder what this could be. Well, this simply means the psychiatric problems that may be seen in a child with intellectual disability.

Psychiatric co- morbidity in the intellectual disabled population

Abnormal behaviours that occur in the mental retardation population

- Psychiatric disorders occur more frequently in the Intellectual Disability population than the general population. They include:
- Schizophrenia – Symptoms in severe LD include unexplained aggression, bizarre behaviours, mood lability, increased mannerisms and stereotypies.
- Bipolar Affective Disorder – Symptoms include hyperactivity, wandering, mutism, temper tantrums.
- Depressive disorder
- Biological disorders more marked, with diurnal variations. Suicidal thoughts / acts may occur in border line – moderate LD.
- Anxiety disorders, Obsessive Compulsive Disorder, Attention Deficit Hyperactive Disorder, and personality disorder.

Behavioural disorders and 'challenging' behaviour

These are pathological behaviours that are common in the ID population. They create a significant burden for parents / carers. They are as follows:

- Antisocial – shouting, screaming, general noisiness, anal poking/faecal smearing (may reflect constipation), self induced vomiting/choking, stealing.
- Aggressive outbursts – against persons or property
- Self injurious behaviour – skin picking, eye gouging, head banging, face beating (more common in severe/profound LD.
- Social withdrawal
- Stereotypic behaviours (some of which may be injurious)

Hyperactive disruptive behaviours

Repetitive communication disturbance

Anxiety fearfulness

When these behaviours are particularly severe, they are often termed 'challenging'. Management of children with intellectual disability is done while they continue to live in their homes. The best way to care for these children is to allow them to continue to be with their loved ones in a familiar and caring environment. They have to be encouraged to work on their strengths or strong points or activities they are good at, with assistance from their caregivers. Caregivers and parents need a lot of counselling and social support from nurses for such an environment to be achieved.

The role of the nurse in management of children with L.D. is to participate with other members of the Multidisciplinary Team (psychiatrist, clinicians, neurologist, psychologist, sociologist, physiotherapist and surgeon) in delivering and facilitating psychosocial support for both the affected child and his or her care giver, as follows:

Having looked at the role of a Nurse in managing a child with intellectual disabilities, now look at the treatment modalities that can be employed.

Treatment methods

The different types of psychological therapies are administered by psychologists. You will need to read on the different psychological approaches which you covered in psychology in nursing to understand them better. However, the nurse should involve herself by ensuring that patients receive treatments prescribed, and participate in the simpler ones such as the behavioural and cognitive ones. These treatments work for children with mild and moderate intellectual disability because they are able to think and reason fairly well.

Behavioural treatments: Based on operant conditioning. Behaviour may be shaped towards the desired final modification through the rewarding of small, achievable intermediate steps. In school good behaviour can be rewarded with material items, privileges and 'star' charts, when a certain level is achieved.

- May be used to help teach basic skills (feeding, dressing, toileting),
- Establish normal behaviour patterns (sleep), or more complex skills (social skills, relaxation techniques, assertive training).

- May also be used to alter maladaptive patterns of behaviour (inappropriate sexual behaviour, phobia)

Cognitive Therapy

You will remember cognitive therapy from the different psychological theories that you covered in Psychology of Nursing (read and revise). Cognitions are thoughts or thinking patterns. These thinking patterns can become negative. For example the child begins to think that they are not good enough to be alive, or that they cannot achieve anything in life, leading to poor self esteem, anxiety and depression.

Cognitive therapy is treatment that is targeted at changing the negative thoughts and replacing them with thoughts that increase the self esteem (self respect) of a person. When self esteem is increased the behaviour will also improve and feelings of anger will be dealt with. This means that in the case of children with borderline, mild or moderate LD, cognitive approaches may be adapted for teaching of:

- Problem solving skills
- Management of anxiety disorders
- Depression,
- Dealing with issues of self esteem,
- Anger management, and
- Treatment of offending behaviours (for example, sex offenders).

Psychodynamic therapies

Psychoanalysis is helpful in addressing issues of emotional development, relationships, and adjustments to life events (losses, disabilities, and bereavements). They range from basic supportive psychotherapy, to more complex group and family therapies. In psychoanalysis the therapist uses probing and open ended questions to bring out hidden feelings that are the cause of abnormal behaviour from the subconscious mind of a client. Such feelings originate from early traumatic childhood experiences. Once they are brought to awareness with the help of the counsellor or therapist ways can be found to resolve them.

Pharmacological treatments – add drugs commonly used in the presence of epilepsy and other disorders that coexist with ID

Drugs used in treatment of epilepsy

Please check with your pharmacology notes on the actual names of the drugs, side effects, dosages, actions and nursing implications.

- For children that need medications the nurse must ensure that they are reviewed regularly to supply drugs and observe any side effects. Co morbid physical disorders (epilepsy, constipation, cerebral palsy) increase the need to monitor side effects.

- Antipsychotics

- Used to treat co morbid psychiatric disorders and acute behavioural disturbance, autistic disorders, self injury, social withdrawal, ADHD – Attention Deficit Hyperactive Disorders and tic disorders.

- Antidepressants

- Effective in depression, OCD – Obsessive Compulsive Disorder, anxiety disorders, violence, self injury, 'non specific' distress.
- Anticonvulsants -For underlying epilepsy and in episodes of difficulty in controlling movements.

Summary

Children with mental retardation are prone to developing behavioural disorders, and psychiatric problems. Nurses must be observant so that when the need arises they are managed in the community using different psychological approaches and medication and if the condition worsens admission may be needed for further management.

Self Assessment questions - write whether true or False

1. Define Mental Retardation - This is when children are not taken to school – T/F

2. Mention some of the predisposing factors of Mental Retardation? Eating too much, having a different blood group from the husband – T/F

3. Explain what you understand by the word intelligence quotient – These are valid measures of the kind of intelligence required to perform academic tasks –T/F

4 How can mental Retardation be prevented in the community? – By attending antenatal clinic, giving birth in hospital by qualified people, having a balanced diet –T/F

Compare your answers with the ones below after you have finished writing – good luck.

Answers

1 – F

2. – F

3 –T

4 – T

4.4 Attention Deficit Hyperactivity Disorder.

Attention deficit or hyperactivity disorder (ADHD) is characterized by a developmentally inappropriate poor attention span of ageinappropriate features of hyperactivity and impulsivity or both. Hyperkinetic disorders are several times more frequent in boys than in girls. The characteristic behavioural problems should be of early onset.

Diagnostic Guidelines

The cardinal features are impaired attention and over activity, both are necessary for the diagnosis and should be evident in more than one situation

Impaired attention is manifested by primarily breaking off from tasks and learning activities unfinished.

Over activity implies excessive restlessness, especially in situations requiring relative calm. They are often reckless and impulsive, prone to accidents and find themselves in disciplinary trouble because of unthinking breaches of rules.

The standard of judgement should be that the attention deficit and activity is excessive in the context of what is expected and by comparison with other children of same age and IQ.

Clinical Management

Once the diagnosis has been communicated and psycho-education given, this usually involves a combination of medication and behavioural management. It is important to assess the impact of the condition on the child, family and school, to provide basic counselling, and to advise on local resources.

Pharmacology – The most widely used medication is the psychostimulant methylphenidate (Ritalin). This is given in a single morning dose or a divided dose at morning and midday. This is because it is short-acting, it may interfere with sleep and it may severely inhibit appetite if given throughout the day. The usual starting is 5 mg increasing weekly until marked behavioural improvement. For those who do not respond to this drug, antidepressants for example, Imipramine 25-100 mg at night is the most common regime.

Non pharmacological – Psychotherapy aims to support the parents in their long-term task of applying effective behaviour control without rejecting the child, and to help them devise strategies to modify undesired behaviour, by using positive reinforcement and other techniques.

Summary –The basic deficit is difficulty in focusing and maintaining attention. There is hyperactivity and impulsivity. They are easily distracted, difficulty in following instructions, difficulty in sustaining attention during tasks, shifting attention from one uncompleted activity to another, not listening, and losing things**.**

4.5 Summary

4.6 Self Assessment Test

Indicate whether True or False

1. Hyperkinetic disorders are several times more frequent in boys than girls – T/F

2. Antidepressants can be used to reduce restlessness in children with hyperkinetic disorders –T/F

3. Parental counselling cannot do much in helping these children –T/F

4. The children with hyperkinetic disorder are often reckless but not impulsive - T/F

Answers

1. True

2. True

3. False

4. False

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UNIT 5: NURSING MANAGEMENT OF A CLIENT WITH PSYCHIATRIC EMERGENCY

5.1 Introduction

Welcome to unit 5. This unit looks at clients with psychiatric emergencies and how they can be managed. You will meet clients with psychiatric emergencies in almost all health facility settings regardless of what services they offer. Some of the conditions discussed under Unit 3 may present in a form that calls for an emergency response in terms of management and treatment.

Psychiatric emergencies encompass situations in which an individual cannot refrain from acting in a manner that is dangerous to himself or herself or to others. The patient may be aware of the danger his behaviour poses (as with an overdose with the intent to die) or he may lack insight into the effects of his actions (as in the case of a manic patient who engages in reckless sexual behaviour). Even if the patient perceives that his actions are dangerous, he may be bent on engaging in these behaviours despite the risks. (A patient with schizophrenia who follows command hallucinations to commit theft is an example). Because of their lack of insight and judgment, patients in psychiatric emergencies are often brought to the attention of medical professionals by people in the community, including friends, family, police officers, or even bystanders.

You may also recognize psychiatric emergencies during routine outpatient care. Patients may report their inability to remain safe, either spontaneously or as established by yourself or a psychiatrist. In this unit, we will define what constitutes psychiatric emergencies, identify common psychiatric emergencies, outline the process of assessing patients with psychiatric emergencies, and finally describe the management of psychiatric emergencies.

5.2 Objectives

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

1 Define psychiatric emergencies
2. Describe the management suicidal attempts
3 Describe the management of aggressive patients
4. Describe the management of alcohol intoxication
5 Describe the management of drug poisoning
6. Describe the management of drug and substance abuse

5.3 Definition of psychiatric emergencies

Psychiatric emergencies are situations that require immediate attention for an acute psychiatric problem that could lead to a serious outcome, such as self-harm or violence.

Activity

Now try to come up with a list of situations that may present as an emergency to a nurse in a Mental health unit, ward or hospital?

Well done! I am sure you had various answers. Now look at the following:

5.4 Suicidal Attempts

A failed suicide attempt (Latin: tentamen suicidii), or nonfatal suicide attempt, is a suicide attempt from which the actor survived. (Wikipedia.org/wiki/failure suicide).

Attempted suicide is a serious situation. Suicide attempts are usually categorized into two groups: those who intend to take their lives and wish to die; and those who make impulsive suicide gestures or harm themselves deliberately. The latter attempts are categorized as parasuicide, but it is important for you to remember that both groups are at serious risk for completing suicide with any future attempt.

Risk factors for suicide

Demographic Factors

- Males have a higher rate of completed suicide than females
- Older people are at a higher risk for completed suicide than those of a younger age
- Completed suicide is much more likely to take place in the two opposites between the rich and privileged and the poor and underprivileged.
- Some occupations with easier access to the means for completing suicide such as doctors, policemen are more at risk

Biomedical factors

- People with serious physical illnesses are more at risk for suicide than others because of the pain and anguish they have to endure over longer periods of time.
- Some people may be biologically disposed to the risk for suicide

Psychiatric factors

- Suicide ideas are more common in people who are depressed
- Abuse of alcohol and other psychotropic drugs may impair a person's judgment in terms of controlling impulsive and risky behaviour.
- People with major mental illnesses such as Schizophrenia and Mania are also at greater risk for suicide because of the 'commanding voices' or hallucinations that may be experienced in the course of the illness and as a result of impulsive and risky behaviour seen in manic patients.

Psychosocial factors

- Individuals with personality disorders such as borderline personality traits are more at risk for suicide

- A history of previous suicide attempt or history of suicide indicates a higher risk
- Stressful life events such as the loss of a loved one, unemployment, divorce among others may predispose someone to suicide attempt.

Assessment of suicide risk

It is important to make a thorough assessment of the individual who has made a suicide attempt in order identify whether the patient is at imminent risk for a further attempt. Information about risk factors needs to be obtained and documented for every patient attempting suicide, regardless of whether the attempt was potentially lethal or not.

Following a suicide attempt, it is important to interview family as well as close friends and others if appropriate in order to obtain comprehensive information leading to the attempt as well as verifying the accuracy of the patient's story.

After a suicide attempt, the following information needs to be obtained in order to establish whether the patient is in imminent danger of a further attempt:

- Did the patient's wish to die?
- Was the attempt premeditated or planned?
- Was the attempt hidden from others and undertaken in a place where the individual was unlikely to be found?
- Had the patient put their affair in order in preparation for death (for example, made a will)?
- Did the patient communicate an intention to die before the attempt, or leave a note?
- Was the patient under the influence of drugs or alcohol at the time of the attempt

Note that a positive response to any of these questions is indicative of high risk for a further attempt, and the patient will require urgent hospitalization.

Management of Suicide attempt

Patients who are evaluated to be at high risk for further suicide behaviour must be admitted to a psychiatric hospital immediately. Hospitalization of the actively suicidal patient is usually accomplished by means of an involuntary admission procedure. This empowers the doctor to transfer a severely mentally ill patient to a psychiatric hospital under the Mental Health Act of 1951 (see Unit 6). Once in hospital, a decision is made as whether the patient will need containment in a closed ward facility in order to ensure a safe environment while actively suicidal.

It is important to provide ongoing supportive counselling for any patient who makes a suicide attempt in a crisis situation. Regular counselling sessions provide an opportunity to review the mental state and risk of suicide, and to support the patient through a stressful period. If there is concern about a possible further attempt, it is important to come up with an agreement or contract with the patient stating that the patient will

not carry out any suicidal act, and will contact the named caregiver or nurse in the event of feeling desperate and suicidal. This contract is binding on both parties where the patient undertakes to seek constructive help when in despair, and the nurse is committed to providing the appropriate support.

The patient will be closely monitored in terms of behaviour that may be indicative of intent to commit self-harm. With the patient's permission and where appropriate, the involvement of close family members may be helpful in monitoring and supporting the patient.

If the patient is assessed as depressed or anxious, it will be necessary to administer prescribed anxiolytic medication and antidepressants to alleviate the distressing symptoms.

Self-assessment questions

Indicate whether the statements below are TRUE or FALSE.

1. Males are more likely than females to commit suicide.
2. The rate of suicide attempts is lower in the elderly.
3. 'No Harm' contracts can be an effective way to reduce the risk of suicide in a patient.
4. Risk factors for attempted suicide in the elderly DO NOT include living with a spouse
5. A history of previous suicide attempt or history of suicide DOES NOT indicate a higher risk

Answers to the questions

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

5.5 Aggressive Patients

Aggression arises from an innate drive or occurs as a defence mechanism and is manifested either by constructive or destructive acts directly towards self or others. Aggressive people ignore the rights of other people. They must fight for their own interests and they expect same from others. An aggressive approach to life may lead to physical or verbal violence. The aggressive behaviour often covers a basic lack of self-confidence. Aggressive people enhance to their self-esteem by overpowering others and there by proving their superiority. They try to cover up their insecurities and vulnerabilities by acting aggressive.

Meaning

Anger: Anger is defined as a strong uncomfortable emotional response to provocation that is unwanted and incongruent with one's values, beliefs or rights.

Aggression: Aggression refers to behaviour that is intended to cause harm or pain. Aggression can be either physical or verbal.

Characteristics of aggressive behaviour

- Aggressive behaviour is communicated verbally or non-verbally

- Aggressive people may invade the personal space of others
- They may speak loudly and with greater emphasis
- They usually maintain eye contact over a prolonged period of time so that the other person experiences it as an intrusive
- Gestures may be emphatic and often seem threatening. (For example they may point their figure, shake their fists, stamp their feet or make slashing motion with their hands)
- Posture is erect and often aggressive people lean forward slightly towards the other person. The overall impression is one of power and dominance

Types of aggression

Instrumental aggression -- Aggression aimed at obtaining an object, privilege or space with no deliberate intent to harm another person

Hostile aggression -- Aggression intended to harm another person, such as hitting, kicking, or threatening to beat up someone.

Relational aggression -- A form of hostile aggression that does damage to another's peer relationships, as in social exclusion or rumour spreading.

Predisposing factors to aggressive behaviour

Genetic factors

- Aggressive behaviour is more likely to be inherited and as such it is considered as being familial.
- Chromosomal influences: XYY syndrome contributes to aggressive behaviour. The person with this syndrome is tall, below average intelligence and likely to be in conflict with the law.

Neurophysiological disorders

Epilepsy of temporal lobe and frontal lobe origin results in episodic aggression and violent behaviour. Tumours in the brain, particularly in the areas of the limbic system and the temporal lobe, trauma to the brain, resulting in cerebral changes and the disease such as encephalitis have been implicated in the predisposition to aggression and violent behaviour.

Psychological factors

Intrinsic behaviours

Freud's view:

Sigmund Freud held the view that all human behaviour stems either directly or indirectly from two instincts. In this frame work, aggression was viewed simply as a reaction to blocking or thwarting of libidinal impulses

and was neither an automatic nor an inevitable part of life. Thus according to him, aggression primarily stems from the redirection of the self-destructive death instinct away from the self and towards others.

Learned behaviour

According to learning theory, aggression is primarily a learned form of social behaviour. The learning of aggressive behaviour occurs by observation and modelling. For example, a child watches an angry parent strikes out another person. Learning aggressive behaviour also takes place by direct experiences. The person feels anger and behaves aggressively. If behaving aggressively brings rewards, the behaviour is encouraged.

Social factors

Frustration: The single most potent means of inciting human beings to aggression is frustration. This hypothesis indicated that frustration always leads to a form of aggression and that aggression always stem from frustration. However, frustrated persons do not always respond with aggressive thoughts and words, or deeds. They may show a wide variety of reactions ranging from resignation, depression and despair to attempts to overcome the sources of frustration.

Direct provocation: Evidence indicates that physical abuse and verbal taunts from others often elicit aggressive actions.

Observational learning: in this case, observers acquire new means of harming others not previously present in their behaviour

Disinhibition: A person's restraint or inhibition against performing aggressive action is weakened as a result of observing others engaging in such behaviour

Environmental factors

Noise: several studies have reported that persons exposed to loud, irritating noise direct stronger assaults against others than those not exposed to such environmental.

Activity

Using your personal experiences or experiences of people you know or know of, write down any examples you can think of that represent

a) instinct based aggression

b) frustration-based aggression

c) social learning experiences of aggression

Well done! I am sure you could come up with even more of such examples. Now go back to look at predisposing factors and compare your examples and what the explanations above state.

Nursing management of aggression

As you may be aware nurses provide care for patients with many types of problems; people who enter the health care system are often in great distress and exhibit many maladaptive coping responses. Nurses who work in the setting such as emergency rooms, critical care areas and acute psychiatric wards often care for people who respond to events with anger and aggressive behaviour that can pose a significant risk to themselves, other patients and health care providers. Thus preventing and managing behaviour are important skills for all nurses to have.

General Principles of Management

- The safety of patient, clinician, staff, other patients and potential intended victims is of most importance while looking after aggressive patients
- The doors should be open outwards and not be lockable from inside or capable of being blocked from inside.
- While working with impulsively aggressive or violent patients in any setting one must take care to reduce accessibility to patients of movable (harmful) objects as well as jewellery and other attire that might add to the risk of injury during an assault, including neckties, necklaces, earrings, eyeglasses, lamps and pens.
- Adequate nurse training and the availability of appropriate supervision are critical safeguards in the treatment of potentially dangerous patients.
- The nurse may choose to communicate a few key observations in a calm and firm but respectful manner, putting space between self and patient; avoiding physical or verbal threats, false promises and build rapport with client.
- For nurse treating patients with a high risk for violence behaviour, training in basic self defence techniques and physical restraint techniques are useful.

Drug Treatment in Aggressive and Violent Behaviours

Careful diagnosis has to be made to avoid overuse and misuse of medication. Medications are used primarily for 2 purposes-

- To use sedating medication in an acute situation to calm the client so that client will not harm self or others.
- To use medication to treat chronic aggressive behaviour.

Factors influencing choice of drug are: availability of an IM injection; speed of onset; and previous history of response.

Acute agitation and aggression

Antipsychotic medication –often it is the sedating property of antipsychotic medication that produce the calming effect for the client. Atypical antipsychotic are also commonly used. But only Ziprasidone is available in intramuscular form.

Haloperidol-1 mg or 0.5 mg IM

Risperidone 0.5mg-1mg- In dementia and schizophrenia.

Trazodone – 50-100mg in older clients with sun downing syndrome and aggression.

Benzodiazepines- used due to the sedative effect and rapid action. Most commonly lorazepam, oral or injection. Other sedating agents used include Valproate, chloral hydrate and diphenhydramine.

Self-Assessment questions

You are required to answer the following multiple choice questions below by circling the most appropriate answer

1. Hitting, kicking, spitting, and verbal 'cuts' are all signs of

   A. Assertiveness

   B. Disappointment

   C. Aggression

   D. Annoyance

2. Which theory of aggression argues that the blocking of one's goals will lead to aggressive behaviour because of anger and hostility?

   A. Instinct theory

   B. The frustration theory

   C. Social learning theory

   D. The Catharsis theory

3. Peter is a school-going teenager who likes to threaten his school mates for the purpose of obtaining favours from them, but in reality, he does not intend to engage into a fight. What type of aggression is this?

   A. Instrumental aggression

   B. Hostile aggression

   C. Relational aggression

   D. Beneficial Aggression

Answers:

1. C, 2. B 3. A

5.6 Depressed Patient

Remember you learnt about depression in full under unit 3. As a reminder to you, it can be defined as a state of low mood and loss of interest in most normally interesting activities that can affect a person's thoughts, behaviour, feelings and sense of well-being. Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless.

Apart from presenting as suicide/suicide attempt and or agitation, the severely depressed patients may come to the emergency unit because of refusal to eat and drink, leading to dehydration which in turn may lead to physical illness or death. Therefore severely depressed patients are sometimes considered to be part of psychiatric emergencies.

Activity

Go back to unit 3 where you learnt about depression and list down some of the symptoms of depression that you think can pose a danger to the patient's life?

Good! Now compare what you have listed down and the following conditions in depression which are discussed under nursing care management below.

Management of Depression in an Emergency

Suicide Ideation

In order to have understanding of the management of severely depressed patients with suicidal ideas, you are requested to revisit the notes on suicide attempts under unit 5.1.

Patient in a Depressive Stupor

In an emergency situation, the general aspect of the patient's symptomatology is not the main focus of the care, but the worry of patient starving or being dehydrated to death due to refusal to eat or drink. In this regard, nursing care will focus on interventions that will encourage the patient to eat and drink such as persuasion of patient through a well-established nurse-patient relationship or giving of fluids through intravenous line in extremely weak patients. The idea is to replace fluids and boost energy levels in the patient**.**

Self-assessment questions

Indicate whether the statements below are true or false.

1. suicide attempt in depression does not present as an emergency

    A. true

    B. false

2. depression does not affect a person's interest in life activities

A. true

B. false

Answers: 1. False 2. False

5.7 Alcohol Intoxication

When someone binge drinks or takes in a lot of alcohol in a short amount of time, their blood alcohol level becomes very high that it becomes toxic; therefore developing alcohol toxicity or poisoning. Alcohol intoxication is when a person becomes disoriented, unresponsive, extremely confused, shallow breathing, and can perhaps pass out or go into a coma. Alcohol intoxication or poisoning is life-threatening when not treated urgently.

A common cause of alcohol poisoning is binge drinking. Although less common, it also occurs when somebody drinks household products containing alcohol.

When alcohol is consumed it is filtered through the liver from the bloodstream. Alcohol is absorbed a lot faster into the bloodstream than food. The liver is only able to process a limited amount. In fact, only one unit of alcohol every hour is processed through the liver. Whenever there is more than one unit consumed within an hour means that there are extra units of alcohol in the bloodstream. The faster someone drinks, the higher their blood alcohol concentration (BAC) becomes.

Rapid drinking subsequently elevates BAC, both physical and mental tasks become harmfully affected. Breathing, heartbeat and gag reflex are some of the reactions to elevated BAC. Someone may choke, be unable to breath, and develop heart arrhythmia. These vital physical functions can cease performance and someone can stop breathing and lose consciousness (passes out).

The population at highest risk of developing alcohol poisoning are college students, chronic alcoholics, people on medication that contraindicate with alcohol, adolescents experimenting and accidental consumption from younger children on household products.

Activity

Using your personal experiences or experiences of people you know or know of, write down any signs and symptoms of a person who has ingested (taken in) alcohol.

Well done! Now go on and compare your listed signs and symptoms with what has been stated below to see if at all those experiences were in fact alcohol intoxication.

Alcohol intoxication Symptoms

BAC continues to rise up to a half an hour and forty minutes after someone's last drink which can make symptoms worse.

The following are symptoms of alcohol intoxication:

- Major decrease in reaction time or no reactions
- Loss of consciousness or deep sleep
- Problems with breathing
- Weak pulse
- Repeated vomiting
- Excessive sweating
- Skin that is moist or cold to the touch (hypothermia)

Assessment

Detection of suspected alcohol intoxication can be informed by:

- Direct communication - the person informs staff that they have been using alcohol
- Through observation of the person for example, smells of alcohol, disinhibited behaviour, and slurred speech.
- Where available, an alcohol meter must always be used to confirm alcohol use (patient compliance allowing) followed by periodic use of an alcohol meter to establish on going alcohol breath level. The reading will give an accurate indication of alcohol breath level

Take Note:
The use of an alcoholmeter aid the confirmation of alcohol NOT the level of intoxication.

Management of a patient with alcohol intoxication

In more severe cases of alcohol poisoning the following can occur: choking on one's own vomit, breathing stops completely or a heart attack. Hypothermia also becomes dangerous as there's risk of brain damage. Also dangerous are when there are fits or seizures which happen when blood glucose levels drop to low levels. Extreme cases of alcohol poisoning are coma, sometimes leading to death.

Once a patient has been admitted to the hospital for alcohol poisoning, the medical team may only monitor them until alcohol levels have dropped. An airway or tube may be inserted into the windpipe to help with breathing. They also may have an I.V. drip to assist with hydration and blood glucose and vitamin levels. Catheters are given to those that have become incontinent. In severe cases where BAC levels are very high and symptoms are severe their stomach may be pumped out. Stomach pumping consists of fluids being flushed through a nasal-gastric tube that goes down their mouth or nose.

5.8 Drug Poisoning

Before we look at the actual definition, undertake the following activity;

Activity

What comes to your mind in terms of the meaning of drug poisoning?

Well done and quite interesting! Now go on to look at the definition below:

Drug poisoning or intoxication is a condition that follows the use of psychoactive substances or drugs of abuse such as heroin, cocaine and many others and results in a disturbance of levels of consciousness, impaired cognition (thought process), altered perception and behavioural changes and other changes to psycho-physiological functions and responses (ICD 10). This occurs because of the acute pharmacological effect of the substance.

It is important for you to note that the state of intoxication will resolve in time with complete recovery. However, there are complications/risks associated with the intoxicated state such as trauma, inhalation of vomitus, coma, and if these are not properly managed, may result in longer-term complications or possibly death.

Assessment

Detection of suspected intoxication can be informed by:

- Direct communication - the person informs staff that they have been using illicit substances
- Through observation of the person for example, Disinhibited behaviour, and slurred speech.
- An examination of the patient's mental health should systematically aid the detection of the presence of signs indicative of acute poisoning or intoxication.
- The use of urine 'dip sticks' according to manufacturer's instructions should detect substance use.

A urine test may give an indication of the drug / drugs the person has taken in the last 7 days but not the level of poisoning or intoxication.

If intoxication is confirmed, or continues to be suspected in a patient who has denied use, the nurse should aim to collect the following information:

- Type and amount of substance(s) used and by which route
- Time frame for example, all at once, over a specific time period, last ingestion/injection

- If not known, the patient's relevant medical history including alcohol and/or substance misuse. Information may need to be gathered from other services/agencies.

- Prescribed and non-prescribed medication used by the patient including amounts taken.

Management of drug poisoning (intoxication)

1. The primary goal of management of confirmed drug intoxication (or suspected drug use; in cases where no other cause for the patient's presentation has been found) is to ensure the patient's safety whilst the effect of the substance taken remains in the body.

2. The level of intoxication is on a continuum from mild to life threatening.

Take Note

The nurse must always be vigilant to the fact that the level of intoxication may continue to rise after cessation of use (for a specific time-frame based on the substance(s) taken and when last taken). Therefore monitoring will be required over a period of time.

3. If concerns are raised due to the patient presenting with complications of intoxication, for example, trauma, marked perceptual distortion, altered states of consciousness and/or an acute confusion then medical assistance must be sought.

- Specific attention must be given to consciousness levels and it is vital that this is assessed accurately as a decreased level of consciousness can occur in intoxication.

- Monitoring requirements will be informed by the individuals presenting condition, however, as a minimum these must be carried out half hourly initially and then hourly until it is confirmed by clinical judgment.

- Where there is presence of potential increased risk factors associated with illicit drug use, extra vigilance is required for example, patients who have injected themselves with substances such as heroin (the injecting of a drug makes it most pharmacologically accessible and hence an increased risk).

- Where there is a history of using illicit drugs and now prescribed concurrent drugs that depress the central nervous system for example, methadone, benzodiazepines. Benzodiazepines can cause respiratory depression and this effect can be increased when combined with drugs of abuse.

4. If it is deemed a medical emergency for example, cardiac arrest, then institutional emergency procedures must be initiated immediately.

Self Test questions

You are required to answer the following multiple choice questions below by circling the most appropriate answer

1. Binge drinking can lead to which of the following?

   A. Extreme intoxication

   B. Unconsciousness

   C. Alcohol poisoning

   D. All the above

2. Which factor influences how quickly your body absorbs alcohol?

   A. The alcohol concentration in your drink

   B. The amount of alcohol consumed

   C. The amount of food in your stomach.

   D. All of the above

3. A drinker's Blood Alcohol Concentration (BAC) depends on all but which of the following factors?

   A. Weight

   B. Height

   C. Body Fat

   D. Water content in body tissues

4. The excessive use of alcohol that interferes with work, school, or personal relationships or that entails violations of the law is called:

   A. Alcohol abuse

   B. Binge drinking

   C. Alcoholism

   D. Both a and c

5. Problems associated with long-term, habitual use of alcohol include:

   A. Diseases of the nervous system

   B. Diseases of the cardiovascular system

   C. Diseases of the liver

   D. All of the above

Answers

1. D 2. D 3.D 4.D 5.D

5.9 Drug and substance abuse

Drug abuse, also called substance abuse or chemical abuse, is a disorder that is characterized by a destructive pattern of using a substance that leads to significant problems or distress (American Psychiatric Association, 2000).

Activity

List down names of some drugs that are commonly abused in your area and elsewhere

Well done! I am sure you had several other names in mind. Now look at some of the commonly used drugs stated below:

Commonly abused drugs

Virtually any substance whose ingestion can result in a euphoric ('high') feeling can be abused. While you may be aware of the abuse of legal substances like alcohol or illegal drugs like marijuana and cocaine, less well known is the fact that inhalants like household cleaners are some of the most commonly abused substances. The following are many of the drugs and types of drugs that are commonly abused and/or result in dependence:

Alcohol: Although legal, alcohol is a toxic substance, particularly to a developing fetus when a mother consumes this drug during pregnancy. One of the most common addictions, alcoholism can have devastating effects on the alcoholic individual's physical health, as well as his or her ability to function interpersonally and at work.

Amphetamines: This group of drugs comes in many forms, from prescription medications like methylphenidate (ritalin, concerta) and dextroamphetamine and amphetamine (adderall) to illegally manufactured drugs like methamphetamine ('crystal meth'). Overdose of any of these substances can result in seizure and death.

Anabolic steroids: A group of substances abused by bodybuilders and other athletes, this group of drugs can lead to terrible psychological effects like aggression and paranoia, as well as devastating long-term physical effects like infertility and organ failure.

Caffeine: While it is consumed by many in form of coffee, tea and soda drinkers, when consumed in excess this substance can be habit forming and produce palpitations, insomnia, tremors, and significant anxiety.

Cannabis: More commonly called marijuana; the scientific name for cannabis is tetrahydrocannabinol (THC). In addition to the negative effects the drug itself can produce (for example, infertility, paranoia, lack of motivation). A drug that tends to stimulate the nervous system, cocaine can be snorted in powder form, smoked when in the form of rocks ('crack' cocaine), or injected when made into a liquid.

Ecstasy: Also called MDMA to denote its chemical composition (methylenedioxymethamphetamine), this drug tends to create a sense of euphoria and an expansive love or desire to nurture others. In overdose, it can increase body temperature to the point of being fatal.

Hallucinogens: Examples include LSD and mescaline, as well as naturally occurring hallucinogens like certain mushrooms. These drugs can be dangerous in their ability to alter the perceptions of the user. For example, a person who is intoxicated with a hallucinogen may perceive danger where there is none and to think that situations that are truly dangerous are not. Those misperceptions can result in dangerous behaviours (like jumping out of a window because the individual thinks they are riding on an elephant that can fly).

Inhalants: One of the most commonly abused group of substances due to its accessibility, inhalants are usually contained in household cleaners, like ammonia, bleach, and other substances that emit fumes. Brain damage, even to the point of death, can result from using an inhalant just once or over the course of time, depending on the individual.

Nicotine: The addictive substance found in cigarettes, nicotine is actually one of the most addictive substances that exist. In fact, nicotine addiction is often compared to the intense addictiveness associated with opiates like heroin.

Opiates: This group is also called narcotics and includes drugs like heroin, codeine, hydrocodone, morphine, methadone, vicodin, oxycontin, percocet, and percodan. This group of substances sharply decreases the functioning of the nervous system.

Phencyclidine: Commonly referred to as PCP, this drug can cause the user to feel extremely paranoid, become quite aggressive and to have an unusual amount of physical strength. This can make the individual quite dangerous to others.

Sedative, hypnotic, or antianxiety drugs: As these substances quell or depress the nervous system, they can cause death by respiratory arrest of the person who either uses these drugs in overdose or who mixes one or more of these drugs with another nervous system depressant drug (like alcohol, another sedative drug, or an opiate).

Psychological effects of drug abuse

While the specific physical and psychological effects of drug abuse and addiction tend to vary based on the particular substance involved, the general effects of abuse or addiction to any drug can be devastating. Psychologically, intoxication with or withdrawal from a substance can cause everything from euphoria as with alcohol, Ecstasy, or inhalant intoxication, to paranoia with marijuana or steroid intoxication, to severe depression or suicidal thoughts with cocaine or amphetamine withdrawal.

Causes and risk factors for drug abuse

Like the majority of other mental-health problems, drug abuse and addiction have no single cause. However, there are a number of biological, psychological, and social factors, called risk factors that can

increase a person's likelihood of developing a chemical-abuse or chemical-dependency disorder. The frequency to which substance-abuse disorders occur within some families seems to be higher than could be explained by an addictive environment of the family. Therefore, most substance-abuse professionals recognize a genetic aspect to the risk of drug addiction.

Psychological associations with substance abuse or addiction include mood disorders like depression, anxiety, or bipolar disorder, thought disorders like schizophrenia, as well as personality disorders like antisocial personality disorder. Social risk factors for drug abuse and addiction include male gender, being between 18 and 44 years of age, unmarried marital status, and lower socioeconomic status.

Signs and symptoms of drug abuse

- Recurrent drug use that results in a lack of meeting important obligations at work, school, or home
- Recurrent drug use in situations that can be dangerous
- Recurrent legal problems as a result of drug use
- Continued drug use despite continued or repeated social or relationship problems as a result of the drug's effects

Diagnosing drug abuse

In order to be diagnosed with a drug addiction, an individual must exhibit a destructive pattern of drug abuse that leads to significant problems as manifested by at least three of the following signs or symptoms in the same one-year period:

- Tolerance is either a markedly decreased effect of the substance or a need to significantly increase the amount of the substance used in order to achieve the same high or other desired effects.
- Withdrawal is defined as either physical or psychological signs or symptoms consistent with withdrawal from a specific drug, or taking that drug or one chemically close to that drug in order to avoid developing symptoms of withdrawal.
- Larger amounts of the drug are taken or for longer than intended.
- The individual experiences a persistent desire to take the drug or has unsuccessful attempts to decrease or control the substance use.
- Significant amounts of time are spent getting, using, or recovering from the effects of the substance.
- The individual significantly reduces or stops participating in important social, recreational, work, or school activities as a result of using the substance.
- The individual continues to use the substance despite being aware that he or she suffers from ongoing or recurring physical or psychological problems that are caused or worsened by the use of the drug

Management of drug abuse

The primary goals of drug-abuse or addiction treatment (also called recovery) are abstinence, relapse prevention, and rehabilitation. During the initial stage of abstinence, an individual who suffers from drug or chemical dependency may need help avoiding or lessening the effects of withdrawal. That process is called detoxification or 'detox.' That aspect of treatment is usually performed in a hospital or other inpatient setting, where medications used to lessen withdrawal symptoms and frequent medical monitoring can be provided. The medications used for detoxification are determined by the substance the individual is dependent upon. For example, people with alcohol dependence might receive medications like anti-anxiety (benzodiazepines) or blood pressure medications to decrease palpitations and blood pressure, or seizure medications to prevent possible seizures during the detoxification process.

For many drugs of abuse, the detoxification process is the most difficult aspect of coping with the physical symptoms of addiction and tends to last days to a few weeks. Medications that are sometimes used to help addicted individuals abstain from drug use long term also depend on the specific drug of addiction. For example, individuals who are addicted to narcotics like Percodan (a combination of aspirin and oxycodone hydrochloride) heroin or vicodin) often benefit from receiving longer-acting, less addictive narcotic-like substances like methadone (methadose). People with alcohol addiction might try to avoid alcohol intake by taking disulfiram (antabuse), which produces nausea, stomach cramping, and vomiting when the individual consumes alcohol.

Often, much more challenging and time consuming than recovery from the physical aspects of addiction is psychological addiction. For people who may have less severe drug dependency, the symptoms of psychological addiction may be able to be managed in an outpatient treatment program. However, those who have a more severe addiction have relapsed after participation in outpatient programs, or who also suffer from a severe mental illness might need the higher structure, support, and monitoring provided in an inpatient drug treatment rehabilitation centre, Following such inpatient treatment, many people with this level of addiction can benefit from living in a sober living community, that is, a group-home setting where counsellors provide continued sobriety support and structure on a daily basis.

Also important in the treatment of addiction is helping the parents, other family members, and friends of the addicted person refrain from supporting addictive behaviours (codependency). Whether providing financial support, making excuses or failing to acknowledge the addictive behaviours of the addict, discouraging such codependency of loved ones is a key component to the recovery of the affected individual. A focus on the addicted person's role in the family becomes perhaps even more acute when that person is a child or teenager, given that minors come within the context of a family in nearly every instance.

Complications of drug addiction

Drug addiction puts its sufferers at risk for potentially grave social, occupational, and medical complications. Drug addiction increases the risk of domestic violence in families. Individuals with chemical dependency are also much more likely to lose their job and less likely to find a job compared to people who are not drug addicted. Children of drug addicted parents are at higher risk for poor social, educational, and health functioning, as well as being at higher risk for abusing drugs themselves.

In addition to the many devastating social and occupational complications of drug addiction, there are many medical complications of chemical dependency. From the respiratory arrest associated with heroin or

sedative overdose to the heart attack or stroke that can be caused by cocaine or amphetamine intoxication, death is a highly possible complication of drug addiction.

5.10 Summary

Psychiatric emergencies are conditions in mental health practice that present with an urgent need for intervention because of the high risk for self-harm, harm to others and sometimes death. In general psychiatric emergencies constitute a number of psychiatric and mental health conditions ranging from: Suicide attempts, patients with conditions that present with aggression, depressed individuals especially ones with suicide ideas and those who cannot eat or drink anything as a result of the severity of the condition, drug, and alcohol intoxication. Patients may be aware of the danger their behaviour poses (as with an overdose with the intent to die) or they may lack insight into the effects of their actions. Patients in psychiatric emergencies are often brought to the attention of medical professionals by community members because of their impaired insight and judgment.

The goal of management of psychiatric emergencies is to ensure safety of the patient while experiencing psychological impairment and distress. Adequate knowledge in these conditions is vital in managing these patients hence the importance of this unit to a Registered Nurse student

5.11 Self-Assessment Test

You are required to answer the following Multiple choice questions below by circling the most appropriate answer

1. Detoxification is a process of systematic and supervised withdrawal from substance use that is either managed in a residential setting or on an outpatient basis. Drug use during detoxification can take which of the following forms?

   A. Help reduce withdrawal symptoms

   B. Prevent relapse

   C. To wean a user onto a weaker substance

   D. All of the above

2. In biological treatments of substance abuse an example of a user being weaned onto a weaker substance would be which of the following?

   A. Methadone maintenance programmes

   B. Controlled drinking

   C. Barbiturate ban

   D. Amphetamine amnesty

3. The term psychological dependence is used when:

   A. It is clear that the individual has changed their life to ensure continued use of the drug

   B. Their activities are centred on the drug and its use

   C. Leads to neglect of other important activities such as work, social and family commitments

   D. All of the above

4. Which of the following is an example of a substance abuse?

   A. Alcohol related disorders

   B. Caffeine related disorders

   C. Inhalant related disorders

   D. All of the above

Answers

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

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UNIT 6: FORENSIC PSYCHIATRY

6.1 Introduction

Welcome to this unit on forensic psychiatry. Forensic psychiatry deals with some of the most disturbed and difficult to manage patients in psychiatric practice. We discussed these patients in Unit 3. Such patients include those with personality disorders, psychiatric emergency, schizophrenia, mood disorder and anxiety disorders. Because of the behavioural disorders that characterize mental illness a patient might commit a crime without realizing it. When this happens, they cannot be dealt with like other criminals. Instead they have to undergo psychiatric assessment and observations by psychiatrists who have to determine whether the patient was mentally ill at the time of committing the crime or not. This is what forensic psychiatry is all about.

It focuses on the assessment and treatment of mentally disordered offenders, and other patients, presenting with severe mental disorder in association with significant behavioural disturbance. Treatment settings vary from high security hospitals through to medium secure units and community forensic services, as well as the opportunity to treat patients in prison settings. Knowledge of the law in relation to clinical practice is central to the work and there is regular involvement with criminal justice agencies.

Forensic psychiatry is a multi-professional discipline where it is the norm to function as part of a clinical team which will include psychologists, occupational therapists, clinicians and social work colleagues as well as community forensic psychiatric nurses. Most forensic services operate from well-equipped, purpose built modern facilities. The patients are invariably fascinating, with complex, often multiple psychopathology. The range of referrals is immense, covering minor and very serious offenders, non-offenders with worrying behaviours and requests for advice from the courts, the probation service, the prison service and psychiatric colleagues.

In this unit, we will define key terms used in forensic psychiatry, outline types of patients that need forensic psychiatry, describe care of patients during detention; and discuss referral and discharge during forensic psychiatry and describe the nursing management of forensic patients.

6.2 Objectives

By the end of this unit you should be able to:

1. Define terms used in forensic psychiatry.
2. Explain types of patients that need forensic psychiatry.
3. Describe the care of patients during detention
4. Discuss the process of referral and discharge

6.3 Definitions used in forensic psychiatry

We will first go through the definitions that are used in Forensic Psychiatry. They are as follows:

a. Forensic

Pertaining to or applied in legal proceedings.

b. Forensic psychiatry

It is the branch of psychiatry that deals with the assessment and treatment of mentally disordered offenders and includes those areas where psychiatry interacts with the law.

c. Forensic nursing

It is defined as a subspecialty of nursing that has as its objective of assisting the mental health and legal systems in serving individuals who have come to the attention of both the health personnel and legal practitioners.

6.4 Types of patients that need forensic psychiatry

The patient in the forensic setting is guilty of committing a crime believed to be caused by their mental illness. Alternatively, the forensic psychiatric patient might have committed a crime independently of their mental illness, but is presently too ill to participate in court proceedings.

For example, a patient experiencing symptoms of schizophrenia might injure a neighbour because he or she heard voices stating that the neighbour intended to harm her or him. This is quite different from a patient who injures someone whilst their illness is stable. A patient judged to have committed a crime in connection with a mental illness might be found not guilty by reason of insanity. A ruling is made by the courts in which the patient is confined until such a time it is deemed by the treatment facility that the patient is no longer a threat to society.

The following are types of patients that are admitted to forensic facilities:

a. Anti-social personality disorder – is more strongly related to offending and violence. Aspects related to offending in a person with personality disorder include impulsivity, lack of empathy, paranoid thinking, poor relationships with others, problems with anger and assertiveness.
b. Substance dependence (alcohol and drugs such as cocaine, heroine, chamba)
   Intoxication reduces inhibitions and is strongly associated with crimes of violence, including murder. Neuropsychiatric complications of alcoholism may also be linked with crime.
c. Mental retardation or Intellectual disability – People with learning disability may commit offences because they do not understand the implications of their behaviour, or because they are susceptible to exploitation by other people. For example, property offences, sexual offences such as indecent exposure by males and arson.
d. Mood disorders – Depressive disorder is sometimes associated with shop lifting and may also lead to homicide and suicide. Manic patients may spend excessively and fail to pay. They are also prone to irritability and aggression leading to crimes of violence.
e. Schizophrenia and other psychotic disorders – are associated with violence especially if paranoid or coupled with substance abuse.
f. PTSD in cases where battered women have killed a battering partner.
g. Morbid jealousy
h. Organic mental disorders – Dementia and delirium. For example, aggression
i. Epilepsy – Violence is commoner in the post ictal state than ictally.

Forensic psychiatric nursing care

The forensic focus for nursing is the therapeutic nursing inventions targeted at patient's behaviours (psychiatric symptoms) that cause him/her to commit crimes. Nursing interventions therefore, are directed towards reducing the frequency and severity of these behaviours.

You have covered these interventions when learning about counselling during psychology and also in UNIT 2 on psychiatric nursing skills. Remember to continue utilizing The Nursing Process to give individualized care to these patients. Each abnormal behaviour will be assessed, a nursing diagnosis made and intervention planned and then implemented. However common interventions in Forensic nursing include the following:

Crisis intervention
This treatment helps patients cope with the crisis brought about by their criminal behaviour and subsequent detention in their lives, and to learn effective ways of dealing with future difficulties. Treatment is aimed at reducing emotional arousal that takes place during a crisis together with any accompanying behavioural disorganization. This is done by reassuring the patient and enabling him/her to have an opportunity to express emotions, in a supportive environment (empathy, non-judgmental).

Anxiolytic medication may be required for a few days. Once emotional arousal has been contained, a problem solving approach is used, in which the nurse in collaboration with the patient helps identify and list problems that are causing distress. (Check for problem solving counselling in Psychology in Nursing).

Rehabilitation
In order for patients in this setting to be eligible for return to the community, both the criminal act and the psychiatric illness must be addressed. If anger is behind the criminal act specific programs targeting anger management should be offered.

Suicide prevention – treatment for depression and close observation by staff in the ward should be ensured and supported by relatives in the community if discharged.

Behaviour management – any abnormal behaviour such as being anti-social or manipulative is treated using behaviour modification approach..

Substance abuse treatment – Detoxification is done in the psychiatric unit and thereafter the patient is referred and connected to long term support groups.

Discharge planning – begin to plan for the discharge of the patient together with him/her and relatives with the input of the Multi Disciplinary Team (MDT). The way forward and how he/she will go back into the community.

Special challenges a nurse faces with forensic patients
Since forensic patients have two main problems; namely the serious crime they have committed and the mental disorder that caused them to commit that crime, he or she becomes very complicated and difficult to manage. In fact, forensic patients are well known as being very dangerous, both to each other, and to staff caring for them.

Potential for Physical Violence: Since most patients admitted to a forensic setting have a history of criminal behaviour, they pose a high risk of physical violence to both staff and fellow patients. This can be

prevented or reduced by training forensic nurses in violence prevention and management techniques. If a nurse has been exposed to physical violence they must be supported and undergo debriefing.

Verbal abuse: Daily stresses of verbal abuse of nurses need to be addressed so as to maintain staff morale. It is addressed by support from senior nurses in which the affected nurses are given the opportunity to reflect on and discuss reactions to patients.

Difficulties in the nurse patient relationship: Physical or verbal abuse disturbs the forming of a meaningful nurse-patient relationship.

To be able to carry out the above mentioned nursing interventions the forensic nurse functions as follows:

Functions of a forensic nurse

- Patient advocate in which she speaks out for the rights of clients (see UNIT 8).
- A trusted counsellor in which she is able to offer psychological support to patients.
- A provider of primary, secondary, and tertiary health care interventions to clients before during and after forensic admission to psychiatric hospital.

6.5 Care of patients during detention

In Zambia mentally disordered offenders are cared for under the Penal Code 87 and Prisons Act of the Zambian Constitution as follows:

Presumption of sanity: Every person is presumed to be of sound mind, and to have been of sound mind at any time which comes in question, until the contrary is proved. When a person getting psychiatric treatment commits a serious offence while they are not documented legally that they are suffering from mental disorders, such a person is liable to prosecution until proven mentally ill by a qualified and registered psychiatrist.

Insanity: A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is, through any disease affecting his mind, incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission. But a person may be criminally responsible for an act or omission, although his mind is affected by disease, if such disease does not in fact produce upon his mind one or other of the effects above mentioned in reference to that act or omission.

Defence of diminished responsibility: Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or is induced by disease or injury) which has substantially impaired his mental responsibility for his acts or omissions in doing or being party to the killing.' (Laws of Zambia).

Treatment settings for mentally disordered offenders

In Zambia according to the Mental disorders Act of 1951, mentally disordered offenders are treated in all hospitals administered by the Government; and all places declared to be prisons under section three of the

Prisons Act; under compulsory detention (Detention Order) to safe guard the lives and property of the public.

While prisons focus solely on control these forensic facilities focus on both control and treatment. Buildings are therefore designed for maximum security to prevent patients escaping. Prison warders guard these facilities.

In Zambia Chainama East is used to confine people who have committed homicide or grievous bodily harm to others, as a result of being insane. Like a prison, Chainama East is a secure environment with strict rules and regulations to ensure safety and security to prevent patients escaping. Individuals admitted to this place have been charged with criminal offences and are deemed too dangerous to live in the community.

Chainama East is also used to care for persons that develop mental disorder and therefore require psychiatric treatment and care whilst in prison.

Those who have committed violence against property as a result of insanity are kept in the acute wards in Chainama.

Female offenders are detained in the acute female ward of Chainama Hills Hospital and are guarded by female prison warders.

6.5.1 .Leave of absence

Detained patients cannot go on leave or be discharged from the hospital as long as they are a danger to others and to property.

6.5 2 Absconding

Immediately it is noticed that a patient has absconded, the police and relatives should be notified, indicating the date, time, circumstances under which the patient absconded and clothes they were last seen wearing, and direction which they took. A search by police is instituted. This should be documented in the nurses' and ward report

6.5.3 .Correspondence
During detention correspondence between the courts of law and the head of the psychiatric department is entered into concerning the detention and care of patients using the following methods:

Adjudication order forms: Is to hear and settle a case by judicial procedure. In the case of forensic patients it means the patient has to be tried before a court of law, and it has to be determined whether they are guilty of a crime or not. However, before they can be tried, two psychiatrists have to examine and determine whether they are competent to stand trial or not.

Control order forms: After an adjudication order has been made, the courts shall make a control order, for the control, care or detention of the patient, specifying that the patient be detained in a prescribed place whilst his or her case undergoes judicial review. The patient may therefore be transferred from prison to the prescribed place, in Zambia, Chainama East / hospital.

Detention Order form – This is a form that restrains the client with mental illness to be admitted in a mental hospital for a minimum of 14 days after which psychiatric personnel should furnish a report to the magistrate about their findings concerning the patient. (See involuntary or compulsory admission under unit two)

Court reports: Psychiatrists provide a report of the patient's progress whilst in detention. Court reports – are required by the prosecution, court and lawyer. The reports consist of a psychiatric assessment that should be objective, and professional, and should not be influenced by which 'side' has made the request. The report should indicate whether the offender was mentally insane at the time of committing the crime or not. It should also indicate the competence of the mentally disordered offender to stand trial, and whether he understands what he has been accused of, and the meaning of pleading guilty or not guilty.

Give evidence in criminal proceedings on the patient's dangerousness, so that a suitable sentence may be made.

Transfer Order form – This is a form that is used when transferring a patient with mental illness from one hospital to another. It has to be duly filled in by a senior magistrate in the subordinate court.

ACTIVITY

Match the following forms used in forensic psychiatry (column 1) with the corresponding description in (column 2).

	Column 1	Column 2
1.	Adjudication forms	……Ensures patient is admitted for 14 days.
2.	Control order forms	……The patient has to be tried before courts of law.
3.	Transfer order forms	……Courts determine where patient will be detained.
4.	Detention Order forms	……Used to transfer patients with mental illness.

1.5.4 Sexuality

Sexual offences tend to be repeated because patients with psychosexual disorders may not cooperate with treatment as we saw when we covered that particular unit. (The most common offences are indecent assault of women, indecent exposure, unlawful intercourse with girls under 16, rape, paedophilia.)

For this reason psychiatrists may be asked to give an opinion on an offender's dangerousness, which if present may lead to long periods in confinement. Treatment of sex offenders can only be carried out if the offender admits to having committed the crime and if he or she is willing to undergo therapy with a view to changing his or her sex offending behaviour.

Victims of crime are referred to appropriate services where they are given the necessary psychological support available within the community and mental health department. For example women and child shelters, victim support unit in police, support groups, Non Governmental Organizations such as Young

Women's Association (YWCA), Children In Need, orphanages, voluntary counsellors, child counsellors at 'A' Block in University Teaching Hospital and so on.

6.6 Referral / Discharge

Forensic offenders are reviewed every fourteen days by two different psychiatrists under the Detention Order. Their confinement in a mental hospital tends to be for long periods of time until it is determined that they no longer pose a danger to the public and to property; again by two psychiatrists who get their views from the observations and assessments by nurses, psychologists and other members of the MDT.

According to His Excellency's Pleasure (This is Prerogative of Mercy of the President where he pardons prisoners that have been recommended by both prison and mental health personnel); the psychiatrists will complete a medical certificate in which a patient's mental fitness is confirmed. It is this certificate that the court will use to either discharge or reduce the sentence, or sentence a mentally disordered offender.

6.7 Summary

The focus of forensic psychiatry is the assessment and treatment of mentally disordered offenders, and other patients, presenting with severe mental disorder in association with significant behavioural disturbance. In Zambia most of the forensic patients are treated at Chainama Hills Hospital because it is one of the places designated by the Zambian constitution.

In this unit we have defined key terms used in forensic psychiatry, outlined types of patients that need forensic psychiatry, described forensic psychiatric care of patients during detention; and discussed referral and discharge of forensic patients. Finally, we have described the nursing management of forensic patients.

6.8 Self Assessment Test

Indicate whether the following statements are true or false

1. Forensic psychiatry is treating a physically abused individual.
   Pertaining to or applied in legal proceedings.
2. Forensic psychiatry is the branch of psychiatry that deals with the assessment and treatment of mentally disordered offenders and includes those areas where psychiatry interacts with the law.
3. Forensic psychiatry is defined as a subspecialty of nursing that has as its objective assisting the mental health and legal systems in serving individuals who have come to the attention of both.
4. The patient in the forensic setting is guilty of committing a crime believed to be caused by their mental illness.
5. Alternatively, the forensic psychiatric patient might have committed a crime independently of their mental illness, but is presently too ill to participate in court proceedings.
6. Types of people who are found in forensic psychiatry are offenders without mental illness.

Answers

1. FALSE
2. TRUE
3. FALSE
4. TRUE
5. TRUE
6. FALSE

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UNIT 7: COMMUNITY PSYCHIATRY

7.1 Introduction

Welcome to the 7th Unit in Mental Health and Psychiatric Nursing. Community Psychiatry involves delivering mental health care to clients while they continue to live in their homes. You will remember from Unit one (1) in which you covered the history of Mental Health and Psychiatry that before the 20th Century, treatment took place in mental health institutions commonly known as asylums.. Following deinstitutionalization, the practice of psychiatry, shifted from the mental institutions to the community.

This shift into community care required a range of different and new skills, performed by a correspondingly broad range of professionals (social workers,, psychologists, psychiatrists, mental health nurses) and non-professionals such as community mental health workers, and neighbourhood health committees. In addition, emphasis was placed on the client as part of a family and wider community. Service delivery in communities would occur outside health institutions, such as in a client's home, Out Patients Department (OPD), vocational training centres, and after care centres or group homes.

In this way, community mental health services would lessen social exclusion and stigma, as well as reduce neglect of human rights often encountered in mental hospitals. For mental health to be delivered effectively in the community, interventions are carried out on the following levels: promotional activities, primary, secondary and tertiary prevention.

Promotional activities foster good mental health whereas prevention is concerned with avoiding disease. In all levels the nurse has a special role to play, which includes the following: Consultant, clinical, therapeutic, assessor, researcher, educator, trainer, facilitator, manager and liaison.

In this unit we will define key terms used in community psychiatry, explain the concept of community mental health services in Zambia and outline levels of prevention in mental health.

7.2 Objectives

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

1. Define terms used in community psychiatry.
2. Describe the concept of community psychiatry
3. State different levels of intervention in mental health
4. Explain the role of the nurse

7.3 Definition of terms used in Community Psychiatry

Community Psychiatry

Community Psychiatry refers to psychiatry focusing on detection, prevention and early treatment and rehabilitation of emotional and behavioural problems as they occur in the community.

Community mental health services support or treat people with mental health problems whilst they continue to live in their own homes.

Institutionalism is a pattern of passive dependent behaviour observed among psychiatric inpatients, which is characterized by hospital attachment and resistance to discharge.

Deinstitutionalization

At the patient level, it refers to the transfer of a patient hospitalized for extended periods of time to a community setting.

At the mental health care system level, it refers to a shift in the focus of care from long term institutions to the community, accompanied by discharging long-term patients, and avoiding unnecessary admissions.

Severe mental disorders are mental illnesses characterized by functional disability (inability to function in the following areas: occupational, social, Activities of Daily Living (ADLs).

Mental health promotion is a means of reaching the goal of good mental health through actions that are taken for the purpose of fostering, protecting and improving mental health.

Primary prevention is preventing psychiatric illness rather than treating it. This is done by first identifying at risk groups, and then promoting their mental health through educating them.

Secondary prevention is reducing the number of existing mental illnesses through screening early diagnosis, prompt treatment and education of signs and symptoms.

Tertiary prevention

This is an Attempt to reduce the severity of a mental disorder and its associated disability through rehabilitation activities or the prevention of long term disability from chronic and persistent severe mental illness. Such disability includes poor social integration, aggression, indecent behaviours, among others.

Psychiatric rehabilitation is the range of social, educational, occupational, behavioural and cognitive interventions used to increase the role performance of persons with serious and persistent mental illness and to enhance their recovery (Burton, 1999 cited by Stuart and Sundeen, 2006).

Protective factors are factors in a person's life that promote mental health and wellbeing such as psychological support from a spouse, family, friends and health providers.

Resilience is the capacity to adapt well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress -- such as family....

Risk factors are those hazards or circumstances that, if present for a given individual, make it more likely for them to develop a disorder. For example, bio-psychosocial factors, lack of social support, inability to read, exposure to bullying among others.

Resources – Are opportunities available in the community for the promotion, prevention, and treatment of mental disorders. These may include; social and health services, family support, material and human resource

Resource mobilization Is to organize or prepare something, such as a group of people, money, community assets for a purpose so as to support or pay for goods and services used in the delivery of health services.

Concept is a thought or idea or a way of doing or perceiving something for example, a method, plan, or type of design.

7.4 The concept of community psychiatry

In order for us to understand where we are as a country with regard to community mental health, we need to go back and briefly examine the historical background of community psychiatry.

Background of community psychiatry

You will remember that in UNIT 1, you covered history of mental health and care of psychiatric patients. At first mentally ill patients were cared for in large mental hospitals known as Asylums. This led to large groups of patients getting admitted and cared for in mental institutions for long periods of time, even years. This situation led to the development of a condition called psychiatric institutionalism where long stay in-patients develop strange behaviours and are not willing to live outside an institution

Signs of psychiatric institutionalism

- Dependency
- lack of initiative
- inability to solve problems
- not able to make decisions
- Not able to live outside the mental institution

Patients were so dependent that they became helpless and as a result were mistreated and exploited by the health professionals with minimal information of their condition, concerning:

- Course of illness
- Prognosis of the illness care and treatment
- And patients' rights

To put an end to the exploitation of patients who were institutionalized, and improve quality of care to patients with mental illness, the large hospitals were downsized or closed. This process led to deinstitutionalization.

Deinstitutionalization

- Instead, mental annexes were opened at general and central hospitals.
- Consequently, people with mental illness were returned to the community to live there.
- Other reasons for deinstitutionalization included, high costs of institutional care, discovery of psycho tropics, and civil rights activism.
- People in the community were not prepared for the influx of patients from mental institutions which led to some undesirable effects.

Effects of deinstitutionalization

- Barriers of social inclusion leading to stigma and prejudice
- Poor social skills for example, inappropriate behaviours in public places such as shops or restaurants or churches.
- Community not ready to receive patients, so they got readmitted into state hospitals.
- Some other patients fell into the criminal justice system
- Still others became homeless or vagrants.
- In Western countries others were taken into nursing homes, especially the elderly.
- Families were not prepared for the treatment responsibilities they had to assume.
- This plight of patients led to advocacy efforts and movements by consumers, families, mental health professionals and other NGOs.

Introduction of community mental health services

- The plight of mentally ill people in the community world over was taken into account during the Alma-Ata International Conference on Primary Health Care in 1978.
- In the following year, community psychiatry was introduced in Zambia.
- Measures were put in place to develop community mental health services through integration into the existing Primary Health Care system, as proposed at the conference.
- It was proposed that there should be a mental health component in which Community Health Workers with support from Neighbourhood Health Committees and technical guidance from mental health professionals would base their work after a six week training course:

The roles of community Mental Health workers included the following:

- Conducting mental health education in communities
- Identify and refer patients or persons with emotional problems, serious mental illness, epilepsy, learning disabilities and behavioural problems to health facilities.
- Encourage patients in the community to comply with medication and keeping of review dates.
- Encourage acceptance of patients within the community.
- Collect and compile simple data about mentally ill individuals in the community.

Community mental health services in Zambia today The Mental Health Policy of Zambia, which guides the development of Mental Health Services in the country. It states that: Disabilities that result from neurological, mental, and psychosocial disorders shall be reduced through community rehabilitation.

- Mental health services are delivered to the community.
- Services recommended in the mental health policy are implemented through strategic plan which ensures that funds for community based mental health activities are available. Such programs are as follows:

    a) Conducting public educational programmes to create awareness of mental health issues.

    b) Providing care and support skills to neighbourhood health committees through short courses and supervisory guidance

c) Networking with NGOs with similar interests to promote mental health and prevent mental health problems in communities. Such NGOs include user and careers groups.

The new Act of Parliament which is still in the form of a The Mental Health Services Bill, (2006) sets a clear direction and focus for mental health services outside institutional settings in the country.

7.5 Levels of intervention in mental health

Levels of intervention or acting and taking a definite step to reduce symptoms or keep mental illness from occurring include mental health promotion, prevention which can be primary, secondary and tertiary. Promotion and prevention overlap in that prevention is concerned with avoiding disease while promotion is about improving health and wellbeing. Promotional activities may therefore be similar to preventive activities.

For example in a community you might facilitate a cooperative for vegetable growing so that women generate an income for their daily needs and also improve on the nutritional requirements of their children. By so doing you are promoting good mental health because they will be relieved of stress. They do not have to go looking for money very far from home. At the same time using the same activity you are preventing mental illness developing from unresolved stress that results from poverty and malnutrition.

Promotion

Mental health promotion is any action taken to maximize mental health and well being among populations and individuals.

Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health.

A climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

National mental health policies should not be solely concerned with mental disorders, but should also recognize and address the broader issues which promote mental health. This includes mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector.

Specific ways to promote mental health include:

a. Early childhood interventions (for example, home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations);
b. Support to children (for example, skills building programmes, child and youth development programmes);
c. Socio-economic empowerment of women (for example, improving access to education and microcredit schemes);
d. Social support for elderly populations (for example, befriending initiatives, community and day centres for the aged);

e. Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (for example, psycho-social interventions after disasters);
f. Mental health promotional activities in schools (for example, child-friendly schools);
g. Mental health interventions at work (for example, stress prevention programmes);
h. Housing policies (for example, housing improvement);
i. Violence prevention programmes (for example, community policing initiatives); and
j. Community development programmes (for example, 'Communities That Care' initiatives, integrated rural development).

Prevention

Prevention means keeping a disorder from occurring, in this case preventing mental illness.

- It is carried out through specific protective measures (promotional activities) and reducing risk factors in the lives of individuals, families and communities.

- In the community, mental health prevention occurs at three levels: Primary, secondary and tertiary.

Primary Prevention

Primary prevention involves both mental health promotion (enhancing protective factors) and prevention of disorders (reducing risk factors) in the lives of individuals.

Promotional and preventive activities in mental health care delivery therefore overlap and are targeted towards:

A) Assisting individuals to increasingly cope effectively with stress.

B) Target and diminish stressors in the environment. This is done through educating at risk groups in the following ways:

- Teaching parenting skills and child development to prospective new parents.

- Teaching physical and psychological effects of alcohol, drugs to primary and secondary pupils.

- Teaching techniques of stress management to anyone who desires to learn.

- Teaching groups of individuals ways to cope with the changes associated with various maturational changes (adolescence, motherhood, menopause, retirement) among others

- Teaching the concepts of mental health to various groups within the community.

- Providing education and support to unemployed or homeless individuals.

Secondary Prevention

- õ **Treatment**

It is in the secondary level of prevention that treatment takes place to reduce the severity of mental illness as follows:

- This is decreasing or reducing the prevalence of psychiatric illness by shortening the course of the illness. This is accomplished through early identification of problems and 'prompt' initiating of effective treatment.

- Nursing in secondary prevention focus on recognition of symptoms and provision of a referral for treatment.

- Ongoing assessment of individuals at high risk of mental illness is done during home visits, day care, PHC clinics, or any setting where screening of high risk individuals may occur.

- Provision of care for individuals in whom illness symptoms have been assessed eg: counselling, medication, support during high levels of stress (crisis intervention), suicide and child abuse hotlines, rape and victims of domestic violence drop in centres for example, Young Women Christian Association [YWCA].

- Referral for investigations and treatment of individual in whom illness symptoms have been identified.

- The treatment given after referral may include medical and psychiatric medications, and other types of therapies.

Tertiary prevention

- õ **Rehabilitation**

- This is the reduction of residual defects that are associated with severe illness such as loss of social skills, inability to earn a living, side effects of neuroleptics (drugs used in mental illness), stigma and discrimination.

- Most common illnesses with residual defects are epilepsy and schizophrenia. This is accomplished in two ways:

    - Preventing complications of the illness.

    - Promoting rehabilitation that is directed towards achievement of each individual's maximum level of function.

Nurses' role in tertiary prevention

Nursing in Tertiary prevention focus on clients to enable them learn or relearn socially appropriate behaviours; so that they may be able to achieve a satisfying role within the community. For example:-

- Teaching the client daily living skill

- Encouraging independency his/her inability
- Through social skills training
- Assertiveness training
- Anger management techniques
- Referring clients to various aftercare services after discharge (Matero, Sadzu, Chilenje among others)
- Aftercare homes such as Chawama old people's home, support groups, and day treatment programmes
- Monitoring effectiveness of aftercare services through home visits

Consider in what area (or environment of choice) an individual can be rehabilitated in at the time of initial diagnosis and upon recovery. Such areas may be social, occupational, and Activities of Daily Leavings, so that the individual can get integrated into the community.

Resource Mobilization and Use

For community mental health care to be successful and sustainable, use of resources have to come from the community itself. When needs or diagnosis of a community are arrived at, a list of resources required to carry out interventions are listed. At the same time resources available in the community are also identified. Other resources may have to be moved from other sources outside the community. Resources, therefore, are an essential part of carrying out interventions to promote mental health (foster protective factors), and prevent mental illness (inhibit risk factors).

There are a wide variety of resources that may be helpful when planning your mental health promotion initiative.

They include people, facilities, services, material resources, strategic plans and policies, and anything that fosters good mental health (that is, promote mental health) and is found within or outside the community.

A capacity building approach therefore, is used, because it emphasizes what the community has, not what it lacks. Why should we look at things this way? Because every community has assets and strengths that can be used to meet community needs (substance abuse, lack of clean water, illiteracy, high rates of malnutrition in children to mention but just a few); they can improve community life.

How resource mobilization is carried out

In order to create resources to pay for goods and services used in the delivery of health services, a strategic plan (detailed plan to achieve success in a situation) has to be developed and implemented. The resource mobilization strategic plan outlines goals of how resources will be moved or brought in to carry out a particular activity in the community. Resources (such as money, manpower, equipment, transport, medications among others) may be brought in from various sources such as cooperating partners, the major strategies for resource mobilization include:

Major strategies for resource mobilization

a) Develop effective ways of timely provisions of logistical support (logistical support is effective and successful provisions of goods and services through supply of qualified manpower, medications, stationery, transport and supervision) from the government.

b) Working closely with funding sources such as Global Fund, WHO for technical support (workshops, training, supply of equipment, transport, the latest information of mental health care); and developing close collaborative (work together to achieve or create the same thing) relationships with Foundations (an organization that has been established in order to provide money for a particular group of people in need of help) For example, the Clinton Foundation.

c) Develop and implement a plan for cost sharing.

Community Asset

A community asset is a resource that can be used to improve the mental health of a community. For example:

- Job opportunities
- Food security
- Education (colleges, schools)
- Transportation
- Public safety
- Family income
- Culture and recreation
- In Zambia/Africa – extended family system
- Friendly neighbourhoods/people
- Deep traditions / community leaders
- Neighbourhood Resources
    - Strong interpersonal networks (to network is to meet people who might be useful to know, especially in your job).
    - Trust – the shared belief that neighbours can, and should, intervene to support other residents, including children, youths, the elderly and disabled.

Why Community Assets Are Necessary

- External resources such as government funding may often not be available.
- For change to occur, resources must come from within the community. This leads to ownership of community initiatives and projects.
- Identification and mobilizing community assets enables community members to gain control over their lives.
- Projects become sustainable, that is, improvements are more effective and longer lasting when community members dedicate their time and talents to bring about changes they want.

- People can become active and shapers of their own destiny, instead of passive clients receiving services from a variety of agencies.

When to Identify Community Assets

- When you cannot provide routine services and are looking for other ways to strengthen the community.
- When the community includes talented experienced citizens whose skills are valuable but underused (community elders).
- When you want to strengthen existing relationships and build new ones that will promote successful community development in future.

How to Identify Community Assets

To identify a resource, you first need to know what the problem is, then analyze (what's causing it, what can end it, who is affected, how they are affected, and for how long the problem has been present). Answering these questions will enable one know what community resource is needed to solve the problem.

Activity

Now that you have known what community resource is in order to solve a problem, find out what community assets are available by making an inventory of the assets, capacities and abilities available?

For example:

- Problem: Barriers to inclusion
- Cause : Fear, prejudice, lack of education
- Resource: The community mental health nurse facilitates interactions between clients/families and community with people who have positive experiences: Education and motivation of certain community members. Community sensitization

Making an Inventory of Community Assets

1. List of gifts, skills of residents.
2. All people part of action, not as clients, but as full contributors to mental health promotion.
3. Citizen's associations – vehicles through which community assemble to solve problems, common interests and activities.
4. Formal institutions located in the community:
    i. Private businesses
    ii. Public institutions:

- Schools
- Libraries
- Parks
- Museums
- Police
- Fire stations
- Hospitals
- NGO s
- Dam
- Youths/women's clubs

7.6 Role of a nurse

The nurse should approach interventions with flexibility and resourcefulness to meet the broad range of needs represented in a patient with mental disabilities. The following roles have been identified for nurses working in community mental health services:-

- Consultative role – Giving advice to other professionals in the community about the type and level of nursing care required for given client groups.
    - Clinical role – Providing direct nursing care to the patients in the community through home visits.
    - Therapeutic role – Employing or using psychotherapeutic and behavioural methods for management of patients.
    - Assessor / Researcher – The nurse may assess the care given to clients and may also assess the outcome of ongoing care programmes.
    - Educator – Creating awareness in the community about mental health and mental illness with special focus on vulnerable groups
- Trainer / facilitator – Training of other professional community leaders, school teachers and other care giving professionals in the community.
- Manager/administration – Manager of the resources, planning and co-ordination.
- Liaison role
    - Nurses working in the community help clients and their families by bridging the gap between the client and the hospital.
    - Nurses also network (link up with or connect to) with NGOs and other resources in the community to meet the needs of patients.
    - They link patients to various institutions.
- Advocacy – Nurses speak out for the rights and interests of clients in the community by raising awareness of clients' needs in places of employment, school and markets.

- This they do by sensitizing the public, NGOs, policy makers and service providers on the plight of clients.

- Preventive roles as earlier seen, under primary, secondary and tertiary levels.

7.6.1 Support groups

Self-help or support groups are organized and led by patients or ex-patients who have learned ways of overcoming or adjusting to their difficulties. The other group members benefit from this experience, from the opportunities to talk about their own problems and express their feelings and from mutual support. It is important that those who lead such groups have appropriate training and support, so that they can cope up with group processes that develop. Other groups have a professional advisor such as a nurse. Examples of self-help group include:

- Alcohol Anonymous
- Weight watchers
- Groups for people with chronic conditions for example, NPLHA, Mental Health Users Association among others
- Groups for people facing special problems such as parents with a handicapped child among others.

Furthermore, many patients and their relatives are members of church groups and consumer associations, from which they enjoy spiritual, psychological and social support. The extended family still in existence in many developing countries also provides moral, social and material support.

7.6.2 Halfway homes

- Halfway houses are communal living situations that provide an orderly way of doing things (routine), and support from those recovering from addiction or long term illness. This is for those who lack family support and who cannot live on their own.

- A halfway house is located in the community, so that recovering patients can attend school or work during the day.

- Each evening they return to a supportive environment, for meals and emotional sustenance.

- The stay ranges from one to four months.

- Halfway houses provide an effective transitional bridge from the therapeutic inpatient to the outside community.

- In patients who have to attend outpatient treatment it is especially ideal. In Zambia there is no halfway houses system.

7.6.3 Group homes

Group homes are places is living with a large group of people or living in the hospital unit, such as Chainama Hospital.

7.6.4 Villages

This consists of a group of villages where patients can access psychiatric services on a community outreach basis. It is found in some parts of Africa, but not Zambia.

7.6.5 Aftercare homes

Aftercare homes are hostels were homeless mentally ill people are taken upon discharge.
In Lusaka there is Matero Aftercare Centre for youths, Chawama Aftercare centre for the elderly. There is Sadzu in Eastern Province.

7.6.6 Aftercare

Aftercare is distinguished or differs from aftercare homes in that upon discharge, persons recovering from mental illness need continuing care to prevent relapse and other complications occurring. Such continuing care ensures that patients continue to receive support and care after discharge, in the community. It includes:

- Regular reviews in the OPD.
- Home visits, especially if they are unable to come to the OPD for review.
- Referral to aftercare centres.

Aftercare includes a structured (routine) plan for the following:

- Relapse prevention
- Active participation in continuing treatment.
- Belonging to a support group.
- Continued access to the original professional treatment centre as needed.

Why Aftercare is Necessary

- Patterns that lead to substance abuse are hard to erase. Therefore stresses associated with abstinence and recovery is reduced.
- The patient has a daily routine to follow.
- Old companions and stresses that return are prevented, upon discharge.
- Aftercare prevents faulty thinking patterns of relying on drugs rather than other people, of not asking for help, and of not sharing important feelings.

Home visits as part of aftercare

Follow up visits are important for a patient who has been discharged. They can also be conducted to assess the home environment before discharge.

They are important because:-

- You can get to meet and know other family members.
- It reduces the number of readmissions.
    - It helps in the drug monitoring and compliance.
    - It provides H/E to the client and family members.
    - It allows the nurse to see if the patient is able to apply social skills taught.
- Helps the nurse assess whether the patient is able to carry out the Activities of Daily Living (ADLs).
- Enables the nurse give family therapy as well as the community. By so doing it reduces stigma.
- Makes the patient feel cared for.
- It educates the family members to cope with the disease of the patient.

7.7 Summary

Where mental health care was practiced changed from the mental health institutions to the community in the 20th Century. This development resulted from deinstitutionalization of patients that had become institutionalized in mental hospitals.

In Zambia, despite the structure of comprehensive health services being available, for integration, some barriers still have to be overcome to integrate mental health into PHC services. To overcome these barriers, a new Mental Health Services Bill, currently under debate will bring about improvement of care of patients in the community because it clearly directs delivery of mental health services in the community.

There are 3 levels of intervention in mental health care in the community. They are primary, secondary and tertiary interventions. In all the 3 levels the nurses play various roles in delivering mental health care in the community. The roles include the following: Consultative, clinical, therapeutic, assessor/researcher, educator, trainer / facilitator, liaison, advocacy, manager / administrator.

7.8 Self Assessment Test

Multiple Choice Questions

1. Which of the following represents a nursing intervention at the primary level of prevention?
a. Teaching a class in parent effectiveness training
b. Leading a group of adolescents in drug rehabilitation
c. Referring a married couple for sex therapy
d. Leading a support group for battered women

2. Which of the following represents a nursing intervention at the secondary level of prevention?
a. Teaching a class about menopause to middle-aged women
b. Providing support in the emergency room to a rape victim

c. Leading a support group for women in transition
d. Making monthly visits to the home of a client with schizophrenia to ensure medication compliance

3. Which of the following represents a nursing intervention at the tertiary level of prevention?
a. Serving as case manager for a mentally ill homeless client
b. Leading a support group for newly retired men
c. Teaching prepared childbirth classes
d. Caring for a depressed widow in the hospital

4. John, a homeless person, has just come to live in the shelter. The shelter nurse is assigned to his care. Which of the following is a *priority* intervention on the part of the nurse?
a. Referring John to a social worker
b. Developing a plan of care for John
c. Conducting a behavioural and needs assessment on John
d. Helping John apply for Social Security benefits

5. Ann is a psychiatric home health nurse. She has just received an order to begin regular visits to Mrs W., a 78-year-old widow who lives alone. Mrs W's primary-care physician has diagnosed her as depressed. Which of the following criteria would qualify Mrs W. for home health visits?

a. Mrs W. never learned to drive and has to depend on others for her transportation.
b. Mrs W. is physically too weak to travel without risk of injury.
c. Mrs W. refuses to seek assistance as suggested by her physician, 'because I don't have a psychiatric problem.'
d. Mrs W. says she would prefer to have home visits than go to the physician's office.

7. Based on a needs assessment, which of the following problems would Ann address during her first visit?

a. Complicated grieving
b. Social isolation
c. Risk for injury
d. Sleep pattern disturbance

8. Mrs W. says to Ann, 'What's the use? I don't have anything to live for anymore.' Which is the best response on the part of the nurse?

a. 'Of course you do, Mrs W. Why would you say such a thing?'
b. 'You seem so sad. I'm going to do my best to cheer you up.'
c. 'Let's talk about why you are feeling this way.'
d. 'Have you been thinking about harming yourself in any way?'

9. Three predominant client populations have been identified as benefiting most from psychiatric home health care. Which of the following is not included among this group:

a. Elderly individuals.
b. Individuals living in poverty.
c. Individuals with severe and persistent mental illness.
d. Individuals in acute crisis situations.

Answers to Self Test

1. A
2. D
3. B
4. C
5. B
6. C
7. A
8. C
9. B

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UNIT 8: ADVOCACY

8.1 Introduction

Welcome to the last Unit in Mental Health Psychiatric Nursing. In this Unit, we are going to learn about Advocacy in Mental Health and Psychiatric Nursing.

The key to improving mental health among people suffering from mental illness as well as those without mental illness is to increase the pace of advocacy efforts. This advocacy effort should be directed at politicians and the general public who are not fully aware of the fact that effective treatment of most mental disorders is possible. They tend to imagine that when one has a mental illness they become violent, sinful and lazy. Most health workers are not familiar with modern methods of treatment of mental illness and often do not have the essential abilities to manage it. Many of them believe that the only way of dealing with mental illness is to admit patients for care in hospital for a long time. In most countries, including the industrialized ones resources are more available for treatment of physical illnesses than for mental illnesses. It is as a result of these misunderstandings that politicians and the general public have, concerning people suffering from mental illness that stigma has continued to flourish at all levels of society.

Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in mental health policy, laws and service provision for people suffering from mental illnesses. The concept or idea of mental health advocacy has been created to uphold the human rights of persons suffering from mental illness and to reduce stigma and discrimination.

Advocacy in this field began when the families of people suffering from mental illness first made their voices heard. Thereafter, people suffering from mental illness became involved by adding their own voices. Slowly, these people and their families were joined and supported by various organizations, a lot of mental health workers and their associations, and some governments.

Advocacy is considered to be one of the eleven areas for action in any mental health policy because of the benefits that it produces for people suffering from mental illness and their families. The advocacy movement has substantially influenced mental health policy and legislation in some countries and is believed to be a major force behind the improvement of services in others.

8.2 Objectives

By the end of the unit you should be able to:

1. Definition of terms used in advocacy
2. State principles of advocacy
3. Describe community participation and partnerships
4. Identify vulnerable populations
5. Describe the rights of the nurse and the patient

8.3 Definition of terms used in advocacy

1. **Advocacy**

   - Advocacy is acting on behalf of the client's best interests. It includes providing support, feedback and resources that are necessary to make a decision.

   - Advocacy consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations.

2. **Stigma**

Is something about a person that causes him/her to be deeply compromised in his/her social standing, a mark of shame or discredit. Many persons with serious mental disorders appear to be different because of their symptoms or the side effects of their medications. People notice these differences, feel uncomfortable about the persons affected, and act in a negative way towards them. This worsens the symptoms and disability in persons with mental illness.

3. **Discrimination**

Discrimination means treat a person or a particular group of people differently, especially in a worse way from the way in which you treat other people because of their mental illness, disability.

4. **Consumer**

Is a person with a mental disorder who has been a recipient of mental health services same as user.

5. **NGO (Non Governmental Organization)**

Non profit, voluntary or charitable organization that carries out advocacy activities and provides various mental health interventions including promotion, prevention, treatment and rehabilitation.

6. **Participation**

When you take part or become involved in something.

7. **Partnerships**

This is the state of being closely involved with a person or organization in some way.

8. **Collaboration**

Collaboration is when two or more people work together to create or achieve the same thing (Cambridge University Press, 2005).

9. **Stakeholders**

10. **Networking**

11. **Human Rights**

12. **Vulnerable groups**

- Are defined as social groups who have an increased relative risk of susceptibility to adverse health outcomes.

- Vulnerable populations are groups that are not well integrated into the health care system because of ethnic, cultural, economic, geographic, or health characteristics. This isolation puts members of these groups at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health. Commonly cited examples of vulnerable populations include racial and ethnic minorities, the rural and urban poor, undocumented immigrants, and people with disabilities or multiple chronic conditions.

8.4 Principles of advocacy

For advocacy to be effective, the following rules are followed:

- Act in the client's (groups, communities) best interests, in the case of ethical conflicts.

- Act in accordance with the client's wishes and instructions. This means that you put the client in charge, working hand in hand. For example,, 'This is what I think we can do, what do you want me to do. 'Refuse to do anything were self or others can be harmed.

- Keep the client properly informed. This will empower clients to make knowledgeable decisions.

- Carry out instructions with diligence and competence thereby maintaining high standards of practice.

- Act impartially and offer frank, independent advice. This will enable you address fairness and respect for persons.

- Maintain client confidentially. Only share information entrusted to you if there is need for others to know it.

To be able to follow the above principles when advocating for different groups and individuals, the psychiatric nurse should possess the following skills:

They include:

- Interviewing
- Assertiveness and force
- Negotiation
- Self-management
- Legal knowledge (such as rights of persons with mental illness) and research
- Litigation (resort to the courts to determine a legal question or matter).

8.5 Community participation and partnerships

Advocacy can become a success only when the groups that are being supported take part in activities or in mental health interventions.

In primary health, for instance, for strategies to be effective, especially promotional activities, community participation has to take place.

For health promotion to work well, it must be carried out by and with people, not on or to people.
At all levels of health intervention (primary, secondary and tertiary), communities are involved so they can retain ownership of any health action.

To successfully promote mental community health, and prevent mental illnesses, a community assessment must first be undertaken.

After which a community diagnosis is arrived at in partnership and participation with community. This means the community should be able to acknowledge needs or problems they themselves have observed or experienced in their midst. Needs or diagnosis must not be imposed on them.

Needs and problems identified during the community mental health assessment are addressed using community assets.
This ensures that when community assets in the form of human resources, health institutions, schools, a dam, market among others come from within the community or are built, created or managed by the community, ownership will be assured, and projects as well as interventions to improve mental health at all levels (as earlier seen in Unit 9, primary, secondary and tertiary levels) will be sustainable.

For instance, when conducting a mental health assessment in a particular community, say Chibolya, there is need for collecting data through partnering and participation with the community.

When residents of such a community are able on their own to accept that there is a substance abuse problem in their area they will equally be interested in participating with health professionals to speak out on behalf of their community, to other stakeholders and partners (Drug Enforcement Commission, World Vision and Ministry of Community Development) on how this problem can be solved.

Reasons for involving (participation) community through partnering when conducting mental health and advocacy activities

1. Gather information through partnership with other health workers based there and other key players in the community.
2. These are the people within the community with the local knowledge (that you don't have). Local people will be more sensitive to the realities on the ground.
3. They can therefore encourage and influence wider participation.
4. The community also has to have ownership of any interventions.
5. Therefore, all assessment needs to be done in partnership.
6. The health worker acting as knowledgeable facilitator
7. No change will take place without people's involvement.
8. Nothing can be achieved without active participation
9. The data that has led to the community diagnosis has been collected by collaboration with community leaders, health workers, religious leaders, teachers, neighbourhood health committees, TBAs, traditional healers, chiefs among others.

8.6 Vulnerable populations

People who are vulnerable are those who are at increased risk of developing mental illness and physical diseases when compare to the general population. Such individuals or groups in society are also prone to premature death, and poor conditions of life. Poor conditions of living refers to poor sanitation, overcrowded housing, no running water, poor public services such as clinics, good road networks, schools, and other social amenities. Such groups or individuals are prone to increased susceptibility to disease because of low social and economic status.

Activity Think of your community and list down groups of people whom you think are vulnerable

Well done! But now look at the following vulnerable groups below:

Vulnerable groups of society include the following:

- The poor.
- Persons subjected to stigmatization, discrimination, intolerance, subordination (put someone into a less important position), such as albinos, and people with mental/physical disabilities.
- Politically marginalized, disenfranchised (to take away power or opportunities, or right to vote), and denied human rights.
- Women and children.
- Ethnic (different racial groups) minorities.
- Immigrants.
- Homeless (street kids, vagrants, mentally ill)
- Elderly
- Refugees
- People living with HIV/AIDS
- Orphans

Nurses role towards vulnerable populations
Once the vulnerable groups or individuals in society have been identified it is the nurse's duty to make interventions that will reduce mental and physical illness. In order to reduce vulnerability to disease, society as a whole (politicians and the general public) is responsible for ensuring justice and human rights protection. This is done by advocating for availability of resources (income, jobs, education, and housing) to reduce relative risk to morbidity and mortality, thus leading to improved health status.

Nursing interventions to vulnerable groups are targeted towards resource availability through advocacy and early interventions that start prenatally and throughout the life span. Such interventions include:

- Prenatal (family planning, tetanus vaccines, HIV testing, parental classes);

- Antenatal – health education on different topics that could affect the mental health of both mother and unborn baby;

- Postnatal care – so as to detect early postnatal depression/ psychosis in children's clinics, nurses should identify early, children at risk for mental disabilities and disorders and refer them for appropriate management. For example, to psychologists, organizations like ADD or Community Based Action for Disability – physiotherapy services.

- Vulnerable rural people who are far away from health services may be helped or given the above mentioned services through outreach services to places were these people live or are found; and the recently introduced mobile clinics; and through the already existing PHC care services that ensure equity of access, cost effective and affordable and comprehensive care, closest to one's door step.

- Throughout the lifespan, especially during maturational crises such as at puberty, midlife crisis, approaching old age among others.

Nursing interventions are primary, secondary and tertiary as earlier discussed in community nursing.

8.7 The rights of the nurse and the patient

For a nurse to be able to advocate for clients successfully she/he has to be conversant with her/his rights as a nurse, as well as being able to articulate the rights and mental health rights of a patient suffering from mental illness.

When a nurse knows her rights in relation to the patient, she will also be aware of how much she can help and when to consult as well as what her limitations are, in advocacy activities.

When the nurse knows her patient's rights her aim should be to use this knowledge to advocate for the patients by fighting or breaking down such barriers. This is because whatever benefits are due to the patient is guided by rights. The barriers that a nurse has to address in advocating for her patients with mental illness are as follows:

Barriers to mental health
Only a small minority of people with mental disorders receive even the most basic treatment and even so a lot of them become objects of stigma and discrimination. Many vulnerable groups of people in varying communities, are faced with factors that present risks to mental health, such as poverty, substance abuse, physical and mental disabilities, and HIV/AIDS to mention a few.

Among the barriers to mental health are the following:

- Lack of mental health services. For example, only 51% of the world's population
- Have access to treatment for severe mental disorders at the primary care level (World Health Organization, 2001b). Moreover, the available treatment is not necessarily effective or comprehensive.
- Unaffordable cost of mental health care, including out-of-pocket payments, even in

- Developed countries. For example, out-of-pocket expenditure is the primary method of
- Financing in 39.6% of low-income countries (World Health Organization, 2001b).
- Lack of parity between mental health and physical health. For example, investments
- Made by governments and health insurance companies in mental health are disproportionately small.
- Poor quality of care in mental hospitals and other psychiatric facilities.
- Absence of alternative services run by consumers
- Paternalistic services, in which the views of service providers are emphasized and those of consumers are not considered.
- Violations of human rights of persons with mental disorders.
- Lack of housing and employment for persons with mental disorders.
- Stigma associated with mental disorders, resulting in exclusion.
- Absence of programmes for the promotion of mental health and the prevention of mental disorders in schools, workplaces and neighbourhoods.
- Lack or insufficient implementation of mental health policies, plans, programmes and legislation. More than 40% of countries have no mental health policy, over 30% have no mental health programme, and over 90% have no mental health policy that includes children and adolescents (World Health Organization, 2001b).

Common misconceptions about people with mental disorders

- People with mental disorders are often thought to be:
- lazy - unpredictable
- unintelligent - unreliable
- worthless - irresponsible
- stupid - untreatable
- unsafe to be with - without conscience
- violent - incompetent to marry and raise children
- out of control - unable to work
- always in need of supervision - increasingly unwell throughout life
- possessed by demons - in need of hospitalization
- recipients of divine punishment

What are the effects of stigma?

- Unwillingness of persons with mental disorders to seek help
- Isolation and difficulty in making friends
- Damage to self-esteem and self-confidence
- Denial of adequate housing, loans, health insurance and jobs because of mental disorders
- Adverse effect on the evolution of mental disorders and disability
- Families are more socially isolated and have increased levels of stress
- Fewer resources are provided for mental health than for other areas of health

How to combat stigma

1. Community education on mental disorders (prevalence, causes, symptoms, treatment, myths and prejudices).
2. Anti-stigma training for teachers and health workers

3. Psychoeducation for consumers and families on how to live with persons who have mental disorders
4. Empowerment of consumer and family organizations (as described in this module)
5. Improvement of mental health services (quality, access, deinstitutionalization, community care)
6. Legislation on the rights of persons with mental disorders
7. Education of persons working in the mass media, aimed at changing stereotypes and misconceptions about mental disorders
8. Development of demonstration areas with community care and social integration for persons with mental disorders

The role of general health workers and mental health workers in advocacy

General nurses and mental health nurses are less involved in advocacy actions as compared to patients with mental illness, their families and nongovernmental organizations. However, in places where care has been shifted from psychiatric hospitals to community services, mental health nurses are more active in upholding the rights of people with mental illness and bringing up concerns that deal with the need for improved services. Nurses and other workers in psychiatric annexes and hospitals can identify with some of the human rights abuses that take place in these facilities and denounce any such practices. Furthermore, mental health workers such as psychiatric nurses, clinical officers and psychiatrists have been known to have experienced similar discrimination and stigmatization to those experienced by persons with mental disorders.

The Mental Health Services Bill of 2006 and Advocacy

According to the Mental Health Services Bill of 2006 Part VIII Fundamental Freedoms and Rights of Persons with Mental Illness are as follows:

Mental health Service users are entitled to all human rights enshrined in:

(a) The United Nations Bill of Rights
(b) Part III of the Zambia Constitution
(c) And all international human rights instruments to which Zambia is a party.

Code of Ethics for Nurses and Advocacy

The International Council of Nurses' (ICN) Code of Ethics also includes a central role for advocacy. As with the definition offered by Benner, the role of collaboration with patients, other healthcare providers, and society is evident in these statements from the ICN Code of Ethics for Nurses:

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The Code of Ethics describes the responsibility of the nurse to work through appropriate channels to address concerns about the healthcare environment. In addition, the Code of Ethics identifies a range of advocacy skills and activities that nurses are expected to demonstrate. These activities promote the profession and form the basis of the advocacy role for the professional nurse.

The skills include service to the profession through teaching, mentoring, peer review, involvement in professional associations, community service, and knowledge development/dissemination (ANA, 2001). These activities and skills form the basis of advocacy role of the professional nurse.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

Activity

Take some time to go to your nearest health facility, which can be a clinic or a hospital and find out what the rights of a nurse are then list them down and add on to the rights in this lesson

Mental health rights for protection of people with mental illness

- All persons have the right to the best available mental health care, which shall be part of the health and social care system
- All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
- All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
- There shall be no discrimination on the grounds of mental illness.
- Every person with a mental illness shall have the right to exercise all rights under the United Nations Bill of rights, Principle 13 of principle for the protection of persons with mental illness and the improvement of mental health care, Part III of the Zambian Constitution and African Charter on Human and People's Rights (1981)
- Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial Board established by domestic law.
- Where a court or other competent Board finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.
- Pronouncements meant to ridicule or embarrass a user shall constitute an offence.
- Special care should be given within the purposes of this Bill and within the context of domestic law relating to the protection of: minors, women and aged to protect the rights of minors, women and the aged including, if necessary, the appointment of a personal representative other than a family member preferably a social worker.

8.8 Summary

People suffering from mental illness are at risk to poor health outcomes and in many instances are not able to speak out for themselves hence the need for advocating or speaking out on their behalf. In order for advocacy to be a success the principles or rules have to be adhered to, incorporating skills of interviewing amongst others. For advocacy efforts to be sustainable the patients with mental illness as well as their relatives have to take part in addressing barriers to good mental health alongside or in partnership with other stake holders such as patient or family associations among others. Other groups of people in society that fall prey to increased adverse outcomes for mental illness such as vulnerable groups (people with HIV/AIDS, women and children, street children to mention but a few), are also to be included in advocacy efforts. Patient groups and families tend to be more in the forefront of advocacy. However, nurses must be aware of their own rights so that they are sure of the extent to which they must be involved, when to consult and when to admit to their limits.

8.9 Self Assessment Test

Cross match words in column 1 with appropriate response or letter in column 2

Column 1

1. Stigma
2. Vulnerable
3. Advocacy
4. Discrimination
5. Participation
6. Partnerships

Column 2

A. Increased risk of adverse health outcomes.

B. A mark of discredit and shame.

C. Treat mentally ill people confidentially.

D. Treat in a worse way than others because of their illness.

E. For health promotion to work well, it must be carried out by and with people, not on or to people.

F. Various actions aimed at changing the major structural and attitudinal barriers.

Answers

1. B

2. A
3. F
4. D
5. E

8.9 References

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