LECTURE NOTES

For Nursing Students

PREFACE

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

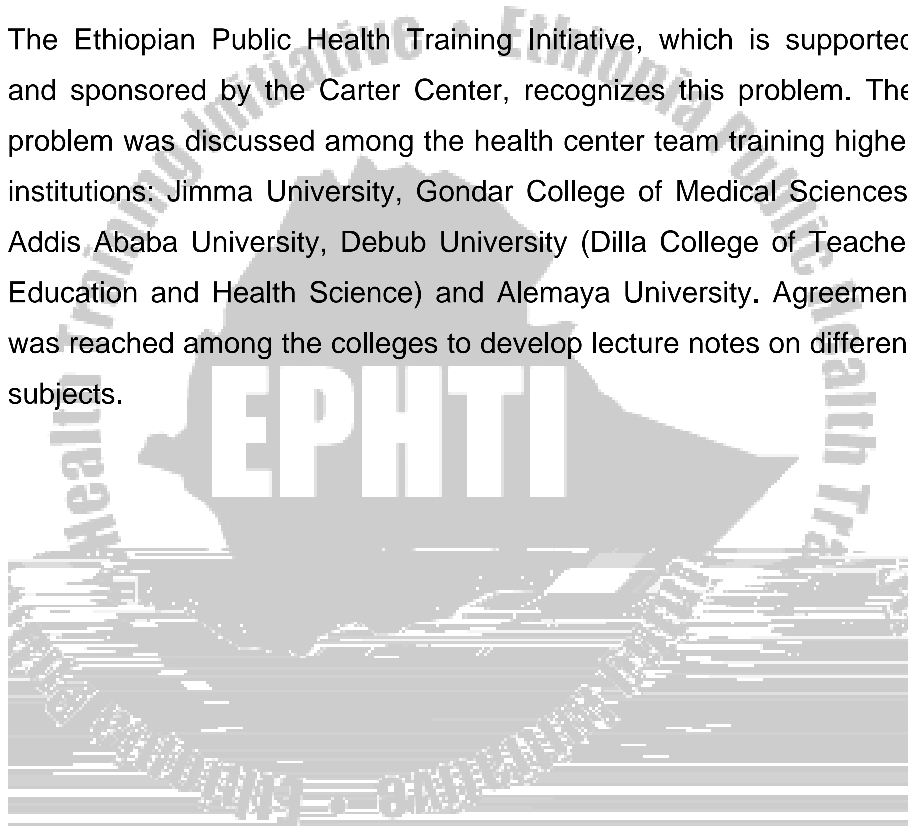
The training of psychiatric nurses who are well equipped in the profession is the priority issue for the higher teaching institutions and service giving organizations, in order to respond to the country mental health need.

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

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

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

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



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First and foremost I would like to express my gratitude to The Carter Center for the initiative and its assistance in developing these lecture notes.

I would like to convey my appreciation to Alemaya University, particularly to the office of the Academic Vice President and Ato Melake Damene, Dean of the Faculty of Health Sciences for the continuous support and facilitation of the development of this manuscript. I would like to extend my appreciation to the faculty staff for their valuable support in the development of the draft. I would also like to thank Professor Kate Ashcroft for English language edition, Sister Tiruwork Tafessie and Ato Telake Azale for their meticulous review of the final draft.

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

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

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

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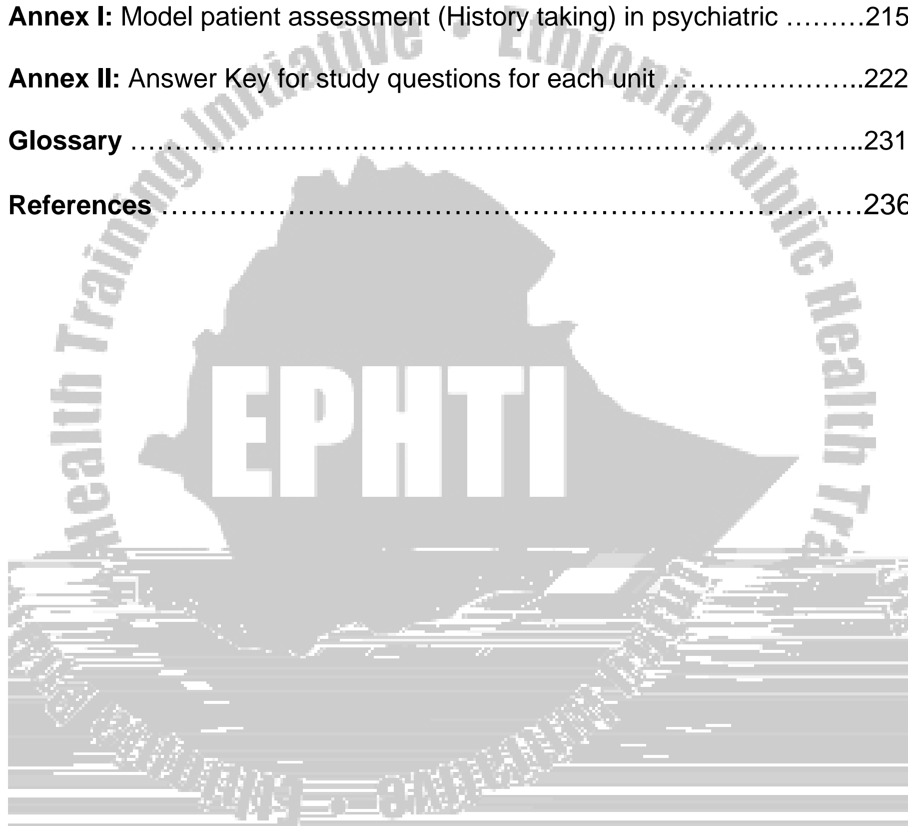

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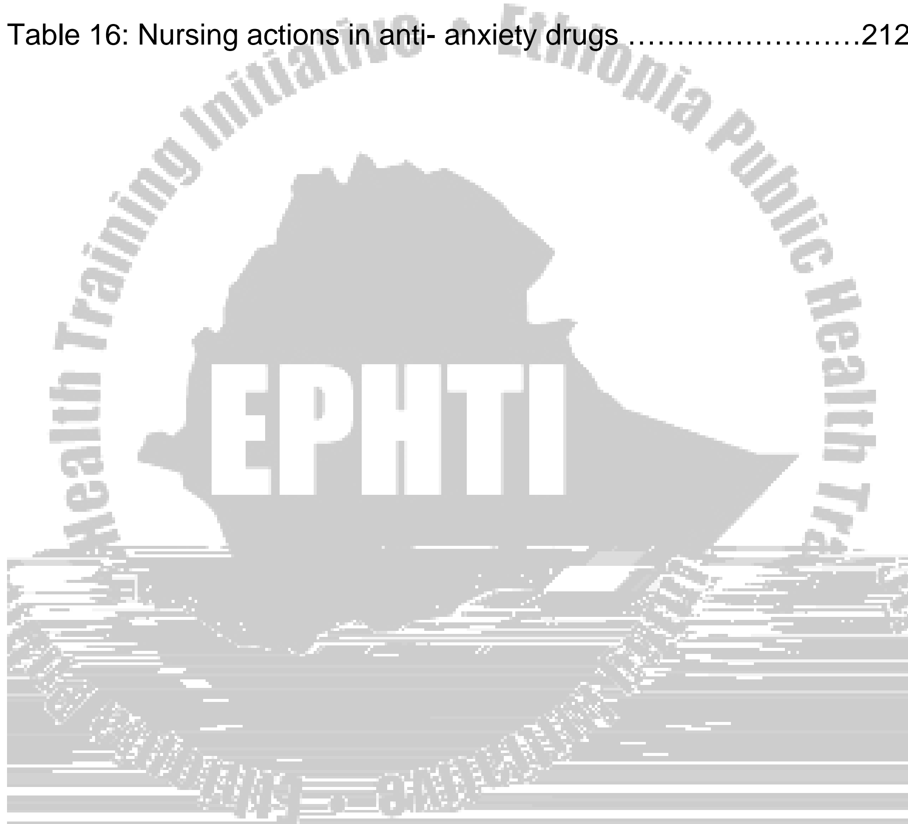


INTRODUCTION

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

Each chapter in this manual contains the following components:

(a) Objectives at the beginning of each chapter to guide students in their studies:

(b) Study questions related to each chapter

(c) A glossary for students to familiarize students with some new terms

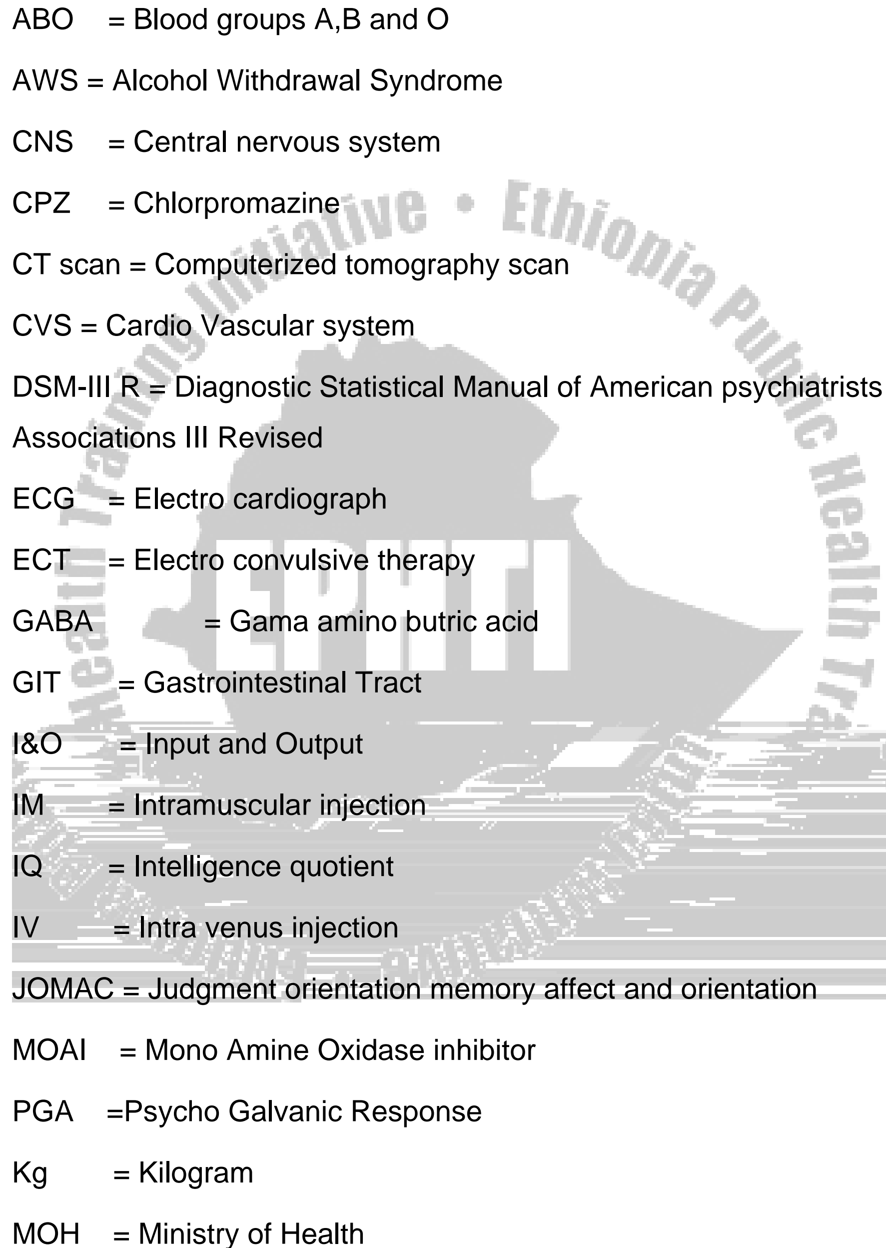
(d) A reference suitable for beginning students are listed at the end of the manual.

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

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

is glad to contribute to this particular profession by producing this

LIST OF ABBREVIATIONS



ABO = Blood groups A,B and O

AWS = Alcohol Withdrawal Syndrome

CNS = Central nervous system

CPZ = Chlorpromazine

CT scan = Computerized tomography scan

CVS = Cardio Vascular system

DSM-III R = Diagnostic Statistical Manual of American psychiatrists Associations III Revised

ECG = Electro cardiograph

ECT = Electro convulsive therapy

GABA = Gama amino butric acid

GIT = Gastrointestinal Tract

I&O = Input and Output

IM = Intramuscular injection

IQ = Intelligence quotient

IV = Intra venus injection

JOMAC = Judgment orientation memory affect and orientation

MOAI = Mono Amine Oxidase inhibitor

PGA =Psycho Galvanic Response

Kg = Kilogram

MOH = Ministry of Health

Mg = Milligram

MOAI = Mono amine oxidase inhibitor

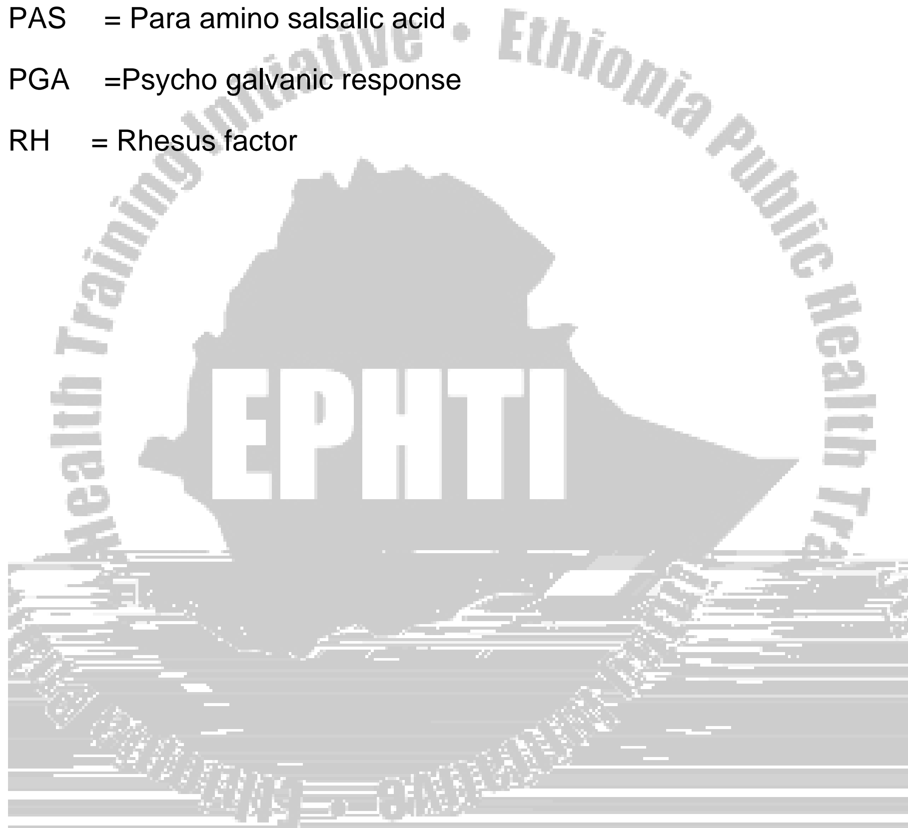
NPO = Nothing per os (mouth)

OPD = Out patient department

PAS = Para amino salsalic acid

PGA =Psycho galvanic response

RH = Rhesus factor



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

Normality

What is normality?

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

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

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

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3. Loss of reality contact
4. Lack of insight

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

MENTAL HEALTH	MENTAL ILLNESS
1. Accepts self and others	1. - Feelings of inadequacy - Poor self-concept
2. Ability to cope or tolerate stress. Can return to normal functioning if temporarily disturbed	2. - Inability to cope - Maladaptive behavior
3. Ability to form close and lasting relationships	3. Inability to establish a meaningful relationship
4. Uses sound judgment to make decisions	4. Displays poor judgment
5. Accepts responsibility for actions	5. Irresponsibility or inability to accept responsibility for actions
6. Optimistic	6. Pessimistic

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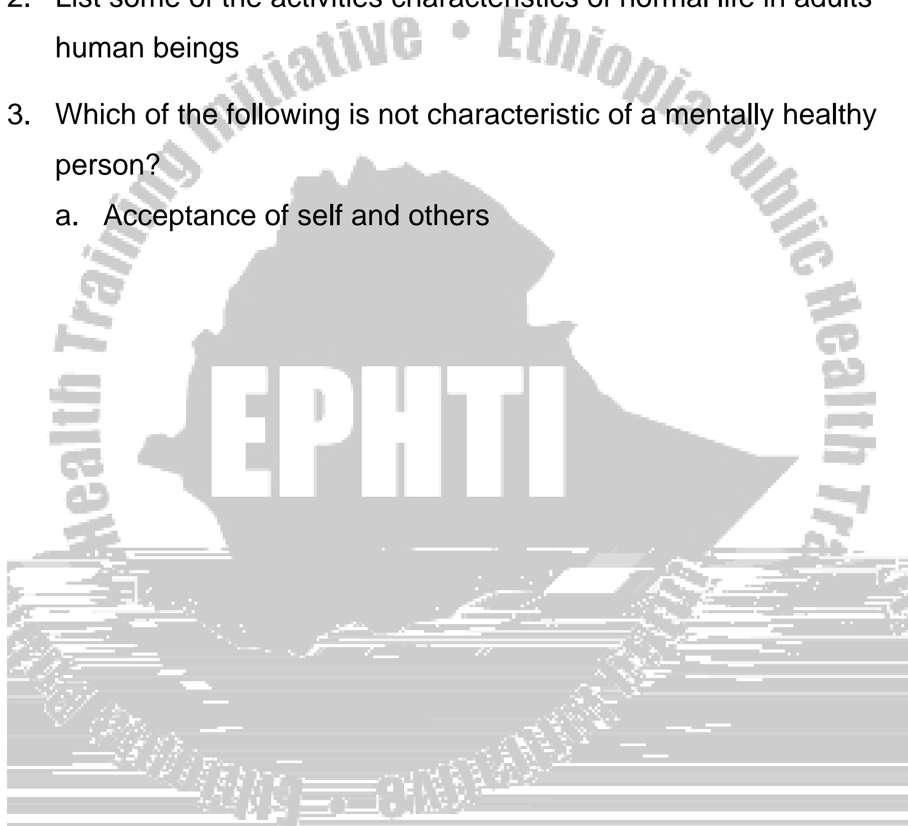
stress with automatic, unconscious behavior that serves to satisfy their basic needs in a socially acceptable way.

REVIEW QUESTION

1. In the context of mental health list at least six points the enable us to say someone is normal.
2. List some of the activities characteristics of normal life in adults human beings
3. Which of the following is not characteristic of a mentally healthy person?
   a. Acceptance of self and others



a. True

b. False

CHAPTER TWO

HISTORY AND TRENDS IN PSYCHIATRIC NURSING

Learning objectives

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

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

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

In the ancient civilization, Greeks, Romans and Arabs viewed mental deviations as natural phenomena and treated the mentally ill humanely. Care consisted of sedation with opium, music, good

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

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

Mental illness was considered irreversible. The mentally ill were beaten for disobedience and confined to cages or closets. Generally,

could be cured by having them hold rods filled with iron filings in

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

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

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

Slowly and gradually a more humanitarian type of care was introduced by one psychiatrist. Dr. Fikire Workineh. The first psychiatric nursing school was established in Emanuel Hospital in

in 18 Belmotreat(E)o6.71wn a

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

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

REVIEW QUESTIONS

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

CHAPTER THREE

GENERAL NURSING TECHNIQUES USED IN PSYCHIATRIC NURSING

Learning objectives

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

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

Understanding 'self'

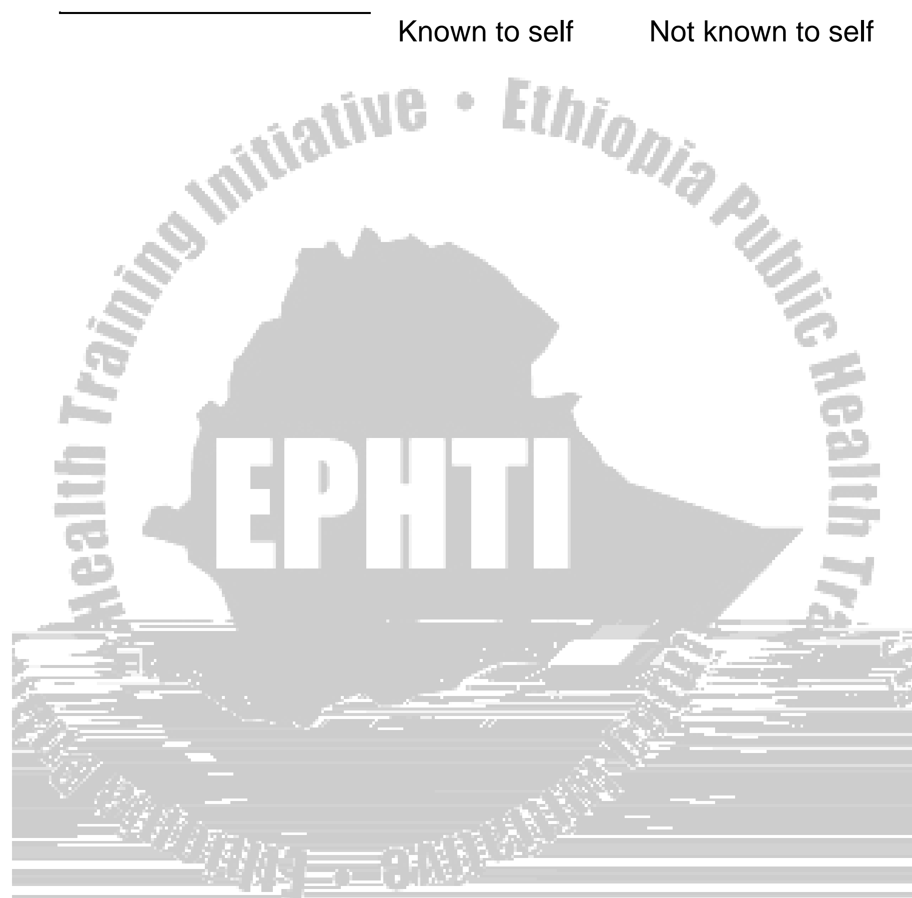
Self is the sum of the attitudes that make up the personality. According to the psychologist Erik Eriksson, certain developmental tasks must be accomplished during each of stages of the life cycle (infancy, childhood, adolescence, adulthood, old age). Each step is necessary for self development.

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

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

Table 2: Jo-Hari's window of self

	Known to self	Not known to self



Self acceptance

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

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

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

Communication

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

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

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

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

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

Therapeutic communication

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

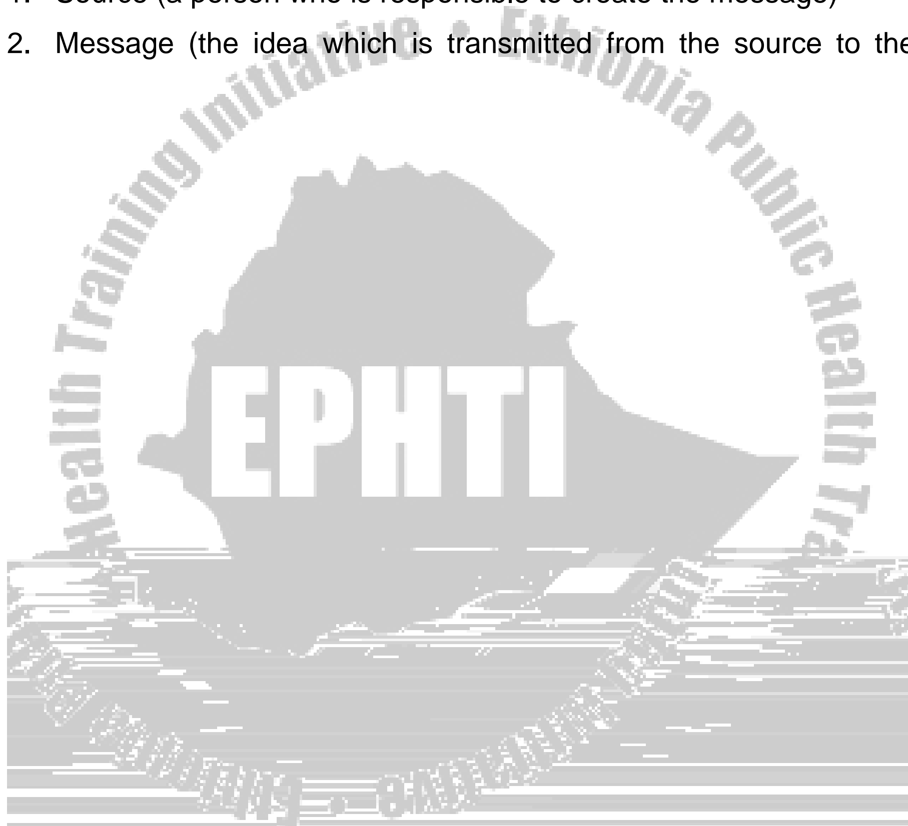
Non-verbal communication includes:

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

- Vocal cues and
- Distance or spatial territory.

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

1. Source (a person who is responsible to create the message)
2. Message (the idea which is transmitted from the source to the



Some barriers to effective communication

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

Communication skills

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

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

Psychiatric assessment techniques

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

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

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

1. ***History of present illness***

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

2. ***Social history***

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

- Father

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

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

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

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

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

3. ***Physical examination***

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

4. ***Psychiatric examination (mental status examination)*** Record the following aspects of the psychiatric patient's state General behavior, appearance, word behavior since admission attitude towards hospital staff etc.

- Talk (form of talk), much or little, spontaneous, answers to questions etc.
- Mood
- Form of thought; Does the patient experience blocking pressure or poverty in thinking?
- Content of thought
- Delusions and misinterpretations
- Hallucinations
- Obsessional phenomena
- Orientation to time place and persons.
- Memory

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

REVIEW QUESTIONS

1. Self is a sum of the attitudes that make up the personality

   a. True b. False

2. Verbal communication is considered a more accurate description of true feelings because one has more control over non verbal reactions.

   a. True b. False

3. A special form of communication that has a health-related purpose and develops in a continuous flow of interaction between nurse and patient, with input from both of them contributing to its nature is termed as therapeutic communication.

   a. True b. False

4. List the complete scheme of patient assessment/history taking/ in psychiatric nursing.

5. Which of the following is not categorized under psychiatric examination /mental status communication?

   a. Delusion and misinterpretation
   b. Attention and concentration
   c. Blood test for biochemical analysis
   d. Content of thought.

CHAPTER FOUR

COUNSELING TECHNIQUES IN PSYCHIATRIC NURSING012 Tcsc98 0 0 10398 139.32

Listening

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

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

B. Demonstrating the body language of listening:

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

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tells someone you are listening.

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

Exploring the person and their problems

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

A. The counselor must try to understand.

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

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

B. Try to make statements instead of asking questions

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

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

D. Be concrete

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

F. Do not give advice.

Understanding the person's point of view

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

A. The counselor acts as a mirror

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

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

B. Do not give advice.

Problem solving

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

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

1. People are usually doing the best they know how
2. Perhaps the best way for you is not the best way for them.

B. List alternatives:

1. Do not judge them, just list them
2. Be creative

C. Evaluate the alternatives, list advantages and disadvantages.

D. Choose one solution

1. The person with the problem should make the decision if at all possible.
2. Give your opinion if you want but remember to let the person have control and take responsibility.
3. Be realistic

E. Encourage the patient to try it:

1. Be specific
2. Set time limits

F. Evaluate results.

G. If not successful explore the reasons why, list new alternatives and try again.

H. Don't give up

REVIEW QUESTIONS

1. In counseling, the problem which is presented from a client is always a true problem.

   A. True B. False

2. In counseling the four processes to teach people and solve their own problem are:- Listening, Explaining, understanding, and problem solving.

   A. True B. False

3. During counseling as a counselor one has to listen to things to be listened and desired to be listened.

   A. True B False

4. A counselor, while listening to the client has also to listen to his/her self.

   A. True B. False

5. During counseling, as a counselor it is desirable to make decision on behalf of the client.

   A. True B. False

UNIT-TWO

GENERAL CLASSIFICATION OF MENTAL ILLNESS AND SPECIFIC MENTAL ILLNESSES

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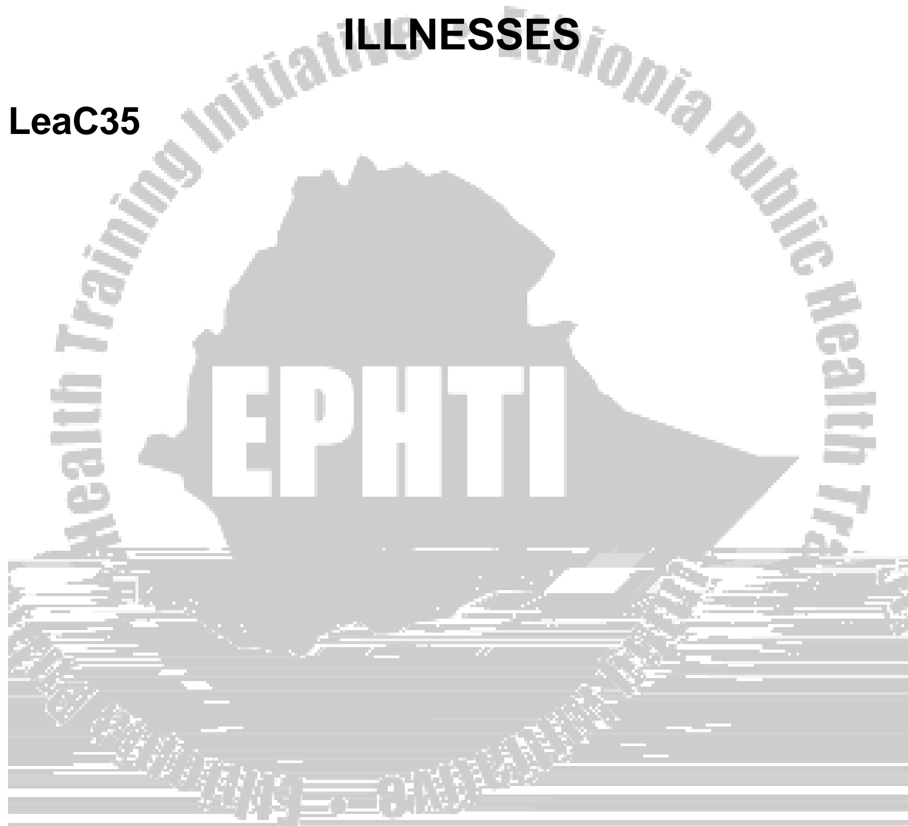

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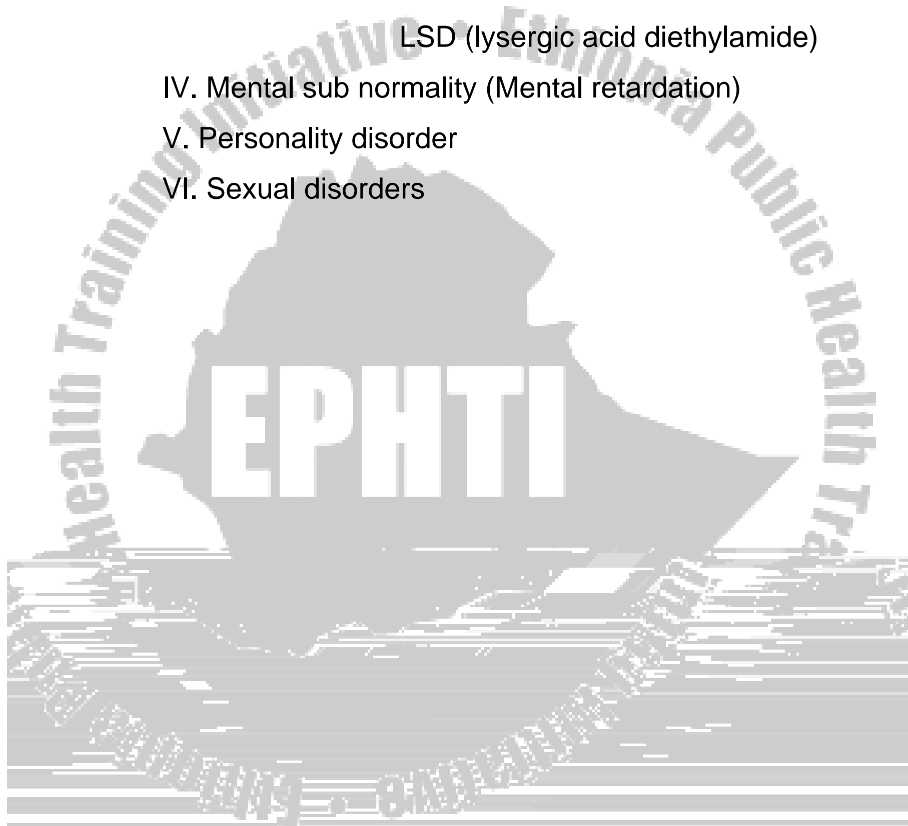
Substances abuse such as

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

IV. Mental sub normality (Mental retardation)

V. Personality disorder

VI. Sexual disorders



Different miner mental illnesses

Anxiety disorders

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

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

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

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

Below are listed sub classifications of general anxiety disorders:

Sub types of anxiety disorders

1. Anxiety
2. Phobia

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

1. Anxiety disorder

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

a. Normal anxiety
b. Pathological anxiety can subdivided in to two sub categories:
    - panic anxiety
    - diffusive anxiety.

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

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

Epidemiology

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

Etiology

Risk factors include:

1. Constitutional:

- genetic (it can be inherited genetically)
- developmental: if the developmental process is full of anxiety.
- provoking conditions e.g. war, famine, home disturbance etc.

2. Physiological:

- endocrine e.g. thyrotoxicosis
- head injury (traumatic neurosis)

3. Psychological:

- stress
- interpersonal conflict
- external:
    - social
    - occupational etc.

Clinical Features of Anxiety

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

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

Differential diagnosis

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

Method of Diagnosis

1. History
2. Clinical findings

Treatment

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

Prognosis:

Prognosis depends up on:

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

Complications

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

2. Phobia

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

Epidemiology

Phobia occurs in 3-5% of population.

Etiology

The etiology of phobia is not clearly known

There are two types of phobias

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

Examples of simple phobias include:

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

2. Complex phobia (social phobia)

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

Examples of complex phobias include:

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

Epidemiology

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

Etiology

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

Clinical features

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

Differential diagnosis

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

Treatment

1. Behavioral therapy
    - Desensitization - enabling the patient to adapt to a situation piece by piece or part by part.
    - Systematic – slow and gradual adaptation and understanding of reality.
    - Flooding - exposingthe individual to the feared object.
2. Antidepressant - phenotizine

    - MAOI (monoamine oxidase inhibitors)

Prognosis

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

Complications

- Alcoholism
- Drug abuse
- Social and occupational disabilities.

3. Conversion disorder

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

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

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

Epidemiology

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

Etiology

According to psychodynamic theory, hysteria can be directed at:

- Fixation stage - during oedipal phase
- Anxiousness - the relief of unbearable somatic symptoms.

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

4. Obsessive compulsive disorder

Obsession

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

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

Epidemiology

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

Etiology

- Constitutional function there is a heredity tendency

- Obsessional impulses
- Obsessional phobias

Treatment

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

Prognosis

- 50% will be chronic
- A few develop schizophrenia

5. Hypochondria

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

Epidemiology

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

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

Etiology

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

Signs and symptoms

- Ranges from simple preoccupation with illness to delusion
- Primarily mono-symptomatic (occurs with single disease symptom)
- It may develop in to multi symptomatic (many disease symptoms)

Treatment

- Treat any under lying illnesses
- Antidepressant (amiltriptline)
- Psychotherapy and supportive ideas

Prognosis

Hypochondria is refractive in some cases

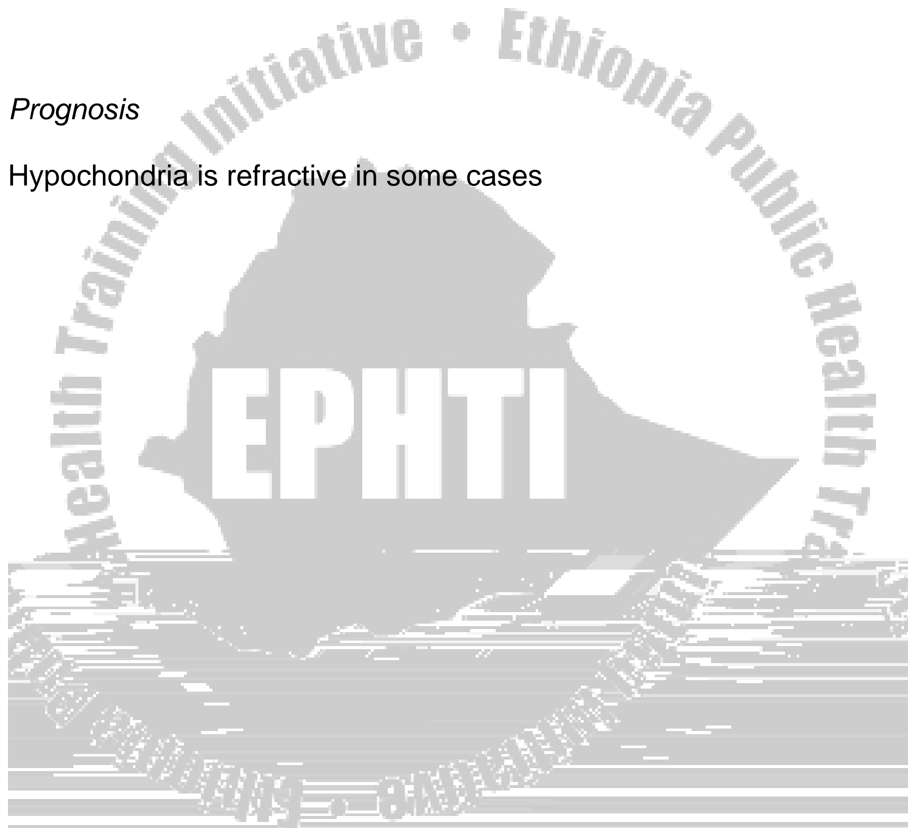

Table 3: Differences between neurosis and psychosis

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

Nursing intervention

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

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

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

During the panic state the nursing interventions may include:

1. Staying with the patient at all times
2. Remaining calm: he patient will sense any anxiety exhibited by

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

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

The nurse provides supportive care by:

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

Reassuring the patient

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

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

10. Exploring one's own feelings.
11. Administering treatments or medications to reduce anxiety or other discomfort

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

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

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

Nursing Diagnoses	Nursing Interventions
Anxiety	Assess the patient's level of anxiety. (Nursing interventions for the panic state and mild to moderate anxiety were covered in depth earlier in this chapter.) Assess for suicidal ideation.
Ineffective individual coping. Obsessive compulsive, ritualistic behavior.	Remove patient from any situation that stimulates or increases behavior. Observe for signs of increasing anxiety and intervene before the patient resorts to ritualistic behavior if possible. Establish trust and one-to-one

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

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UNIT THREE

AFFECTIVE DISORDERS (MOOD DISORDERS)

Learning objectives

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

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

Affective disorder

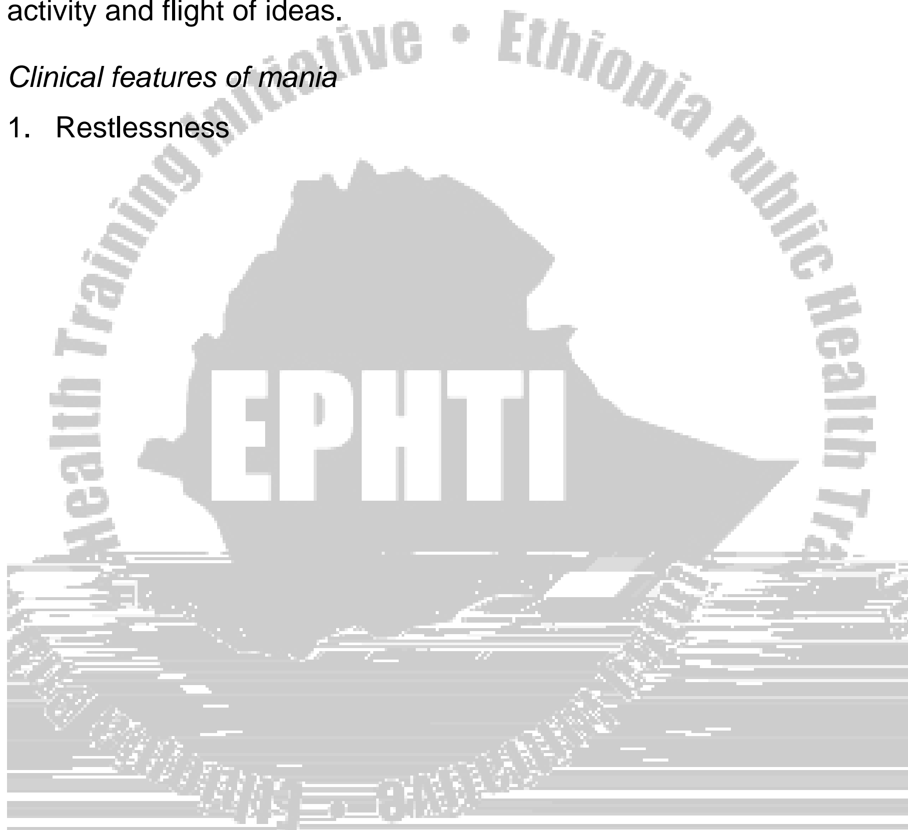
Affective disorder is defined as a mental disorder exhibiting prominent and persistent mood changes of elation or depression accompanied by symptoms such as fatigue and insomnia. An abnormality of affect, activity or thought process is present. The mood changes appear to be disproportionate to any cause.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

Manic psychosis

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

Clinical features of mania

1. Restlessness



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

Differential diagnosis (DDX)

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

Methods of diagnosis (DX)

History and physical examination

Treatment (RX)

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

Prognosis

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

Depression

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

Classification of depression

1. *Reactive Depression:*

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

2. *Endogenous depression (autonomous depression*)

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

3. *Bipolar depression*

- The patient experiences depression and manic episodes.

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Anxiety features: such as

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

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

The common signsare

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

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

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

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

Nursing interventions for depression and mania

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

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

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

1. Acceptance
2. Honesty

3. Empathy
4. Patience

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

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

1. Do you have difficult falling asleep at night?
2. Do you wake in the middle of the night?
3. If so, are you able to return to sleep?
4. Do you wake earlier than usual in the morning?
5. Are you alert or depressed when you get up in the morning?
6. Do you sleep excessively?
7. Have you been experiencing feelings of worthlessness, self reproach, or guilt?
8. Do you have difficult concentrating or making decisions?

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

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

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

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

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

importance of outpatient treatment as well as the continuation of

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

Alternation in bowel elimination: Constipation	Monitor Input and output. Encourage the intake of

REVIEW QUESTIONS

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

UNIT FOUR

SCHIZOPHRENIA

Learning objectives

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

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

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

Schizo - split } = meaning split mind

Phrenia - mind}

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

Types of Schizophrenia

A. Disorganized (hebephrenic type)

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

B. Catatonic type

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

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

C. Paranoid type

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

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

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

D. Undifferentiated type

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

E. Residual type

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

F. Simple type

The patient Experiences:

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

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

DSM III diagnostic criteria for schizophrenic disorders

The DSM III diagnostic criteria include the following:

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

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

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

B. Deterioration

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

C. Duration:

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

D. symptoms of depression or manic syndrome

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

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

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

Bawleres symptoms 'The 4 A's' Of schizophrenia

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

Differential diagnosis

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

Prognosis:

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

Treatment (Rx)

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

Nursing interventions

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

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

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

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

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

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

The nurse must observe for extra pyramidal side effects of

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

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

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

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UNIT FIVE

EPILEPSY

Learning objectives

After this unit, the student should be able to:

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

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

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

   (Brunner and Sundarth: 1998)

The following are important characteristics of epilepsy:

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

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

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

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

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

Etiology

The etiology of seizures varies remarkably in adults and includes:

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

Clinical manifestations

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

1. Generalized seizures:
- Tonic clonic seizures (grand mal)
- Absence (petit mall)
- Minor motor seizures (akinetic, myoclonic, atonic)

2. Partial seizures (focal epilepsy)
- Partial seizures with motor components
- Partial seizures with sensory components
- Partial seizures with complex symptoms
- Partial seizures that secondarily generalize

Diagnostic assessment

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

Medical management

Medical management includes:

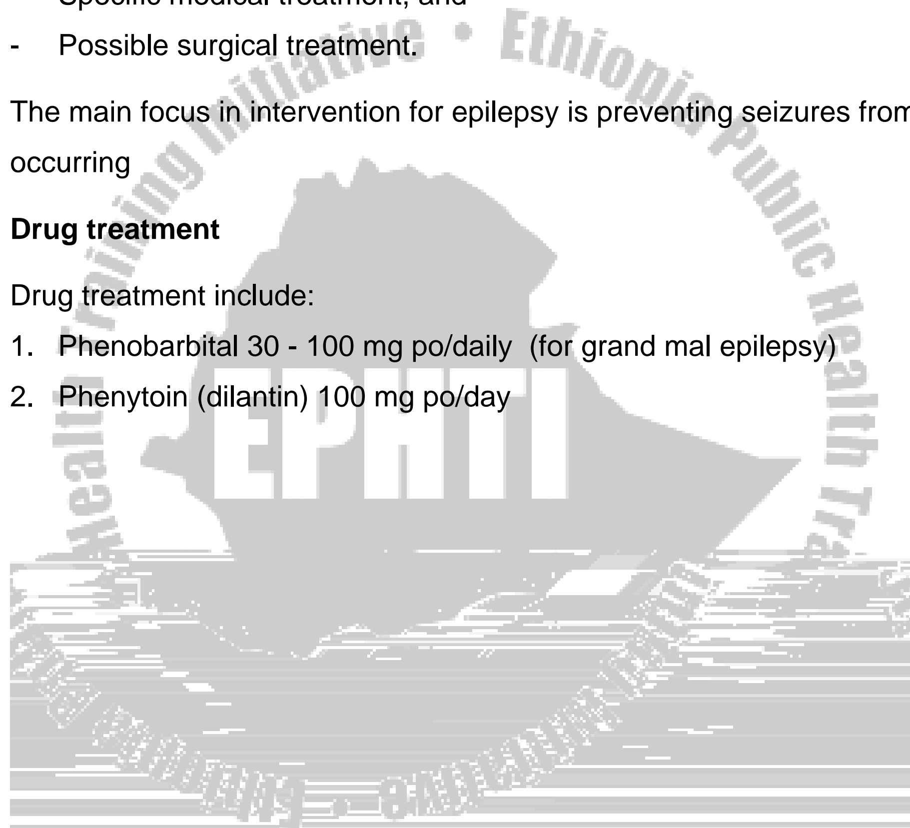
- Eliminating factors that may cause or precipitate seizures.
- Improving the client's physical and mental health
- Specific medical treatment, and
- Possible surgical treatment.

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

Drug treatment

Drug treatment include:

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



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

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

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

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

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

Emotional effects of epilepsy

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

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

Observation (assessment during the seizure attacks)

Nurses should make the following observations during seizures:

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

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

Family education

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

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

REVIEW QUESTIONS

1. List at least four major characteristics typical of epilepsy
2. Seizure is a paroxysmal, uncontrolled discharge of electrical activity in the brain's gray matter that interferes with normal function of the brain and also it is a symptom rather than a disease

   a. False b. True
3. Which one of the following activity is restricted or performed with maximum safeguards in epileptic patients.

   a. Horse back riding b. Swimming

   c. Tree climbing d. All of the above
4. Which one of the following doesn't trigger or precipitate the occurrence of seizure in epileptic patients

   a. Increased stress

   b. Increased sleep

   c. Emotional upset

c. Positioning of the patient to the side

d. All of the above

UNIT SIX

ORGANIC MENTAL SYNDROMES AND DISORDERS (COGNITIVE FUNCTION DISORDERS)

Learning objectives

After studying this unit the student should be able to:

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

Definition

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

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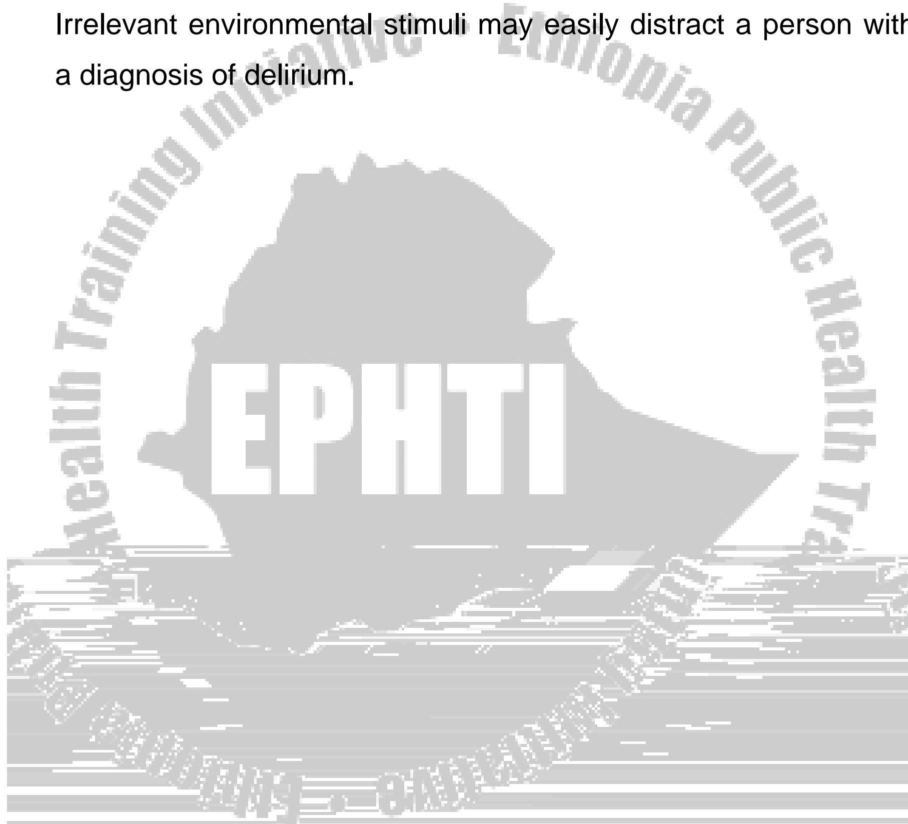
This disorder is characterized by a clouding of consciousness, accompanied by

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



B. Dementia

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

Diagnostic criteria for dementia

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

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

   d. Depression

4. Unclouded state of consciousness

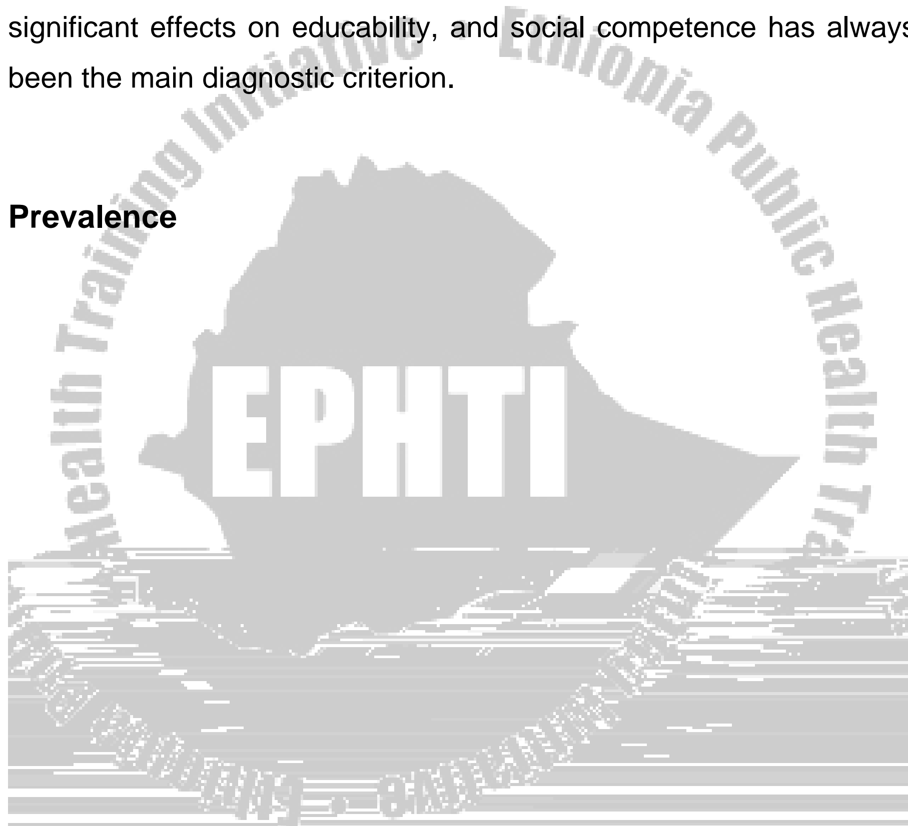
physical examination, or laboratory tests, an organic factor can be presumed.

C. Alzheimer's disease (primary degenerative dementia)

Alzheimer's disease

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

Prevalence



can be expected to occur at one end of the normal distribution curve.

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

Infancy

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

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

Childhood

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

School

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

Classification of the causes mental handicap

Organic causes

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

E. Down's syndrome (mongolism)

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

different abnormality translocation, in which there are 46 chromosomes, one of which is large and atypical. Clinically, mongolism is common, 1 in 700 live births, but up to 50 per cent of the infants die during their first year. Mongols formerly had a short life due to infection, but those who survive infancy now live longer. All

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

Some of these abnormalities are described in more detail below.

Acquired metabolic abnormality

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

sm (Cretinism): This has various causes: enzyme deficiencies, absent or mal developed thyroid, ingestion of drugs such as phenylbutazone,

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

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

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

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

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

G. Neurological defects

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

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

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

H. Bony defects

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

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

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

Treatment and care

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

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

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Remaining learning potential should be maximized while the person is made to feel comfortable both physically and emotionally. New

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

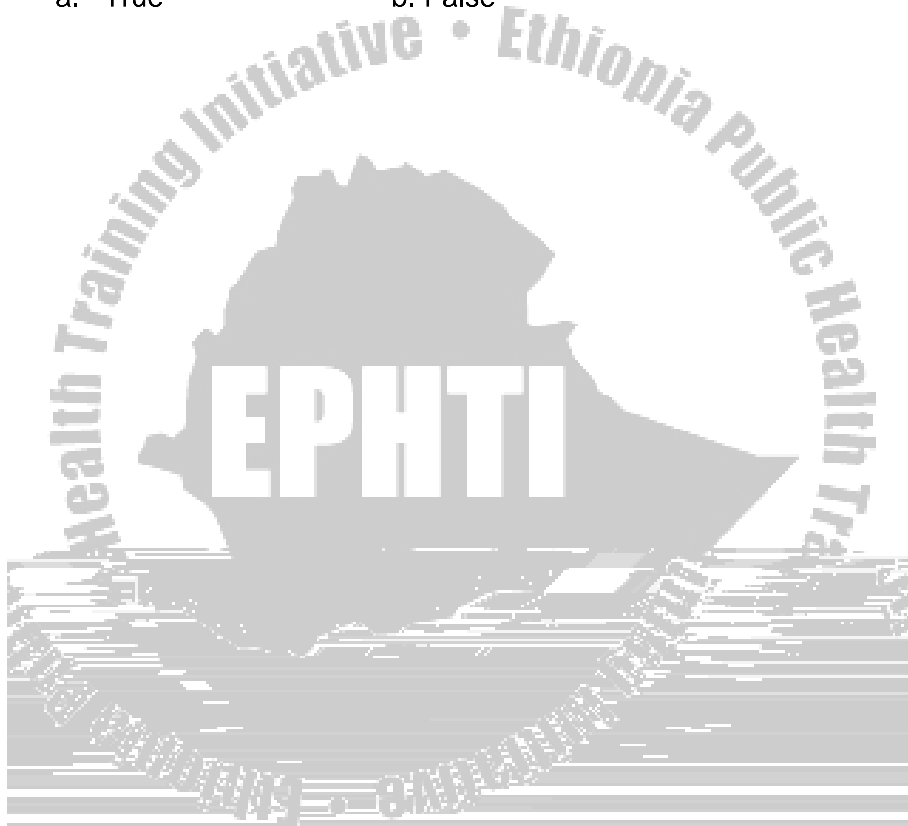
NURSING DIAGNOSES	NURSING INTERVENTIONS
Alteration in though process related to disorientation	Assess level of disorientation. Use the following reality therapy: 1. Orient to person, place, and time by using clocks, calendars, or other visual aids. 2. Refer to date, time of day, and recent activities during interactions with the patient. 3. Address the person by name 4. Correct errors in a matter-of-fact manner, Establish a set daily routine. Encourage the person to have familiar personal belongings or possessions in his room. Assign the same nursing personnel to care the patient whenever possible.
Self-care deficit because of loss of independent functions such as bathing and dressing	Encourage independent functions by giving verbal step by-step instructions. Remain with the patient. Allow ample time to perform a given task to avoid frustration. Assist the patient if sensor motor impairment prevents him or her form functioning without help.

Alteration in though process because of memory loss for recent information	Provide the patient with clear, simple, step-by-step directions while performing ADL routines. Use supportive statements if fabricated stories or untruths are given in defense of memory loss (i.e. "It's hard to find your glasses when their location slips your mind.").
Potential for injury owing to sensory motor deficits such as impaired vision and unstable gait	Establish a safe environment by 1. Providing adequate lighting in the patient's room 2. Providing a night light 3. Placing the light switch close to the bed for easy accessibility 4. Assessing the patient's ability to ambulate independently, providing assistance as needed (i.e. walker, cane, or assist with ambulation) 5. Providing adequate restraints such as a poesy or vest if patient is disoriented as well as physically unstable

REVIEW QUESTIONS

1. Organic mental disorder refers to a particular organic mental syndrome in which the etiology is unknown.

   a. True b. False



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

2. Separation from parents

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

3. Other stresses

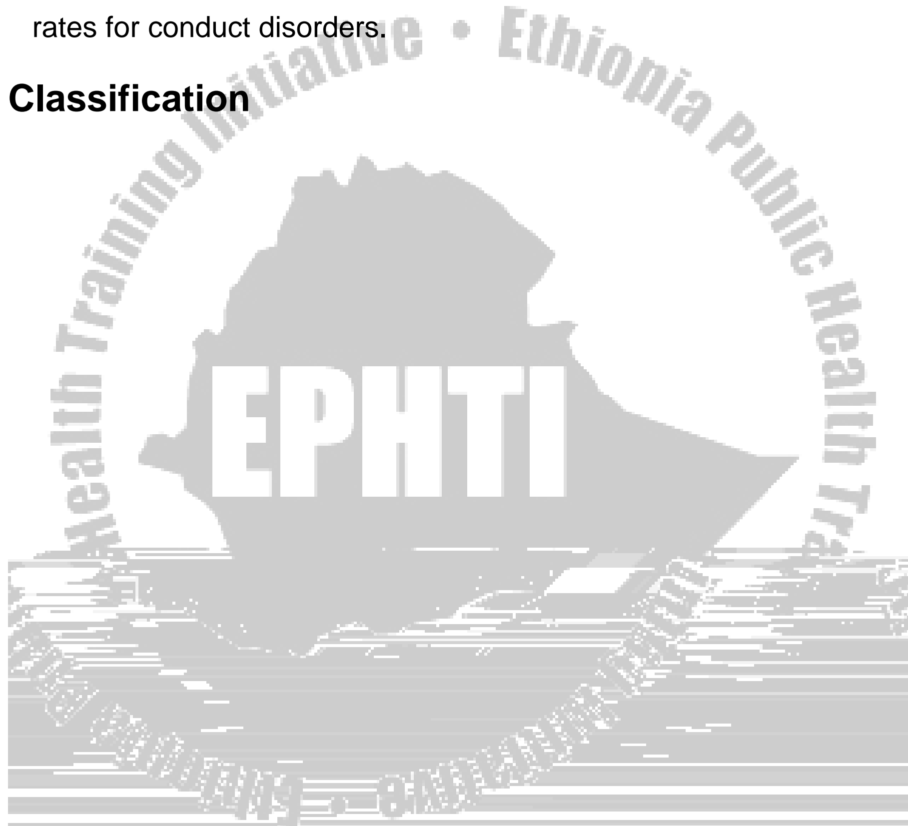
Other damaging stresses for children include moving house, bereavement and a broken home. The latter is especially associated with conduct disorders. The in the case of divorce, the associated marital discord is more important than the parents' separation. Children of one parent families have more psychiatric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

4. Delinquency

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

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

Classification



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

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

Specific syndromes of childhood psychiatric disorder

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Types of adolescent disorder

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

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

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

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

The weight of patients with the disease typically falls to 30 to 35 kg. The may be best regarded as a phobic avoidance of adolescent weight gain and the physical and psychological changes d b0es self-

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

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

Drug abuse is common in adolescence and alcoholism increasing.

Treatment methods

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

Treatment services

Many adolescents do not seek medical help with their symptoms.

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UNIT EIGHT

ALCOHOL AND OTHER SUBSTANCE ABUSE

Learning objectives

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

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

Definitions

Teetotaler: Person who do not drink alcohol at all

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

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

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

GIT (gastrointestinal tract)*:* Alcohol *e*rodes the stomach and causes mucosa-gastritis, acute pancrititis, cirrhosis in the liver and alcoholic hepatitis.

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

Kidney: Alcohol causes diuresis.

Eye: Alcohol causes pupilary dilation, hyper reflexia.

Alcoholism

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

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

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

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

Etiology

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

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

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

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

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

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

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

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

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

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

Alcohol-related disorders

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

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

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

Treatment

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

Detoxification

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

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

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

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

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

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

Alcohol withdrawal delirium

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

Additional features of withdrawal are:

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

Treatment

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

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

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

Alcoholic amnestic syndrome (Wernicke Korsakoff's syndrome)

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

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

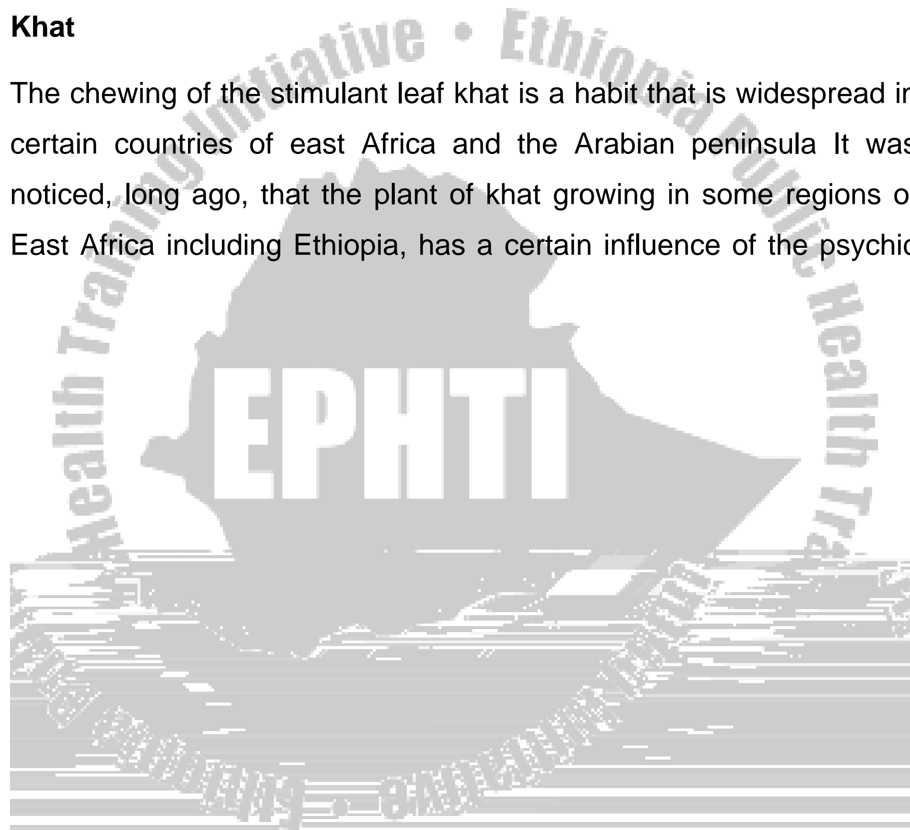
Etiology

Epidemiology

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

Khat

The chewing of the stimulant leaf khat is a habit that is widespread in certain countries of east Africa and the Arabian peninsula It was noticed, long ago, that the plant of khat growing in some regions of East Africa including Ethiopia, has a certain influence of the psychic



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

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

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

Khat is used because of the effect it has on the person's psychic and physical condition. Khat has an extreme social effect (individual sociability and ease within social gatherings). It provides a major

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

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

Khat is known for producing amphetamine-like effect. It is an amphetamine-like substance with the following behavioral and physical effects: alertness, euphoria, hyperactivity, irritability, aggressiveness, agitation, paranoid trends and hallucinations. Other physical effects include mydriasis, tremor, dry mouth,

tachycardia, arrhythmias, weight loss and convulsions. Patients can also develop psychotic disorder, mood disorder, and sexual dysfunction and sleep disorders.

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

Treatment

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

Cannabis

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

Euphoria

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

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

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

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

symptoms.	Provide reassurance and comfort.

REVIEW QUESTIONS

1. In alcohol users, a need for markedly increased amount of alcohol use to achieve the desired effect is termed as tolerance

    a. True b. False

2. One of the following organ system is the main target of alcoholism in alcohol user individuals

    a. GIT (gastrointestinal tract)

    b. Cardiovascular system

    c. Kidney

    d. Central nervous system (CNS)

3. Alcoholism is a problem which needs, physical, psychological and sociological intervention, not only psychiatric intervention

    a. True b. False

4. Detoxifying an alcoholic requires a co-operative patient and a co-operative significant others.

    a. False b. True

UNIT NINE

DEFENSE MECHANISMS

Learning objectives

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

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

Definition

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

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

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

1. *Repression:* This is an involuntary rejection of ideas. unconscious thoughts, feelings and memories that are painful (automatic forgetting): for example, the inability to remember the reason for an argument or recall feelings of fear following an automobile accident.

2. *Suppression:* This is the voluntary act of pushing unacceptable feelings out of one's consciousness. This mechanism is generally used to protect one's self-esteem.

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

3. *Rationalization:* This is the most common ego defense mechanism. It is used to justify ideas, actions or feelings by providing good, acceptable reasons and explanations. It is used to maintain self-respect, prevent guilt feelings, and obtain social approval or acceptance: for example, a teenage girl who was not asked to the junior prom might tell her friend someone really wanted to date her but felt sorry for Sue and took her to the prom instead.

4. *Identification (the imitator):* This is an unconscious adoption of some of the characteristics of another person.

5. *Sublimation:* This is one of the defense mechanism that is not pathogenic. It involves re-channeling of consciously intolerable or occasionally unacceptable impulse or behaviors into activities that

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

6. *Displacement:* This is a mechanism that serves to transfer feelings such as frustration, hostility, or anxiety from one idea, person, or object to another: for example, a person might disagree at his boss but instead picks a fight with his wife or his children when he is back at home.

7. *Compensation:* This is the act of 'making up'for a real or imagined inability or deficiency with a specific behavior to maintain self respect or self- esteem: for example, a short girl may become the manager of the girl's basketball team because she is not tall enough to qualify for the team, or an unattractive man may select expensive, stylish cloths to draw attention to himself or an unattractive woman may dress like a fashion plate to attract attention.

8. *Introjection:* This involves attributing to oneself the good qualities of another: symbolically taking on the character trait of another person by 'ingesting' his philosophy ideas, knowledge, or attitudes. the term is often used loosely as synonymous with identification. An example would be a psychiatric patient who claims to be Mosses or Jesus Christ or other biblical or well known person, who is observed dressing and acting like the personage they profess to be. One patient who claimed to be Moses grew a beard and long

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

9. *Projection:* This is often termed as the 'escaping goat' defense mechanism. The person rejects unwanted characteristics of her or

situation (it is also referred to as overcompensation). Examples would be a young man who dislikes his mother-in-law who acts very polite and courteous towards her, a woman who hates

16. Fantasy: This refers to imagined events or mental images (e.g. day dreaming) to express unconscious ideas, conflict, gratify

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

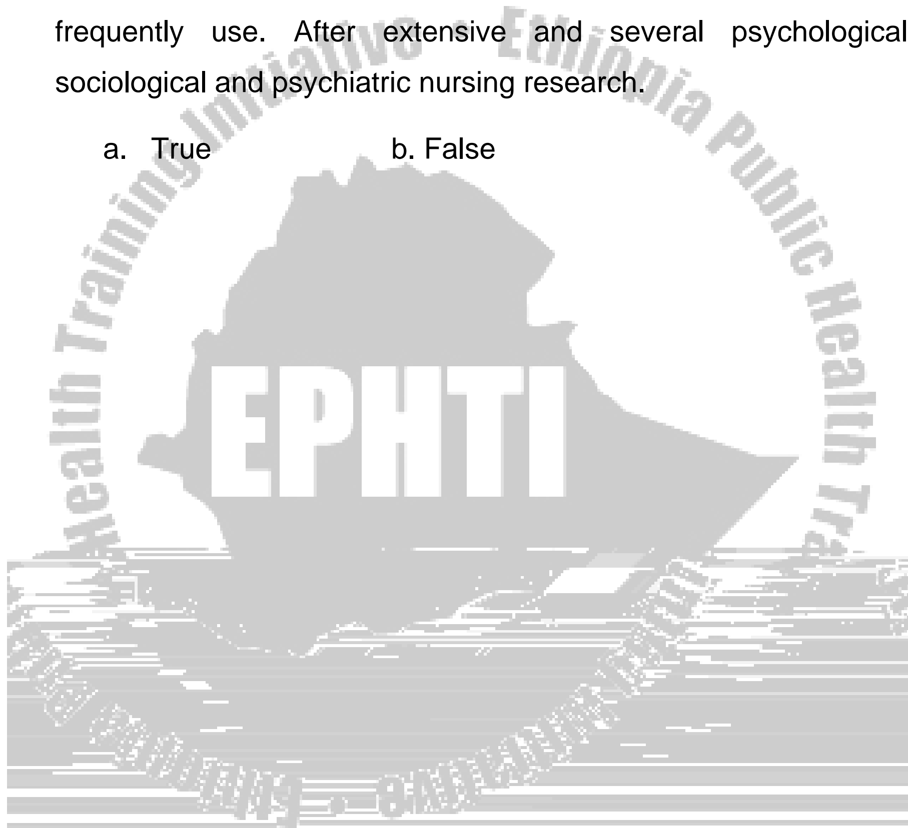
20. *Intellectualization:* This refers to the act of transferring emotional concern in to the intellectual sphere: for example, a young man may use intellectualization as method of avoiding confrontation with his fiancé if she changed her mind about wishing to marry him.

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

REVIEW QUESTIONS

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

    a. True b. False



UNIT TEN

PERSONALITY DISORDER (CHARACTER DISORDER)

Learning objectives

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

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

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Characteristics of personality disorder

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

Etiology of personality disorders

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

Clusters of Personality Disorders

Cluster A

Paranoid personality disorder

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

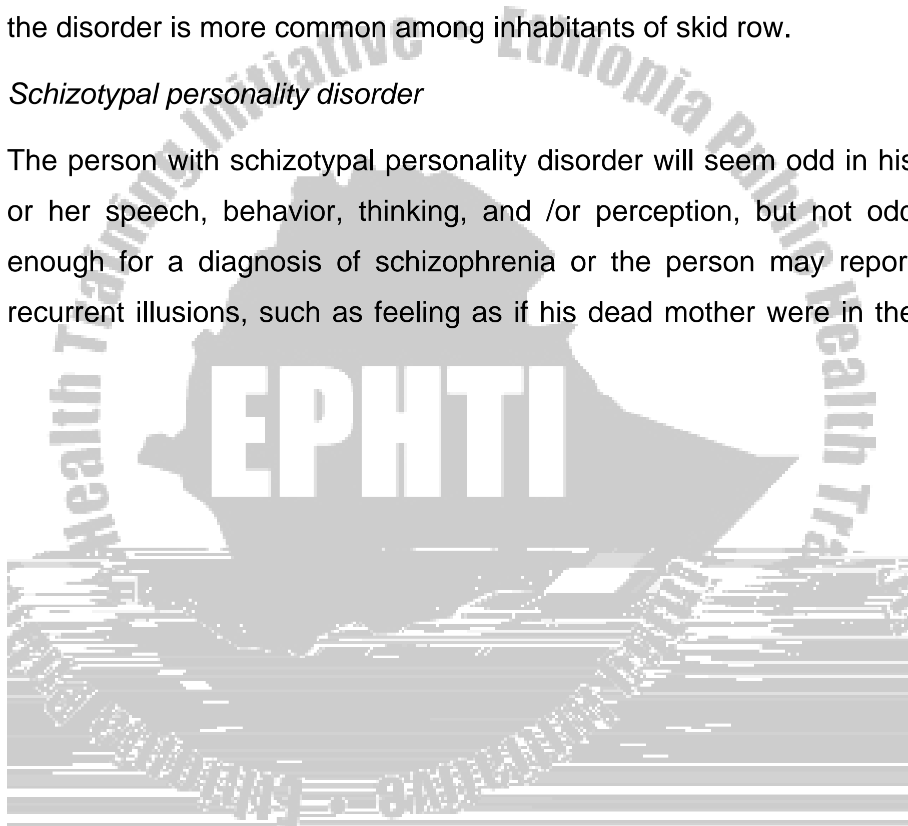
Schizoid personality disorder

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

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

Schizotypal personality disorder

The person with schizotypal personality disorder will seem odd in his or her speech, behavior, thinking, and /or perception, but not odd enough for a diagnosis of schizophrenia or the person may report recurrent illusions, such as feeling as if his dead mother were in the



Cluster B personality disorder

Antisocial

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

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

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

Borderline personality disorder

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

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

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

Histrionic personality disorder

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

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

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

Obsessive compulsive personality disorder

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

Passive aggressive personality disorder

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

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

Dependent Personal Disorder

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

Nursing Intervention

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

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

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

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

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

	tasks. Administer p,r,n, medication to decrease anxiety. Use external controls (e.g. restraints) as a last measure.
Noncompliance manipulative behavior	Be aware of 'power play' or attempts to manipulate members of the staff. Identify types of manipulative behavior exhibited by the patient. Explore your own feelings regarding such behavior. Confront the patient if necessary, but without anger, disappointment, or disgust. Assume a parental surrogate role to reinforce authority when necessary. Discuss expectations with patient. Set limits and be consistent with care. Maintain consistency and continuity of approach with staff. Observe interactions with other patients to discourage manipulative behavior. Intervene if necessary.
Self- care deficit: dependency on staff to meet basic human needs	Evaluate patient's developmental level and ability to

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

REVIEW QUESTIONS

UNIT ELEVEN

HUMAN SEXUALITY AND SEXUAL DYSFUNCTION

Learning objectives

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

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

Definition

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

Normal sexuality

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

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

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

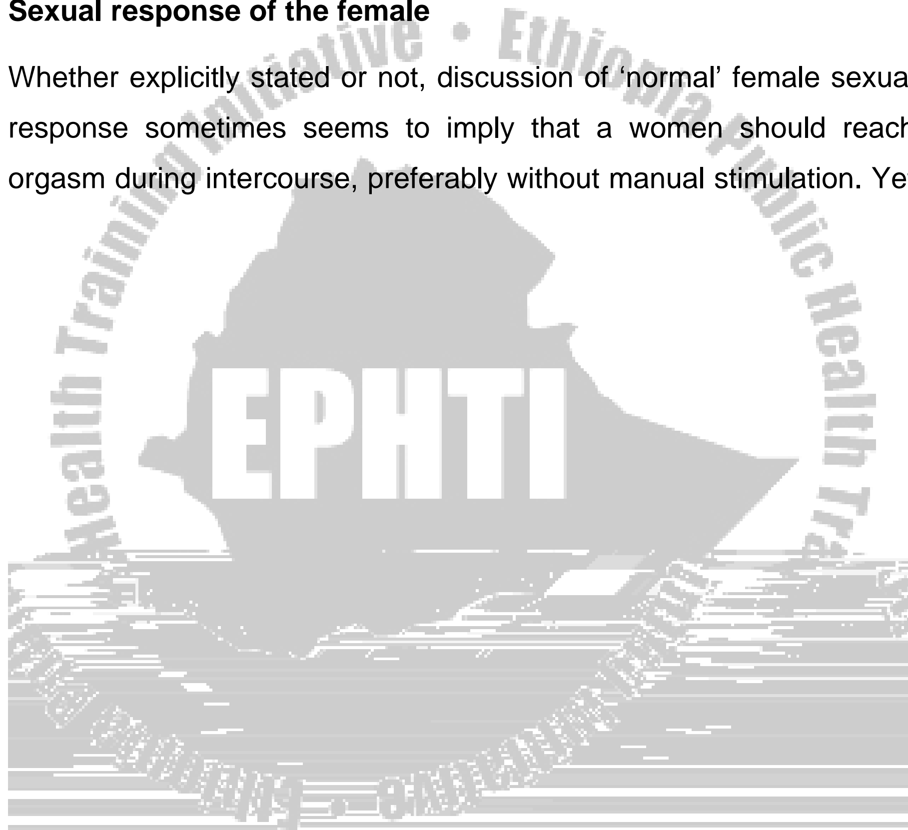
Plateau: This is a continuous stimulation and characterized by an increase in intensity. It lasts from 30 seconds to several minutes depending up on the sexual stimuli and drive.

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

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

Sexual response of the female

Whether explicitly stated or not, discussion of ‘normal’ female sexual response sometimes seems to imply that a women should reach orgasm during intercourse, preferably without manual stimulation. Yet



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II) Decreased libido and impotency

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

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

Classifications of Sexual dysfunctions:

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

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

There are three types of premature ejaculation known as

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

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

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

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

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

and those in higher socioeconomic groups. Sexual trauma as rape

6. *Transvestitism:* This involves sexual arousal and satisfaction by wearing the clothes appropriate to the opposite sex.

7. *Sadism:* This involves a sexual gratification from inflicting of pain on one's sexual partner.

8. *Transsexualism:* This involves a persistent sense of discomfort about one's anatomic sex and wish to live as a member of the opposite sex.

9. *Masochism:* This involves the enjoyment of pain, humiliation and punishment by the sexual partner.

10. *Zoophilia (bestiality)*: This involves obtaining sexual gratification through contact with animals.

11. *Rape:* Violence and the lack of consent by the sexual partner are the elements in rape that makes it both criminal and deviant.

12. *Incest:* This involves sexual union of close relatives. This is a taboo that is one of the strongest in our culture.

13. *Nymphomania*: This is excessive sexual derive or desire in females.

14. *Satyriasis:* This is excessive sexual drive or desire in males.

15. *Telephone scatologia:* Sexual gratification is achieved by telephoning someone and making lewd remarks or remaining silent on the line.

16. *Frotteurism:* Sexual excitement is achieved by touching and rubbing against a non consenting person.

Nursing intervention in sexual disorders

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

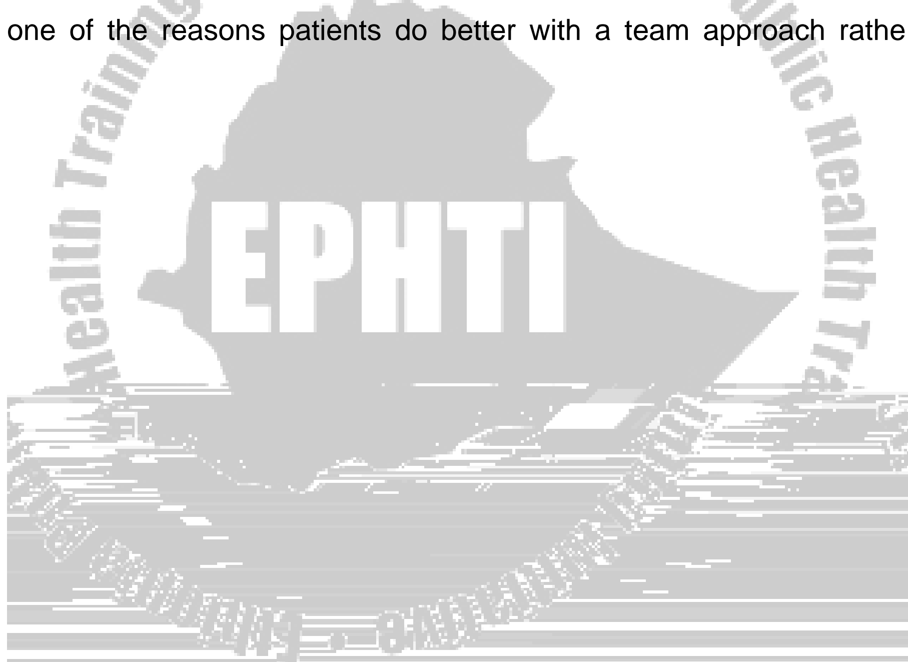
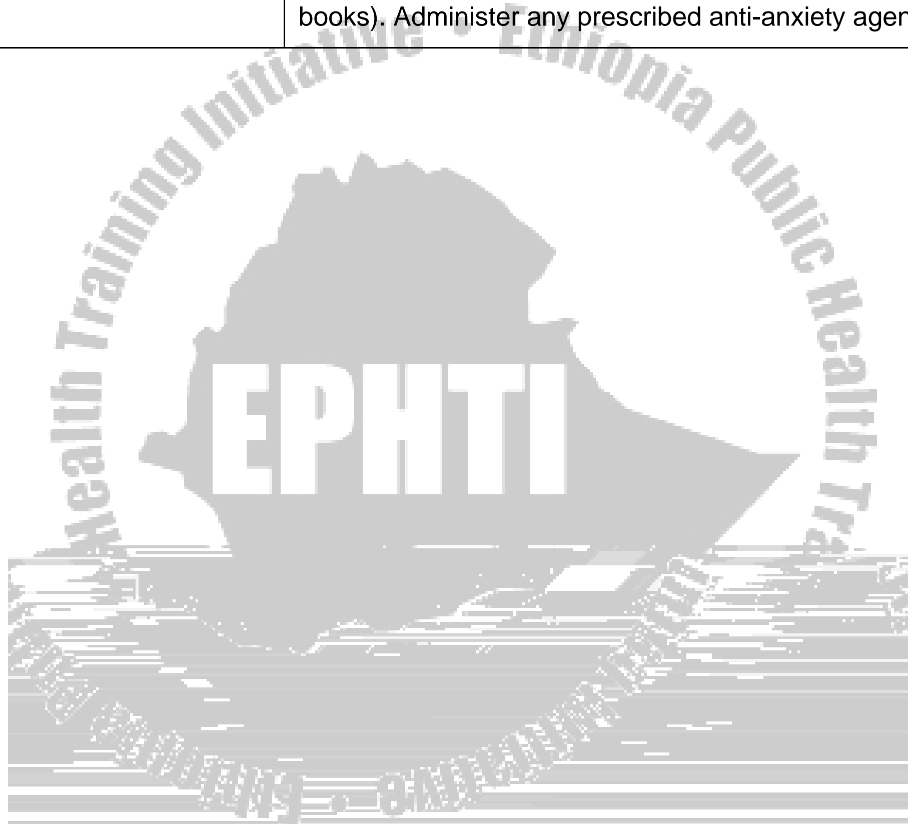


Table 10: Nursing diagnoses and interventions for patients who exhibit symptoms of sexual disorders

Nursing diagnoses	Nursing interventions
Alteration in pattern of sexuality: impulsive sexual actions resulting In physical contact.	Explain to the patient that touching makes you feel uncomfortable. Ask the patient to explain his feelings t the time he acted impulsively - Explore the meaning of specific behavior. Be firm but nonjudgmental when setting limits. Be consistent. Intervene in any overt acts towards other patients. Explain to the patient that he must respect the rights of others. Avoid placing the patient in activities requiring physical contact. Provide protective isolation for other patients if necessary since his overt behavior may provoke hostility.
Alteration in pattern of sexuality: verbal comments with sexual overtones	Respond by recognizing the patient's feelings (i.e., "it must be difficult to be away from your fiancée"). Allow the patient to ventilate the reason for his comment without encouraging his behavior. Explore alternative ways to channel the patient's advances to result in a more positive outcome.
Alteration in pattern of sexuality: masturbatory behavior	Request that the patient limit his activity to private area to avoid offending others. Intervene in any attempt by the patient to involve others in his activity. Explore the meaning behind the patients behavior. Discuss alternative behavior with the patient.

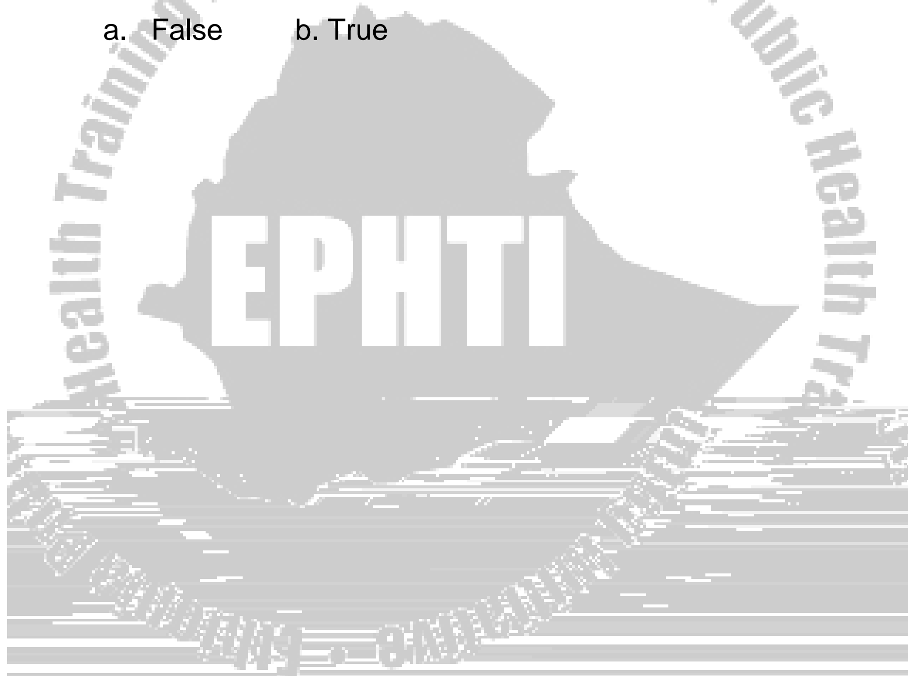
Sexual dysfunction owing to increased anxiety.	Encourage verbalization of feelings. Explore reasons for increased anxiety. Assess the patient's knowledge of cause of sexual dysfunction. Inform the patient of various resources available (e.g., sex education courses, clinics, counseling therapy, and reference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



REVIEW QUESTIONS

1. List at least four types of drugs which can affect libido and cause impotency.
2. List at least five types of human sexual dysfunctions.
3. Sadism is a sexual gratification from inflicting of pain on one's sexual partner.

    a. False b. True



UNIT TWELVE

PSYCHOTHERAPY

Learning objectives

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

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

Definition

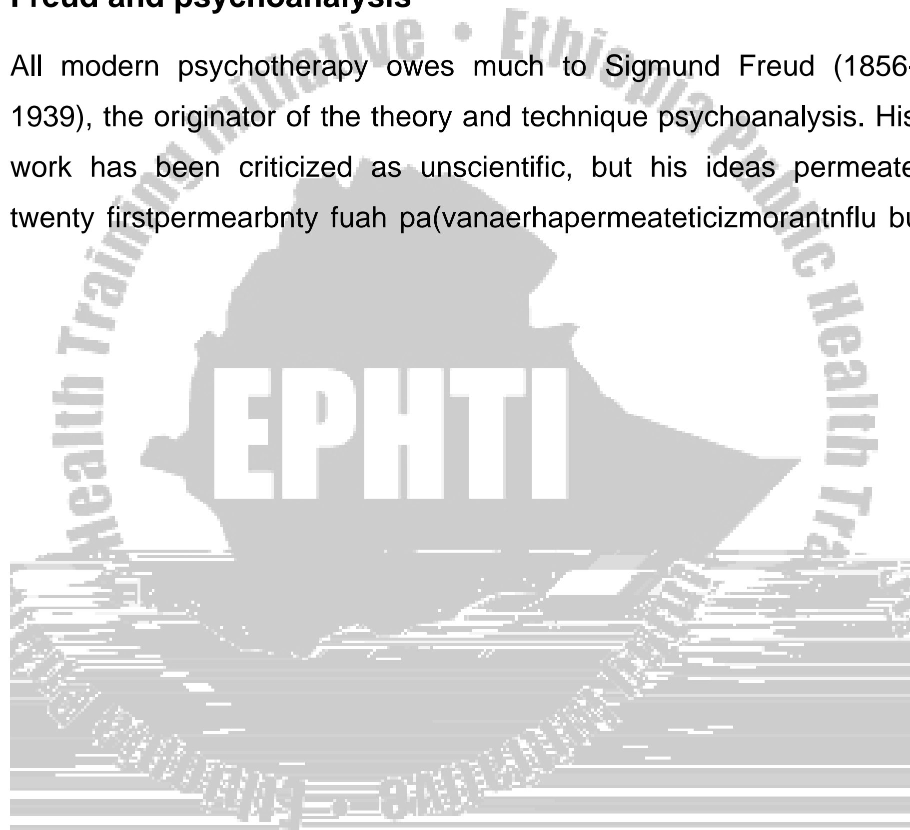
Psychotherapy may be broadly defined as any treatment designed to influence behavior by verbal or non-verbal means. It includes techniques as varied as confession, reassurance, hypnosis, psychoanalysis and brain-washing.

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

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

Freud and psychoanalysis

All modern psychotherapy owes much to Sigmund Freud (1856-1939), the originator of the theory and technique psychoanalysis. His work has been criticized as unscientific, but his ideas permeate twenty firstpermearbnty fuah pa(vanaerhapermeateticizmorantnflu butal-1.7268 TD03Freu Tc0.3



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

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

Freud's methods

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

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

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

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

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

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

Indications for psychotherapy

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

Types of psychotherapy

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

1. *Brief therapy*. A variety of techniques are exploited, usually in combination: ventilation, in which the patient confides, confesses, and is given the opportunity to ventilate his past and present difficulties; clarification, where problems are discussed and their nature and relations made clear; abreactions, verbalizing emotionally charged material, with the release of anxiety, anger or grief; and desensitization, in which repetitive ventilation of feelings, as in mourning, has a therapeutic effect.

2. *Intensive psychotherapy.* Such treatment is usually practiced by those with specialist training and includes psychoanalysis. In contrast to brief therapy the interviews are longer and more frequent. The

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

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

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

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

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

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

Effectiveness of psychotherapy

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

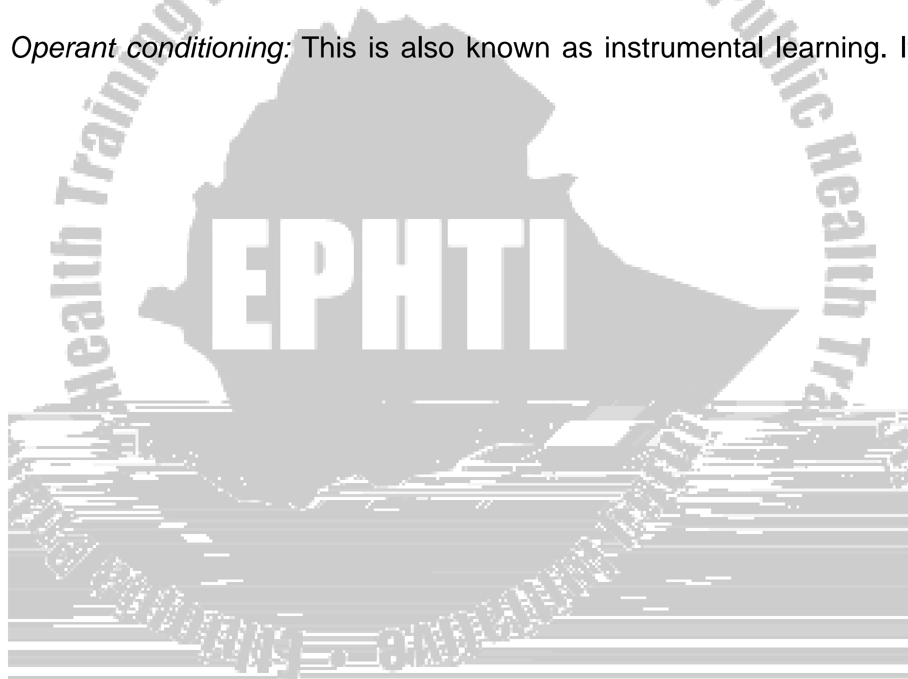
Behavior therapy

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

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

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

Operant conditioning: This is also known as instrumental learning. It



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

Types of behavior therapy

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

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

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

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

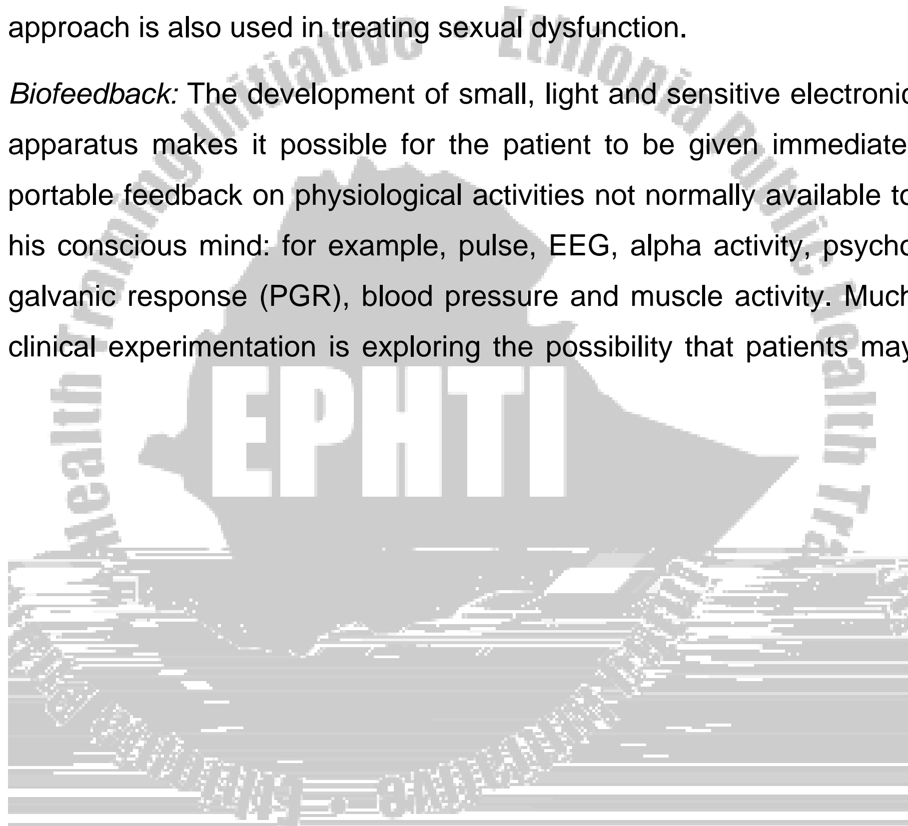
Flooding and response prevention: Research on systematic desensitization suggests that exposure to the feared object is the sole essential ingredient. Flooding involves direct prolonged contact with the feared object with the therapist's support, encouragement and modeling. In the treatment of obsessional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

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

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

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

Biofeedback: The development of small, light and sensitive electronic apparatus makes it possible for the patient to be given immediate, portable feedback on physiological activities not normally available to his conscious mind: for example, pulse, EEG, alpha activity, psycho galvanic response (PGR), blood pressure and muscle activity. Much clinical experimentation is exploring the possibility that patients may



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

REVIEW QUESTIONS

UNIT THIRTEEN

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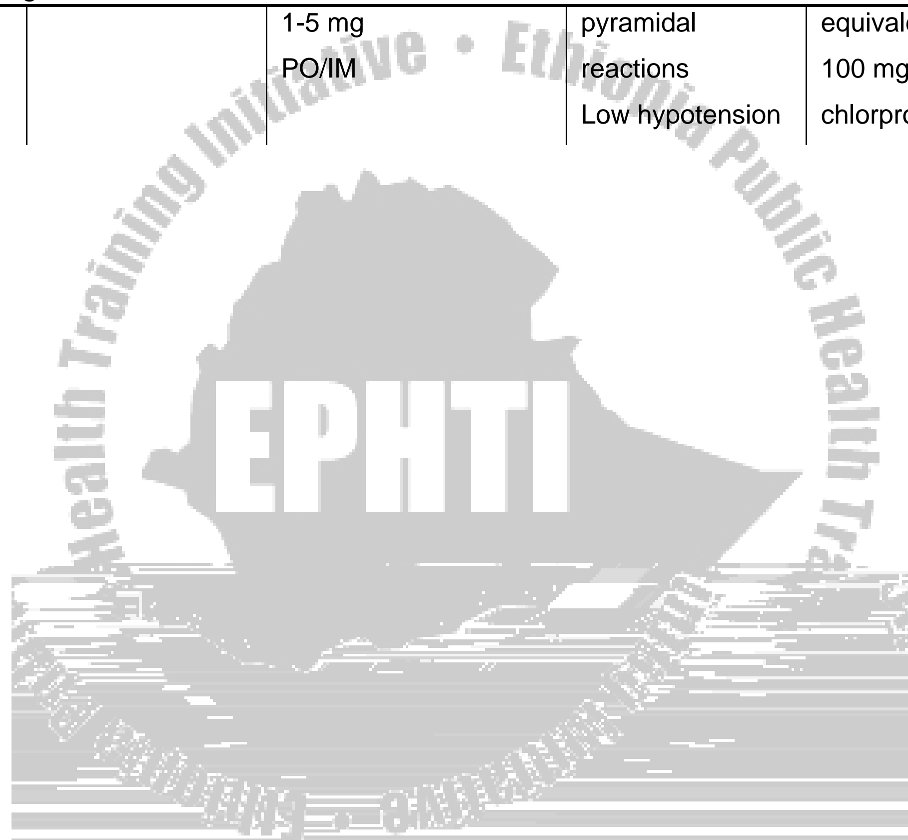
Table 11: Common phenothiazines antipsychotic drugs

Generic name	Trade name	Routs of administration and dosages for adults	Major side effects	Remarks
Chlorpromazine	Thorazine	200-600mg/ day IM, PO	High sedation -Moderate to low hypotension	Tablets, capsules and suspensions are available
Fluphenazine				

		1-5 mg PO/IM	pyramidal reactions Low hypotension	equivalent to 100 mg of chlorpromazine	



Commonly used non-phenothiazines

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

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

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

Actions of neuroleptics: The antipsychotic drugs act primarily by occupying dopamine receptors in brain tissue, thereby decreasing the effects of dopamine, a catecholamine neurotransmitter. Excessive dopamine activity is believed to be an important factor in the development of schizophrenia. This concept is supported by

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

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

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

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

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

Table 12: Commonly used anti psychotic agents

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

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

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Mechanisms of action

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

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

Drug Selection

The choice of an antidepressant depends upon the following major

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Anticonvulsants

Anticonvulsant drugs are used to treat seizure disorders.

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

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

Mechanisms of actions of anticonvulsants

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

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

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

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

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

Indications for use

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

Contraindications

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

Individual anticonvulsant drugs (commonly used anticonvulsant)

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

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

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

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

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

Anti-anxiety drugs

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

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

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

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

Mechanisms of action

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

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

Indications for use

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

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

Contraindications for use

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

Non benzodiazepine antianxiety agents

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

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

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

Table 15: Commonly used anti anxiety agents (anxiolytics)

Generic Name	Brand Name	Clinical indications	Route and dosage rage for adults

Table 16: Nursing actions in anti-anxiety drugs

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

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

REVIEW QUESTION

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

ANNEX I

Model of Patient Assessment (History Taking) in Psychiatric Nursing

I. Personal identification of patient

Name: Ato. X
Age: 27 years
Sex: Male

Marital status: Married
Occupation: Carpenter.
Address: Finkile

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

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

IV Social and personal History

Family history:

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

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

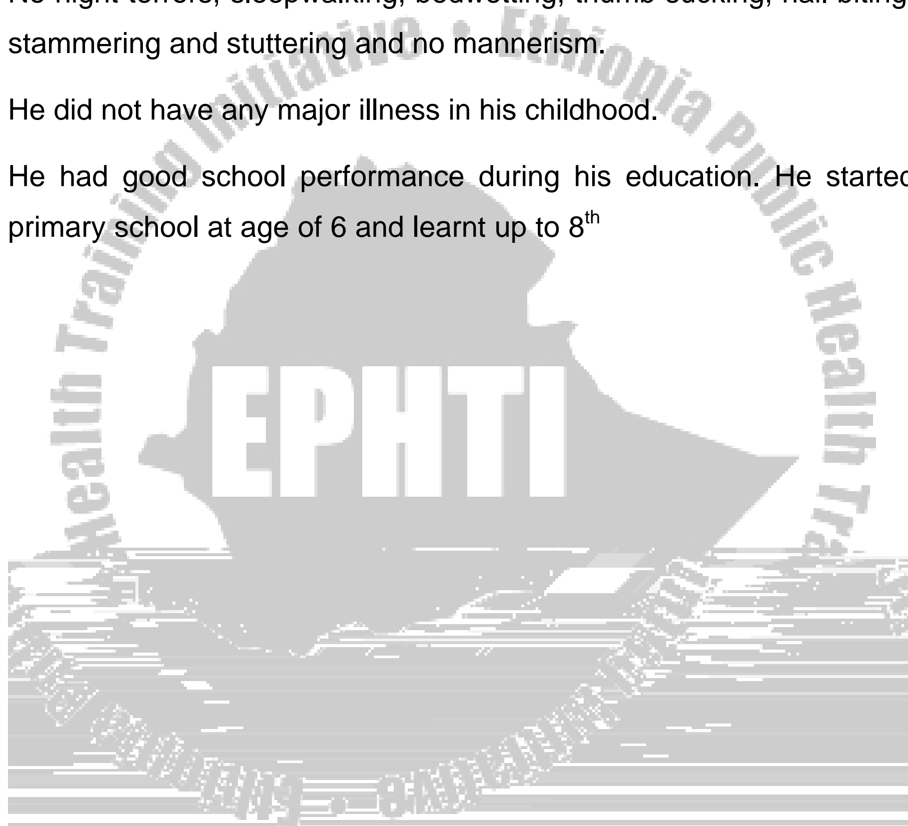
Siblings: He has two brothers and one sister; he is the last child in the family. All of his siblings are married and in a poor occupational and professional standard. There was poor social interaction between

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

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

He did not have any major illness in his childhood.

He had good school performance during his education. He started primary school at age of 6 and learnt up to 8th



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

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

He has no history of previous mental illness.

Pre-morbid personality

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

He has a special inclination in group work with youngsters

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

Physical examination.

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

Psychiatric examination (mental status examination)

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

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

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

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

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

Further investigation

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

Formulation of the case

Differential Diagnosis:

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

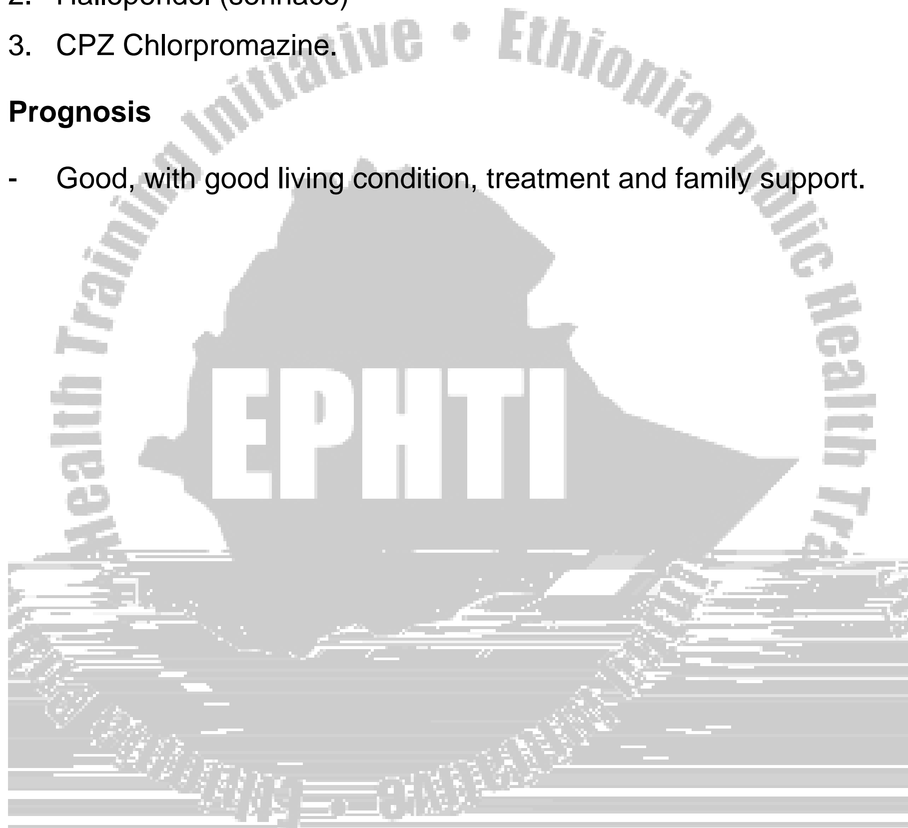
Impression: Mania

Treatment

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

Prognosis

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



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Unit One

Chapter Two

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

Unit One

Chapter Three

1. A
2. B
3. A
4. a) History of present illness

   b) Social and personal history (Supplementary history to be obtained from relative if possible)

   c) Physical examination

   d) Psychiatric examination

   e) Future investigation

   f) For mutation of the case

5. C

Unit One

Chapter Four

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

Unit Two

1. a) Anxiety disorder b) Phobia
   c) Hysteria d) Obsessive compulsive disorder
   e) Hypochondria
2. a) Desensitization
   b) Systematic
   c) Flooding
3. a) Conversion reaction hysteria
   b) Dissociative hysteria
4. a) Primary illness gain is obtaining relief from anxiety by using

Unit Three

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

Unit Four

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

Unit Five

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

Unit Six

1. B
2. a) Clouding of consciousness
3. b) At least two of the following
    1) Perceptual disturbance
    2) Incoherent speech at a times
    3) Disturbance of sleep-wake cycle with insomnia or day time drowsiness
4. D
5. A
6. a) Hypoglycemia

    b) Hyperbilirubinaemia (kernicterus)

    c) Hypothyroidism (cretinism)

    d) Hypoproteinaemia

    e) Hypocalcaemia

    f) Lead poisoning

Unit Seven

1. A
2. B
3. a) Clinical psychiatric syndrome

    b) Intelligence

    c) Organic factors

    d) Psychosocial factors
4. B
5. A
6. B

Unit-Eight

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

UNIT NINE

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

UNIT TEN

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

UNIT ELEVEN

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

2. a) Erectile dysfunction or importance
   b) Premature ejaculation
   c) Frigidity (inhabited sexual excitement) in female
   d) Inhabited female organism (anorganismia)
   e) Dyspareunea and others
3. B
4. B
5. a) Excitement
   b) Plateau
   c) Organism
   d) Resolution

UNIT TWELVE

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

3. a) Systematic desensitization
   b) Token economy
   c) Aversion treatment
   d) Flooding and response prevention
   e) Social sills training

4. a) Informal ping pong
   b) Card games
   c) Trip outside the hospital
   d) Structured soft ball
   e) Basket ball of volley bal games
   f) Attending sport events and so on

5. a) Helps to build a more healthy and integrated ego
   b) It helps to express and deal with needs and feelings
   c) Assist in a gratification of frustrated basic needs]
   d) Strengthens ego defenses
   e) Reverse psychotherapy

UNIT THIRTEEN

1. a) Chlorpromizine
   b) Thiorizadine
   c) Fluphenazine

2. Halloperodol (halidol)

3. a) Accurate adminstration
   b) Observation for therapeutic effect

c) Observation for adverse effect

d) Observation for drug interactions

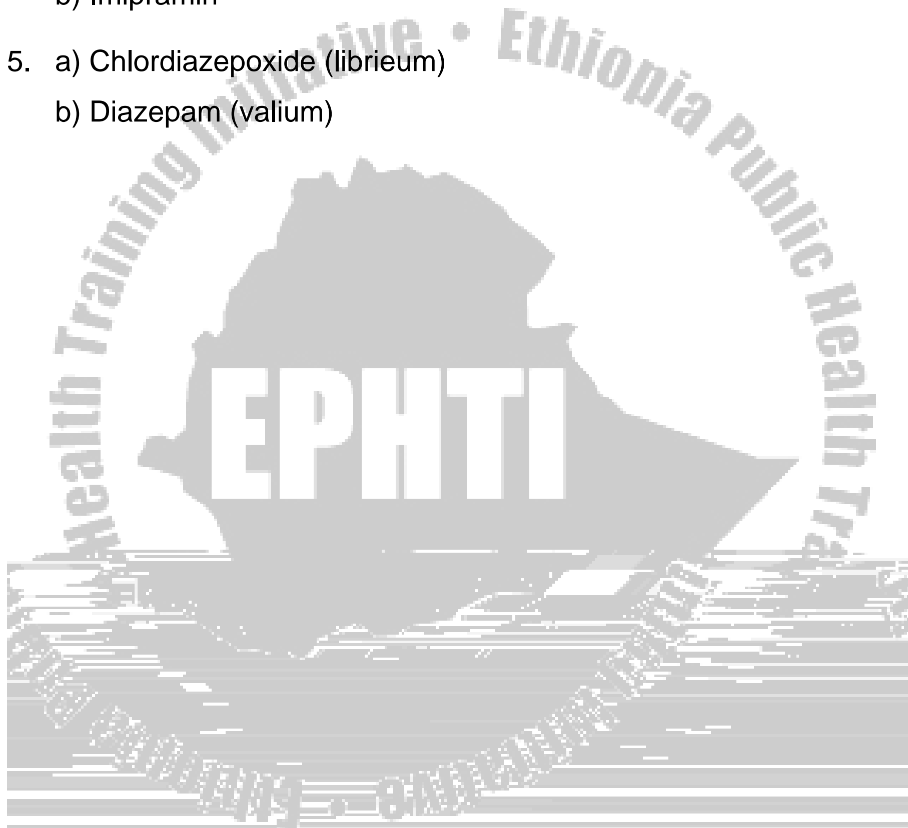
e) Teaching client

4. a) Amitriptlin

   b) Imipramin

5. a) Chlordiazepoxide (librieum)

   b) Diazepam (valium)



GLOSSARY

Akinesia: Absence or poverty of movements

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

Amnesia: Pathogenic impairment of memory

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

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

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

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

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

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

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

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

Delusion:

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

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

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

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

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

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

Spinabifida: A developmental anomaly marked by defective closure of the boney encasement of the spinal cord through which the meanings may or may not protrude.

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

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

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