MENTAL HEALTH & PSYCHIATRIC NURSING

MODULE COMPETENCE

- To enable the learners apply knowledge, skills and attitude in promotion of mental health, diagnose, manage and rehabilitate psychiatric patients.

MODULE LEARNING OUTCOMES

- BY the end of this module, the learner should be able to:
  - Explain the basic concepts, principles and trends in mental health care.
  - Discuss and apply the legal aspects relating to mental health.
  - Assess, diagnose and manage common psychiatric disorders.
  - Diagnose, manage and rehabilitate patients with mental health conditions.
  - Participate in community mental health nursing.

Module content

1. **CONCEPTS AND PRINCIPLES IN MENTAL HEALTH:**

- Factors that promote mental health
- Contributing factors to mental illness
- Classification of mental disorders
- Principles of psychiatric nursing

2. **LEGAL ASPECTS:**

- Mental Health Act
- Admission process
- Criminal procedure code

Ct'…Module content

3. **COMMON MENTAL DISORDERS:**

- Mood disorders
- Schizophrenia/affective disorders
- Delusional disorders
- Psychosis associated with pregnancy & child birth
- Organic psychosis
- Anxiety disorders
- Personality disorders
- Sexual disorders
- Childhood mental disorders
- Mental subnormalities
- Psychosis related to substance abuse
- Psychiatric emergencies

Ct'...Module content

4. **TREATMENT MODALITIES:**

- Psychotherapy
- Electroconvulsive therapy
- Occupational and recreational therapy
- Family and social therapy

5. **COMMUNITY PSYCHIATRY:**

- Promotion of mental Health
- Prevention of mental health
- Rehabilitation
- Involvement of government and non-governmental organisations

CONCEPTS AND PRINCIPLES IN MENTAL HEALTH

INTRODUCTION

- All humans strive attain the highest level of health.
- Mental health does not mean absence of mental illness but a sense of wellbeing felt.
- Mental health and physical health are interrelated and interdependent.

Definitions

Health:

- "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*(WHO 1948)*

Def cont’

Mental health

- The capacity of an individual to form harmonious relationships with others and to participate in or contribute constructively to changes in the social environment. (WHO)

Mental illness/disorder

- "A clinically significant **behavioral** or **psychological** syndrome or pattern that occurs in an individual and that is associated with **present distress or disability** or with a **significantly increased risk of suffering death, pain, disability, or an important loss of freedom** . . . and is **not merely an expectable** . . . response to a particular event"(APA; DSM-IV TR)

Mental illness cont’

- “Maladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviors that are incongruent with the local and cultural norms, and interfere with the individual’s social, occupational, and/or physical functioning” (Townsend, 2009)

CONSEQUENCES OF MENTAL ILLNESSES

- Poverty
- Poor/inhumane living conditions
- Human rights violation
- Marginalization & vulnerability
- Higher rates of mortality & disability
- Physical abuse
- Sexual abuse
- Neglect
- Loss of civil and political rights
- etc

Determinants of mental health

- Individual factors e.g. ability to manage one's thoughts, emotions, behaviours and interactions with others.
- External factors e.g.
  - Social
  - Cultural
  - Economic
  - Political and
  - Environmental

Critical analysis

Who is a mentally healthy person?

- ✓Free from internal conflicts (not at war with self)
- ✓Accepts self and others(well adjusted)
- ✓Ability to cope or tolerate stress.
- ✓Ability to form close and lasting relationships
- ✓Uses sound judgment to make decisions
- ✓Accepts responsibility for actions
- ✓Optimistic in life
- ✓Has good control over own behavior

m/healthy cont’

- ✓Function effectively & independently (productive)
- ✓Able to perceive imagined circumstances from reality
- ✓Able to develop potential and talents to fullest extent
- ✓Able to solve problems
- ✓Can delay immediate gratification
- ✓Searches for identity
- ✓Has strong sense of self esteem
- ✓Recognizes limitations (abilities and deficiencies)

Who is a mentally ill person?

- Feelings of inadequacy *(Poor self-concept)*
- Inability to cope*(Maladaptive behavior)*
- Inability to establish a meaningful relationship
- Displays poor judgment
- Irresponsibility or inability to accept responsibility for actions
- Pessimistic in life
- Does not recognize limitations (abilities and deficiencies)

M/ill cont’

- Exhibits dependency needs because of feelings of inadequacy
- Inability to perceive reality*(Lives in fantasy*)
- Does not recognize potential and talents due to a poor self-concept *(Not strive for actualization)*
- Avoids problems rather than handling them or attempting to solve them.
- Desires or demands immediate gratification

SUMMARY

- Positive mental health includes emotion, cognition, and social functioning and coherence. (WHO: 2009).
- Whereby an individual has ability to maintain:-
  - An even temper
  - An alert intelligence
  - A socially considerate behaviour
  - A happy disposition

Summary cont.

- The mentally healthy person:-
  - Accepts the self
  - Is self-reliant, and
  - Self- confident.

Aetiological Factors of Mental Illness

The causes of mental illness can be classified into three broad categories:

1. Predisposing factors
2. Precipitating factors
3. Perpetuating factors

- **Predisposing Factors**

- Determine the likelihood of one getting a mental illness. Usually they are adverse experiences one undergoes in early life.

- **Precipitating Factors**

- Events that take place shortly before the onset of a disorder. E.g. drug abuse, loss of a job.

- **Perpetuating Factors**

- Once the disorder has been triggered, these factors do prolong the course of the disease.

- They may appear long after the original predisposing factors have been treated.

- Examples include secondary demoralization and withdrawal from social activities.

Biological Causes

a) Genetic factors: inheritance of faulty genes and chromosomal abnormalities e.g. down syndrome, Alzheimer's disease.

b) Physical illness leading to loss of mental capacity e.g. acute malaria

c) Emotional factors: anxiety and neurotic personality traits cause people to develop psychosomatic disorder

Cont'd.

d) Infection, Disease and Toxins

e) Brain defects or injury: Defects in or injury to certain areas of the brain have also been linked to some mental illnesses

f) Others such as prenatal damage(autism), nutrition related, substance abuse etc

Psychological Factors

Psychological factors that may contribute to mental illness include:

- Severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse
- An important early loss, such as the loss of a parent
- Neglect
- Poor ability to relate to others

Social-cultural factors

- Social influence- maladaptive behaviour
- Low socio-economic class.
- Social role- a soldier kills then later develops guilty conscious leading to mental illness
- Violence
- Unemployment
- Broken homes

Factors that Influence Attitudes towards Mental Health and Mental Illness

- Culture
- Health Beliefs
- Religion
- Education

CLASSIFICATION OF MENTAL DISORDERS

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Objective

- By the end of the lesson learners will be able to:-
  - Differentiate between the two major systems of classifying mental disorders
  - Classify mental disorders according to each classification system

2 main systems

1. **International classification of diseases(ICD)-**by world health organization.
   - Currently revised to 11th edition.

2. **Diagnostic Statistical Manual of mental disorders(DSM)-** by American Psychiatric Association.
   - Currently in its 5th edition.

DSM-V class List

- Neurodevelopmental Disorders.
- Schizophrenia Spectrum and Other Psychotic Disorders.
- Bipolar and Related Disorders.
- Depressive Disorders.
- Anxiety Disorders.
- Obsessive-Compulsive and Related Disorders.
- Trauma- and Stressor-Related Disorders.
- Dissociative Disorders

List cont’

- Somatic Symptom and Related Disorders.
- Feeding and Eating Disorders.
- Elimination Disorders.
- Sleep-Wake Disorders.
- Sexual Dysfunctions.
- Gender Dysphoria.
- Disruptive, Impulse-Control, and Conduct Disorders.
- Substance-Related and Addictive Disorders.

List cont’

- Neurocognitive Disorders.
- Personality Disorders.
- Paraphilic Disorders.
- Other Mental Disorders.
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication.
- Other Conditions That May Be a Focus of Clinical attention

ICD 11 CLASSIFICATION

- 05 A: Neurodevelopmental disorders
- 05 B: Schizophrenia Spectrum and Primary Psychotic Disorders
- 05 C: Bipolar and Related Disorders
- 05 D: Depressive Disorders
- 05 E: Anxiety and Fear Related Disorders
- 05 F: Disorders Specifically Associated with stress
- 05 G: Dissociative Disorders
- 05 H: Bodily Distress Disorders and Psychological and Behavioral Factors Associated with Diseases Classified Elsewhere
- 05 I: Obsessive Compulsive and Related Disorders
- 05 J: Feeding and Eating Disorders

ICD 11 Classification ctd'...

- 05 K: Elimination Disorders
- 05 L: Sleep Disorders
- 05 M: Sexual Dysfunctions and Compulsive Sexual Behavior Disorder
- 05 N: Acute Substance Intoxication
- 05 O: Harmful Use of Substances
- 05 P: Substance Dependence

- 05 Q: Substance Withdrawal Syndrome
- 05 R: Substance-induced mental disorders
- 05 S: Behavioral addictions
- 05 T: Disruptive behavior and dissocial disorders
- 05 U: Disorders of Personality

ICD 11 Classification ctd'...

- 05 V: Paraphilic Disorders
- 05 W: Factitious Disorders
- 05 X: Neurocognitive Disorders
- 05 Y: Mental and behavioral disorders attributable to disorders or diseases classified elsewhere

Qualities of Psychiatric Nursing

- Respect for the Patient
- Availability
- Spontaneity in decision making
- Acceptance
- Sensitivity
- Accountability
- Empathy
- Self-understanding
- Permissiveness and firmness
- Skill observation

ASSESSMENT OF A MENTALLY ILL PERSON

Objectives

1. Psychiatric history taking
2. Mental status assessment/examination/evaluation
3. Physical examination(head to toe)
4. Investigations(lab/radiological)

1. History taking

- Patients allowed to tell their stories in their own words in the order that they consider most important.
- Other sources are important e.g. relatives
- Differs from general health history because it focus on psychological/behavioural components rather that physiological.

Comprehensive history

Components/parts

- Identifying data
- Chief complaint
- History of present illness
  - Onset
  - Precipitating/perpetuating factors

- Hx of past illnesses
  - Psychiatric
  - Medical
  - Alcohol and other substance history
- Family history
  - Family tree

Hx cont’

- Personal history (anamnesis)
  - Prenatal and perinatal
  - Early childhood (Birth through age 3)
  - Middle childhood (ages 3-11)
  - Late childhood (puberty through adolescence)
  - Adulthood
    - Occupational history
    - Marital and relationship history
    - Military history
    - Educational history
    - Religion

Hx cont'

- Social activity
- Current living situation
- Legal history/criminal record
  - Sexual history
  - Fantasies and dreams
  - Values

Physical examination

- Should be comprehensive
- 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.
- Brief summary of abnormalities found should be given.

Investigations

1. Biochemical examinations
2. Chemical profile, for example:
    - Liver functions
    - Renal functions
    - Thyroid functions
3. Vitamin levels, for example, B12

INVESTIGATIONS CONT’

4. Psychoendocrinological examination, for example:
   - ✓TRH stimulation test
   - ✓Dexamethasone suppression test
5. Electroencephalographic examination
6. Computer tomography of the brain

Mental status examination(MSE)

- The mental status examination is a description of all the areas of the client's mental functioning.
- MSA is essential to the development of an appropriate plan of care
- Done during admission and periodically to assess patients response to therapy and to determine fitness for discharge from hospital.

Components of MSE

- Appearance -*poise, clothing, and grooming*
- Overt behavior
- Attitude
- Speech
- Mood and affect
- Thinking
  - Form
  - Content

MSE CONT’

- Perceptions
- Cognition/Sensorium
  - Alertness
  - Orientation (person, place, time)
  - Concentration
  - Memory (immediate, recent, long term)
  - Attention/Calculations
  - Abstract reasoning
- Insight
- Judgment

Appearance

- 1. ***Grooming and dress***- Note unusual modes of dress, Note evidence of soiled clothing, Note use of makeup, Is appearance neat or unkempt?
- 2. ***Hygiene***-Note evidence of body or breath odor, Note condition of skin, fingernails
- 3. ***Posture***-Note if standing upright, rigid, slumped over.
- 4. ***Height and weight***- Perform accurate measurements.

cont’

- 5**. *Level of eye contact*-**Intermittent, Occasional and fleeting, Sustained and intense, No eye contact
- 6. ***Hair color and texture*-** Is hair clean and healthy looking? greasy, matted, tangled?
- 7. ***Evidence of scars, tattoos, or other distinguishing skin marks*-** Swelling or bruises, Birth marks, Rashes
- 8. Evaluation of client’s appearance compared with Chronological age

✓ Motor Activity

- ***Tremors***- Do hands or legs tremble? Continuously, at specific times.
- ***Tics or other stereotypical movements***-Evidence of facial tic, jerking or spastic movements
- ***Mannerisms and gestures***-Specific facial or body movements during conversation, Nail biting, covering face with hands, grimacing
- ***Hyperactivity***- Gets up and down out of chair, paces, unable to sit still
- ***Restlessness or agitation***-Lots of fidgeting, clenching hands

Motor activities cont’

- ***Aggressiveness***-Overtly angry and hostile, threatening, uses sarcasm
- ***Rigidity***-Sits or stands in a rigid position, arms and legs appear stiff and unyielding
- ***Gait patterns***-Evidence of limping, limitation of range of motion, ataxia, shuffling
- ***Echopraxia***-Any evidence of mimicking the actions of others
- ***Psychomotor retardation***- Movements are very slow, thinking and speech are very slow, posture is slumped.
- ***Freedom of movement (range of motion)***-Note any limitation in ability to move.

Speech patterns

- 1. ***Slowness or rapidity of speech*-**Note whether speech seems very rapid or slower than normal.
- 2***. Pressure of speech*-**Note whether speech seems frenzied, is speech unable to be interrupted?
- 3.***Intonation*-**Are words spoken with appropriate emphasis? Are words spoken in monotone?

Speech cont’

- 4. ***Volume***-Is speech very loud, soft, low-pitched or high-pitched?
- 5. ***Stuttering or other speech impairments***- Hoarseness, slurred speech
- 6. ***Aphasia***-Difficulty forming words, use of incorrect words, difficulty thinking of specific words, making up words (neologisms)

General attitude

- 1. ***Cooperative/uncooperative***-Answers questions willingly, refuses to answer questions
- 2. ***Friendly/hostile/defensive***-Is sociable and responsive, is sarcastic and irritable
- 3. ***Uninterested/apathetic***-Refuses to participate in interview process
- 4. ***Attentive/interested***-Actively participates in interview process
- 5. ***Guarded/suspicious***-Continuously scans the environment, questions motives of interviewer, refuses to answer questions

EMOTIONS

Mood

- ***Depressed; despairing***-An overwhelming feeling of sadness, loss of interest in regular activities
- ***Irritable***-Easily annoyed and provoked to anger
- ***Anxious***- Demonstrates or verbalizes feeling of apprehension
- ***Elated***-Expresses feelings of joy and intense pleasure, is intensely optimistic

Mood cont’

- ***Euphoric***- Demonstrates a heightened sense of elation,(“Everything is wonderful!”)
- ***Fearful***-Demonstrates or verbalizes feeling of apprehension associated with real or perceived danger
- ***Guilty***-Expresses a feeling of discomfort associated with real or perceived wrongdoing, may be associated with feelings of sadness and despair
- ***Labile***-Exhibits mood swings that range from euphoric to depression or anxiety

Affect

- ***Congruence with mood***-Outward emotional expression is consistent with mood
- ***Constricted or blunted***-Minimal outward emotional expression is observed.
- ***Flat***-Absence of outward emotional expression.
- ***Appropriate***-The outward emotional expression is what would be expected in a certain situation ***Inappropriate***-The outward emotional expression is incompatible with the situation

THOUGHT PROCESSES

Form of Thought-Refers to the way in which a person puts together ideas and associations

- ***Flight of ideas***- Verbalizations are continuous and rapid and flow from one to another.
- ***Associative looseness***- Verbalizations shift from one unrelated topic to another.
- ***Circumstantiality***-Verbalizations are lengthy and tedious, and because of numerous details, are delayed reaching the intended point.

CONT'

- ***Tangentiality*-**Verbalizations that are lengthy and tedious and never reach an intended point.
- ***Neologisms*-**making up nonsensical-sounding words, which have meaning only to him or her.
- ***Concrete thinking*-**Thinking literal; elemental**,** absence of ability to think abstractly**,** unable to translate simple proverbs
- ***Clang associations*-**Speaking in puns or rhymes; using words that sound alike but have different meanings

FORM CONT'

- ***Word salad-*** Using a mixture of words that have no meaning**,** together; sounding incoherent
- ***Perseveration*-**Persistently repeating the last word of a sentence spoken to the client
- ***Echolalia-*** Persistently repeating what another person says
- ***Mutism*-**Does not speak (either cannot or will not)
- ***Poverty of speech*-**Speaks very little; may respond in monosyllables
- ***Ability to concentrate and disturbance of attention*-**Does the person hold attention to the topic at hand? Is the person easily distractible? Is there selective attention (e.g., blocks out topics that create anxiety)?

Content of Thought-Refers to what a person is actually thinking about

1. **Delusions**: are unrealistic ideas or beliefs that cannot be changed by logic.

- ***Persecutory:*** A belief that someone is out to get him or her in some way
- ***Grandiose***: An idea that he or she is all-powerful or of great importance
- ***Reference:*** An idea that whatever is happening in the environment is about him or her

DELUTIONS CONT’

- ***Control or influence:*** A belief that his or her behavior and thoughts are being controlled by external forces
- ***Somatic:*** A belief that he or she has a dysfunctional body part
- ***Nihilistic:*** A belief that he or she, or a part of the body, or even the world does not exist or has been destroyed

CONT.

- 2**. <u>Suicidal or homicidal ideas</u>**: expressing ideas of harming self or others.
- 3. **<u>Obsessions</u>**: verbalizing about a persistent thought or feeling that is unable to be eliminated from his or her consciousness?
- 4. **<u>Paranoia/suspiciousness</u>**: Continuously scans the environment, questions motives of interviewer, refuses to answer questions
- 5. **<u>Magical thinking:</u>** client speaking in a way that indicates his or her words or actions have power.

CONT,

- 6. **Religiosity**: individual demonstrating obsession with religious ideas and behavior.
- 7**. Phobias**: evidence of irrational fears (of a specific object, or a social situation)
- 8. **Poverty of content**: little information conveyed by the client because of vagueness or stereotypical statements.

PERCEPTUAL DISTURBANCES

1**. Hallucinations:** Are unrealistic sensory perceptions.

- ***Auditory***- hearing voices or other sounds that do not exist.
- ***Visual***-seeing images that do not exist.
- ***Tactile***-feeling unrealistic sensations on the skin.
- ***Olfactory***-smelling odors that do not exist.
- ***Gustatory***-false perception of an unpleasant taste.

CONT.

- 2. **Illusions**: Misperception or misinterpretation of stimuli within the environment.
- 3**. Depersonalization (altered perception of the self:** The individual verbalizes feeling “outside the body;” visualizing himself or herself from afar.
- 4. **Derealization(altered perception of the environment):** The individual verbalizes that the environment feels “strange or unreal” and has a feeling that the surroundings have changed.

SENSORIUM AND COGNITIVE ABILITY

- 1. ***Level of alertness/consciousness*-**clear-minded and attentive to the environment. {**conscious, confusion, somnolence, clouding, stupor, coma etc}**
- 2. ***Orientation***: to Time, Place, Person, Circumstances
- 3. ***Memory*-**Immediate, Recent and Remote/long term
- 4. ***Attention*-**calculation, spelling word e.g. world backwards etc
- 5. ***Concentration*-**serial 3 or 7
- 4. ***Capacity for abstract thought reasoning*-**interprets simple proverbs correctly/similarities & differences.

IMPULSE CONTROL

- **-**Ability to control impulses: Check for problems relating to aggression, hostility, fear, guilt, affection & sexual feelings
- **JUDGMENT AND INSIGHT**
- 1**.** ***Judgment***: Patient's capability for social judgment- Ability to solve problems and make decisions; give scenario**.** **{good/intact/normal or poor/impaired/abnormal}**

2.***Insight:*** Patient's degree of awareness and understanding about being ill.

Levels of insight (6)

i. Complete denial of illness
ii. Slight awareness of being sick and needing help, but denying it at the same time
iii. Awareness of being sick but blaming it on others, on external factors, or on organic factors
iv. Awareness that illness is caused by something unknown in the patient

v. Intellectual insight: admission that the patient is ill and that symptoms or failures in social adjustment are caused by the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences

vi. True emotional insight: emotional awareness of the motives and feelings within the patient and the important persons in his or her life, which can lead to basic changes in behavior.

Summary of MSE

- All you need to do is:

ACTMAD

- **A**ppearance (Appearance, behaviour and attitude)
- **C**ognition (thought process and content, memory, judgment, concentration, insight, perceptions)
- **M**ood, Manner and Affect
- **A**ctivities (feeding, sleep, sex, physical exercise, speech)
- **D**anger signs e.g. suicidal tendencies or self harm

- OR be

ASEPTIC

- **A**ppearance and Behaviour
- **S**peech
- **E**motion (Mood and Affect)
- **P**erception (Hallucination and Illusion)
- **T**hought content and process
- **I**nsight and Judgment
- **C**ognition

Summary

- Why is it important to assess a mentally ill patient?
- What are the barriers to effective assessment of mentally ill patients?
- How can a nurse improve the quality and accuracy of assessment data?

ETHICAL AND LEGAL ISSUES

In Mental Health

Martha Kairu

Objectives

By the end of the lesson, the learner should be able to:-

- Differentiate among ethics, morals, values, and rights, malpractice, negligence.
- Explain the ethics theoretical perspectives principles in mental health
- Describe ethical and legal issues relevant to psychiatric/mental health nursing.
- Describe the mental health act: admission and discharge criteria

Definition of Terms

- **Ethics** - the science that deals with the rightness and wrongness of actions.
- **Moral behavior** - conduct that results from serious critical thinking about how individuals ought to treat others; such as the respect for autonomy, freedom, justice, honesty, and confidentiality.
- **Values** - ideals or concepts that give meaning to the individual's life.
- **A right** - a valid, legally recognized claim or entitlement, encompassing both freedom from government interference or discriminatory treatment and an entitlement to a benefit or service.

ETHICAL CONSIDERATIONS
Theoretical Perspectives

- An **ethical theory** - a moral principle or a set of moral principles that can be used in assessing what is morally right or morally wrong hence provide guidelines for ethical decision making.
  - ✓ Kantaniasm
  - ✓ Utilitarianiasm
  - ✓ Christian ethics
  - ✓ Natural law theories
  - ✓ Ethical egoism

- **Kantianism (Deontology)**
- Suggests that decisions and actions are bound by a sense of duty.
- It is not the consequences or end results that make an action right or wrong; rather it is the principle or motivation on which the action is based that is the morally decisive factor.
- Example “I make this choice because it is morally right and my duty to do so” (not because of consideration for a possible outcome).

- **Utilitarianism** - “the greatest-happiness principle.”
- an ethical theory that promotes actions based on the end results that produce the most good (happiness) for the most people
- A second principle of utilitarianism is “the end justifies the means.”
- An ethical decision based on the utilitarian view would look at the results of the decision.
- Action is taken based on the results that produced the most good (happiness) for the most people.

Christian ethics

- Do unto others as you would have them do unto you; alternatively, do not do unto others what you would not have them do unto you.
- The imperative demand of Christian ethics is to treat others as moral equals and to recognize the equality of other persons by permitting them to act as we do when they occupy a position similar to ours.

Natural law theories

- Do good and avoid evil; evil acts are never condoned, even if they are intended to advance the noblest of ends

Ethical egoism

- Decisions are based on what is best for the individual making the decision.
- An individual’s actions are determined by what is to his or her own advantage.
- The action may not be best for anyone else involved, but consideration is only for the individual making the decision.

Ethical Principles

- Ethical principles are fundamental guidelines that influence decision-making.
- The ethical principles of autonomy, beneficence, non-maleficence, veracity, and justice are helpful and used frequently by health care workers to assist with ethical decision-making.

- **Autonomy** – emphasizes the status of persons as autonomous moral agents whose rights to determine their destinies should always be respected
- This presumes that individuals are always capable of making independent choices for themselves.
- Children, comatose individuals, and the seriously mentally ill are examples of clients who are incapable of making informed choices.

Beneficence

- Refers to one’s duty to benefit or promote the good of others (the duty to promote good)
- Health care workers act in their clients’ interests are beneficent, provided their actions really do serve the client’s best interest.
- Nurses serve as advocates to protect client’s rights and interests

Non-maleficence

- Abstaining from negative acts toward another; includes acting carefully to avoid harm. (the duty to do no harm).
- The requirement that health care providers do no harm to their clients, either intentionally or unintentionally (Aiken, 2004).
- An example- administering chemotherapy to a cancer patient, knowing it will prolong his or her life, but create “harm” (side effects) in the short term.

Justice

- The “justice as fairness” principle.
- Based on the notion of a hypothetical social contract between free, equal, and rational persons
- Concept of justice reflects a duty to treat all individuals equally and fairly.
- When applied to health care, this principle suggests that all resources within the society (including health care services) ought to be distributed evenly without respect to socioeconomic status.

Veracity

- Refers to one’s duty to be truthful always
- The principle of veracity refers to one’s duty to always be truthful.
- Aiken (2004) states, “Veracity requires that the health care provider tell the truth and not intentionally deceive or mislead clients.”
- There are times when limitations must be placed on this principle, such as when the truth would knowingly produce harm or interfere with the recovery process.

LEGAL CONSIDERATIONS

- The mental health act provides legal aspects concerning mental health facilities, processes of admission and discharge, patient's rights, supervision and evaluation of mental health among others
- Review The Mental Health Act chap 248 (*due for revision as a result of devolution of health services*)

The Kenya Board of Mental Health

- A chairman, who shall be the Director of Medical Services or a Deputy Director of Medical Services appointed by the Minister;
- 1 Medical practitioner with specialization and experience in mental health care appointed by the Minister;
- 1 Clinical officer with training and experience in mental health care appointed by the Minister;
- 1 nurse with training and experience in mental health care appointed by the Minister;

- The Commissioner for Social Services his nominee appointed by the Minister;
- The Director of Education or his nominee appointed by the Minister;
- A representative of each of the provinces of Kenya being persons resident in the provinces, appointed by the Minister;
- The Deputy Director of Mental Health;
- The Chief Nursing Officer.

Functions of the Board

- To coordinate mental health activities in Kenya.
- To advise the government on the state of mental health and mental health care facilities.
- To inspect mental health care hospitals to ensure that they meet the prescribed standards.
- To approve the establishment of mental health care hospitals.
- To assist when necessary in the administration of mental health hospitals.

- To receive and investigate any matters referred to it by a patient or relative of a patient concerning the treatment of the patient at a mental health hospital and, where necessary, to take or recommend to the minister any remedial action.
- To advise the government on the care of the persons suffering from mental sub-normality without mental disorder.
- To initiate and organize community or family based programmes for the care of persons suffering from mental disorder.

Admission and Discharge Criteria

Voluntary Patients

- Any person who has attained the apparent age of sixteen years, decrees to voluntarily submit themselves to treatment for mental disorder, and who makes to the ‘person in charge’ a written application in duplicate in the form prescribed, may be perceived as a voluntary patient into a mental hospital.
- The person fills form **MOH 613**, in duplicate.

- Any person who has not attained the apparent age of sixteen years and whose parent or guardian desires to submit them for treatment for mental disorder, may if the guardian or parent makes to the ‘person in charge’ of a mental institution, a written application in duplicate in the prescribed forms, be perceived as a voluntary patient.
- In such cases forms **MOH 637** in duplicate should be filled and signed by the guardian or the parent.

Involuntary Patients

- Involuntary patients are those who are incapable of expressing themselves as willing or unwilling to receive treatment. They require the forms **MOH 614** to be filled in duplicate by the husband, wife or relative of the patient, indicating the reasons why they are applying for admission.
- Any person applying on behalf of another person should state the reasons why a relative could not make the application and specify their connection with the patient.

- The patient is admitted for a period of not more than **6 months**. The ‘person in charge’ can prolong this period by six more months provided the total period does not exceed twelve months. An **MOH 615** form should be filled by the doctor indicating why he thinks that the patient can benefit from the treatment.
- Both the MOH 614 and MOH 615 forms must reach the hospital within 14 days of the date they were signed, otherwise they become invalid.

Emergency/Forensic/Criminal patients

- A police officer, chief or assistant chief can arrest any person who is found to be dangerous to themself or others, and take them to a mental hospital for treatment within 24 hours.
- The patient should be reviewed after 72 hours and can be discharged if found to be of sound mind. If found to be of unsound mind, the patient may be admitted for treatment as an involuntary patient.
- Form **MOH 638** must be filled by the police officer or an administrative officer.

Members of the Armed Forces

- Any member of the armed forces may be admitted into a mental hospital for observation, if a medical officer of the armed forces, by letter addressed to the ‘person in charge’, certifies that:
  - The member of the armed forces has been examined within a period of 48 hours before issuing the letter
  - For reasons recorded in the letter, the member of the armed forces is a proper person to be admitted to a mental hospital for observation and treatment

- A member of the armed forces may be admitted under section 17 for an initial period of 28 days from the date of admission, that period may be extended if, at or before the end of 28 days, two medical practitioners, one of whom shall be a psychiatrist, recommend the extension after re-examining the patient.
- The said patient can be discharged if two medical practitioners, one of whom is a psychiatrist, by a letter addressed to the ‘person in charge’, certifying that they have examined the member of the armed forces within a period of 72 hours before issuing the letter.

- Where any member of the armed forces suffers from mental illness while away from his armed forces unit and is under any circumstance, admitted into a mental hospital, the ‘person in charge’ shall inform the nearest armed forces unit directly, or through an administrative officer or gazetted police officer.
- If a member of the armed forces is admitted to a mental hospital they cease to be a member of the armed forces, the ‘person in charge’ shall be informed of that fact and the patient shall be declared an involuntary patient with effect from the date the information is received.

Admission of a Foreigner

- According to this section of the act:
  - No person suffering from mental disorder shall be admitted into a mental hospital in Kenya from any state outside Kenya except under the conditions stipulated in this part.
- This part will not apply to individuals ordinarily resident in Kenya.

- Where it is necessary to admit a person suffering from mental disorder from any foreign country into any mental hospital in Kenya for observation, the government or other relevant authority in that country shall apply in writing to the mental health board to approve the admission
- No mental hospital shall receive a person suffering mental disorders from a foreign country without the board’s written approval.

- The application for the board's approval shall indicate that the person whom it relates to has been legally detained in the foreign country for a period not exceeding **two months** under the law in that country, relating to the detention and treatment of persons suffering from mental disorder, and their admission into mental hospital in Kenya has been found necessary.
- No person shall be admitted under this section unless they are accompanied by a warrant or other documents together with the board's approval.

Discharge and Transfer of Patients

- The ‘person in charge’ of a mental hospital may, by order in writing, and upon the recommendation of the medical practitioner in charge of any person’s treatment in the mental hospital, recommend discharge and that person shall thereupon be discharged as having recovered from mental disorder, provided that:
  - An order shall not be made under this section for a person who is detained under criminal procedure Cap 75.
  - This section shall not prejudice the board’s powers under section 15 M.H.A.

Order for delivery of patient into care of relative or friend.

- If any relative or friend of a person admitted into any mental hospital under this act desires to take the person into their custody and care, they may apply to the ‘person in charge’ who may order that the person be delivered into the custody and care of the relative or friend upon such terms and conditions to be complied with by the relative or friend.
- The person in charge shall consult with the medical practitioner in charge of the person’s Rx in the mental hospital and the board on the relevant district mental health council, which is performing the board’s functions.

Offences under MHA

- It is an offence for a person other than medical practitioner to sign certificates.
- Any medical practitioner who knowingly, willfully or recklessly certifies anything in a certificate made under this act, which they know to be untrue, shall be guilty of an offence.
- It is an offence for any person to assist the escape of any person suffering from mental disorder being conveyed to or from, or while under care and treatment in a mental hospital. It is also an offence to harbour any person suffering from mental disorder that they know have escaped from a mental hospital.

- It is an offence for any person in charge of or any person employed at a mental hospital to unlawfully permit a patient to leave such a hospital.
- Any person in charge of, or any person employed at a mental hospital that strikes, ill-treats, abuses or willfully neglects any patient in the mental hospital, shall be guilty of an offence.
- General Penalty: Any person who is guilty of an offence under this act, or who contravenes any of the provisions of this act or any regulations made under this act, shall where no other penalty is provided, be liable on conviction to a fine not exceeding Ksh 10,000. or to imprisonment not exceeding twelve months or both

Any Question???

GOOD..... I AM OUT!!!

GENERAL SYMPTOMATOLOGY

MARTHA KAIRU

Student learning objectives

- **At the end of the chapter the student should be able to:**
  1. Define and describe different signs and symptoms of psychiatric disorders
  2. Classify signs and symptoms as disorders of perception, thinking, speech, motor activity, memory, orientation, mood/affect, consciousness, and cognitive/intellectual functioning
  3. Explain the relationship between different psychiatric symptoms

Introduction

- Symptoms are vital in diagnosis of psychiatric disorders.
- Diagnosis of a mental disorder shouldn't be made on the basis of an individual symptom.
- Therefore, for proper diagnosis symptoms should be intense and persistent.
- A syndrome should be established i.e. Signs and symptoms should portray a recognizable pattern.

CONT.....

- Psychiatric signs and symptoms fall into groups referred to as systems of psychological functioning. These include:-

1) Perception
2) Thinking
3) Speech
4) Motor activity
5) Memory
6) Orientation
7) Consciousness
8) Cognitive (intellectual functioning)
9) Mood /Affect

- **Different psychiatric disorders may affect each of the above systems as discussed below:**

A: DISORDERS OF PERCEPTION

- Perception is the process of becoming aware of what is presented through the sense organs.
- Response to stimuli from five senses or relating various sensory impressions with previous experiences and knowledge.

1. Illusion

- Misperceptions of external stimuli e.g. mistaking a stick for a snake. Occur:-

❖ When general level of sensory stimulation is reduced e.g. at dusk one may perceive the outline of a bush as that of a man.

❖ When level of consciousness is reduced e.g. acute organic syndrome. In strong affective states e.g. anxiety state one may see a cloud as an angel coming towards them.

❖ When attention is not focused on sensory modality.

❖ Also in depression.

❖ May occur in normal persons but are pathological if they persist or become excessive.

2. Hallucinations

- Mental impressions of sensory vividness without adequate external stimuli.
- A perception experienced in the absence of an external stimulus to the sense organs and with a similar quality to a true perception.
- Not restricted to the mentally ill.
- Normal people may experience hallucinations especially when tired.
- Also occur in healthy people during the transition between sleep and waking. While falling asleep – called hypnagogic hallucinations and While awakening – hypnopompic hallucinations.

Hallucinations occur in:-

- Also can occur in:

❖ Severe affective disorders e.g. during strong feelings or conflicts which cannot be controlled by ordinary coping/defense mechanisms e.g excessive fear/ intense religiosity etc.

❖ Schizophrenia.

❖ Organic disorders e.g. lesions of the sensory centers.

❖ Toxic states e.g. alcohol intoxication.

❖ Dissociative disorders

❖ Some times in healthy people.

- Hallucinations have two very important qualities:

1) experienced as a true perception not imagery
2) seems to come from the outside world (except for somatic hallucinations).

Hence experiences that possess only one of these qualities, are pseudo hallucinations.

Types of Hallucinations

- **Grouped according to:-**
  1)Complexity
  2)Sensory organ affected

Based on Complexity:

- Elementary
  - ❖Such experiences as bangs, whistles, flash of light.
- Complex
  - ❖E.g. hearing voices or music, seeing faces & scenes

Based on Sensory system affected

1. Auditory hallucinations

- Hearing voices which don't exist. Voices may command one to do violent acts e.g. kill or commit suicide. May occur in depression.

2. Tactile hallucinations

- Also called haptic hallucinations or somatic hallucinations.

✓ Sensations of being touched, pricked or strangled usually occur in organic states e.g. marked cocaine toxicosis – called “cocaine bugs” and schizophrenia.

❖ **Subtype- sexual hallucinations**-special type of tactile hallucination. E.g. Male schizophrenics may complain of erection & orgasm being forced into them. Female schizophrenics –may have the sensation of being raped.

Hallucinations ct'd

3. Visual hallucinations

- Seeing figures/images that are not present. May occur in:-Intense fear and organic psychosis

4. Gustatory hallucinations

- Tasting strange things in the mouth which are actually not present. Occurs in:- Schizophrenics and Major/epilepsy

5. Olfactory hallucinations

- Perceiving peculiar non-existent smells. Occur in:-Temporal epilepsy, Depression, Schizophrenia.

Unclassified

- **Reflex hallucinations**
- Where a stimulus in one sensory modality results in hallucinations in another e.g. sound of music provokes visual hallucinations.

3. Depersonalization/Derealization

- Alterations in the perception of one's reality
- **Depersonalization**: Patient feels detached and views himself/herself as strange and unreal. It's the change of self-awareness that the person feels unreal.
- **Derealization**: Alteration of sense of reality of the environment or outside world. Familiar objects/places/persons seem to have changed in shape and size.
- NB: Depersonalization is directed towards self while derialization is directed towards the outside world.
- Occurs in:-Depression, Anxiety states, Schizophrenia, Hysteria.

B: DISORDERS OF THINKING/THOUGHT DISORDERS

- Thinking is the most highly organized function of the brain.
- Combines experiences with perceptions and knowledge which is stored as memory.
- Thoughts are understood through speech and writing.
- Hence disorders of thought are closely related to disorders of speech.

Subtypes

I: Disorders of sequence of thought/thought process

– concerned with speed and amount of speech.

a) Flight of ideas/ accelerated thinking.

- Evidenced by over productive speech characterized by rapid shifting from one topic to another & fragmenting of ideas. Eventually speech becomes incoherent.
- Thoughts follow so rapidly that the expression of an idea is incomplete; Occurs in:-Mania, Organic states esp. due to hypothalamic lesions, excited schizophrenics

b). Retardation/inhibition of thought / poverty of thought

- Stream of thought is slowed down.
- Speech is slow & difficult.
- Occurs in; severe depression, organic states & schizophrenia.

I: Disorders of sequence of thought/thought process

c). Perseveration of thought

- Mental operations persist beyond their relevance. Thoughts or themes repeated though not currently relevant.
- Patient is not able to break away from the theme.
- Also considered a speech disorder common in organic states e.g. Dementia and sometimes in schizophrenia

d). Circumstantial thinking/ Circumstantiality.

- Inclusion of excessive and unnecessary details which are not essential to the subject under discussion.
- Speech is indirect and delayed to reach the goal.
- Occur commonly in:-Mania/hypomania, Organic mental states, Schizophrenics, Obsession personalities

I: Disorders of sequence of thought/thought process

e). Pressure of thought

- Patient compelled to think in an unusually rapid manner.
- Thoughts are abundant & varied.
- Common in mania, anxious patients & sometimes schizophrenia.

f). Thought blocking

- Sudden halt in the train of thought or in the middle of a sentence.
- Commonly occur in Mania and anxiety states

g). Tangentiality/Tangential thinking

- Same as circumstantiality but the final goal is not reached as the patient loses track of the original idea.

h). Fragmented thinking/loosening of association.

- Same as flight of ideas but the topics/ideas are illogical. Common in:-schizophrenia, organic disorders.

II:Disorders of thought content

a). Delusions

- Fixed, usually false beliefs which are incompatible with one's socio-cultural or educational background, and they cannot be explained on the basis of reality.
- The main feature is that it's firmly held on inadequate grounds i.e. the belief is not arrived at through the normal process of logical thinking

Types of delusions

- **Based on onset**

1. Primary delusions

- Appears suddenly and with full conviction but without any mental events leading up to it.
- Special primary delusions may include delusional perception and delusional memory.

2. Secondary delusions

- Derived from some preceding morbid/abnormal experience e.g. hallucinations. Someone who has auditory hallucinations may eventually believe that he is being followed or person who is profoundly depressed may believe that people think he is worthless.

Based on: theme/content

1. Persecutory delusions. Subjects believe that others are plotting against them. He thinks he is the subject of persecution common in:- Paranoid schizophrenia, depression (severe), Organic states, Abnormal personalities

2. Grandiose delusions: Also called expansive delusions or delusions of grandeur.

- Subject believes that he or she is some important person e.g. Jesus, Pope, President, Almighty God etc or endowed with unusual abilities. May also think that he is related to some important people e.g. MPS, royal family etc. common in Mania, and Schizophrenia

Delusions ct'd

3. Nihilistic delusions

- Belief that one is dead & everything around him has stopped working.
- May also believe that some portion of his or hers is non-existence
- Chiefly occurs in severe depression.

4. Religious delusions: Obsession with beliefs that one is holier than others. (Fanatics)

5. Jealous delusions/infidelity delusions: Belief that one's partner is unfaithful. May lead to violence. Common in men.

6. Sexual or amorous delusions: Common in women. Belief that she is loved by a man who has never spoken to her and who is inaccessible e.g. public figure.

Delusions ct'd

7. Paranoid delusions: False belief that makes one over suspicious due to fear of harm.

8. Delusion of reference: Patient believes that people look at him, talk about him and that his or her surrounding has a special significant for him or her . Belief that objects, events & people have significance to him or her e.g. remark on TV. Common in Schizophrenics, Depressive states, Organic states

9. Delusions of control/influence: Individual believes that certain objects or persons have control over his/her behavior. Common in schizophrenia.

10. Somatic delusions: False idea about the functioning of an individual's body e.g. one may believe that he/she is the oldest person on earth.

Delusions ct'd

11. Delusions of guilt: One believes that he or is very wicked, has committed a terrible sin and deserves punishment. Common in depression.

12. Hypochondriacal delusions: Patient believes that he/she has a dreadful disease. Common in-Depression, Schizophrenia, Abnormal personalities

- May seek plastic surgery services if they think parts of body are abnormal e.g. nose.

13. Delusion of poverty

- One is convinced that he is utterly impoverished, despite documentary evidence to the contrary. Rare symptom in depression.

III. Disorders of possession of thought

- Normally we experience our thoughts as belonging to us or there is a quality of “my-ness” of our thoughts.
- Apart from this we feel in control of our thinking.
- Both the control and the possession of thought can be disturbed by mental illness.
- Patient may be compelled to think against his/her will may experience thoughts as alienated from himself in some way.

III. Disorders of possession of thought cont..

a). Obsessions

- Persistent and recurrent ideas or thoughts that cannot be eliminated from consciousness by logic or reasoning.
- The defining characteristic is the subjective sense of a (struggle) resistance against the intruding mental phenomenon.
- Resistance distinguishes btwn obsession and delusions.
- Obsessional thoughts can be about any topic but commonly are centered on the following themes**: - Rationale not clear.**
- **Dirt or contamination** e.g. of hands by bacteria.
- **Aggressive actions** e.g. the person may harm another or speak obscenities.
- **Orderliness** - idea that things have to be arranged in a certain way.

Obsessions ct'd

- Idea that a person may have a certain disease or get a Illness – certain disease e.g. cancer.
- **Sex –** thoughts or images of practices that the person finds disgusting.
- **Religion –** blasphemous thoughts, doubts about the fundamentals of belief etc.
- Obsessions are common in: depression, obsessional Neurosis, organic states, schizophrenia, and anxiety.

Differentiate obsessions from Delusions :

- Ordinary preoccupation of healthy people.
- Intrusive concerns of anxious or depressed people.
- Recurring thoughts & images associated with disorders of sexual preference.
- Recurring thoughts & images associated with drug dependency
- **Patients with non-obsession ideas like in delusions do not regard them as unreasonable & do not resist them.**

III. Disorders of possession of thought cont..

b). Compulsions

- Obsessions are closely associated with compulsions / Compulsive rituals.
- **Definition:** Repeated, stereotyped, and seemingly purposeful actions which the person feels compelled to carry out but resists, recognizing that they are irrational.
- They are not thoughts but abnormal actions usually **closely associated with obsessions** because people act to fulfill unwanted urge arising from an obsession.
- Compulsions usually produce an immediate relief of distress associated with obsessional thoughts. Common themes include:-

1) **Checking rituals –** often concerned with safety e.g. door, gas, electricity
2) **Cleaning rituals –** repeated hand washing or domestic cleaning.
3) **Counting rituals –** counting to a particular number or counting in sets.
4) **Dressing rituals** – clothes set out & put on in a particular order.

III. Disorders of possession of thought cont..

c). Phobias

- These are forms of obsession.
- Persistent, excessive, irrational fears about a real or imagined object, place or a situation.
- Fear not proportional to dangerousness of the object, place, person etc.
- Could also be called obsession phobias – which are obsessional thoughts leading to anxiety and avoidance behavior.

III. Disorders of possession of thought cont..

d). Alienation of thought.

- Patient experience that his thoughts are under control of an outside agency or others are participating in his thinking.

1) **Thought withdrawal-One** experiences as if thoughts are taken away from his mind.

2) **Thought insertion** -Thoughts experienced as being inserted into patients mind.

3) **Thought broadcasting** -Patient has the experience that everyone else is participating in his thinking.

- All these forms of thought alienation are characteristics of schizophrenia.

C. DISORDERS OF ORIENTATION

- Orientation in three aspects i.e. time, person and place
- **Disorientation common in:-**Organic mental disorders, Psychotic disorders e.g. schizophrenia.

D.DISORDERS OF SPEECH

- Characteristics of speech include rate, volume, articulation and tone.
- Closely related to disorders of thinking as speech is frequently an accurate representation of thinking.
- Hence speech can be described as: - retardation of speech, blocked speech, fragmented speech, incoherent speech, and accelerated speech

Examples of speech disorders

- **Echolalia**: Repetition of others/interviewers words. Common in schizophrenia, dementia & autistic children (autism).
- **Neologism**: A patient invents new words/phrases or gives new meaning to standard words.
- **Mutism** – absence of speech.
- **Clang association:** Speech directed by the sound of a word rather than its meaning i.e. choice of words is governed by sound rather than their conceptual meaning e.g. “I am cold and bold” or “The gold has been sold and sold”.
- **Word salad:** Group of words put together in random fashion without apparent logical connection.
- **Loosening of association:** Patients shifts ideas from one to the other without logical connection between them.

E. DISORDERS OF MOTOR ACTIVITY

- The level of motor activity is closely related to the thought processes which also affects speech. Therefore, motor activity, speech and thoughts are closely interlinked. Common in schizophrenia except tics/habit spasms. Examples are :
- **Restlessness**: Inability to remain still. The person keeps on moving entire body or part of it. When associated with anxiety and worry its called agitation.
- **Stereotypes**: Repeated movements that are regular (unlike tics) and without obvious significance (unlike mannerisms) e.g. rocking to and fro
- **Tics/habit spasms**: Irregular involuntary repeated movements involving a group of muscles e.g. sideway movement of the head or wetting ones lips.
- **Choreiform movements**: Brief involuntary movements which are coordinated but purposeless.

E. DISORDERS OF MOTOR ACTIVITY CONT…

- **Mannerisms** – repeated movements that appear to have some functional significance e.g. saluting, matching.
- **Dystonia:** - muscle spasm – painful & may lead to contortions
- **Posturing:** Adoption of unusual bodily postures continuously for a long time. May have symbolic meaning e.g. hands outstretched as if to be crucified or may not have any meaning e.g. standing on one leg.
- **Ambitendence:** Alternate between opposite movements e.g. putting out the arm to shake hands, and then withdrawing it, extending it again and so on.
- **Echopraxia:** Patients purposely imitates the movement of another person. Client may imitate the actions of the examiner. Common in schizophrenia and dementia.

E. DISORDERS OF MOTOR ACTIVITY CONT…

- **Negativism:** An active striving against all external attempts to influence behavior e.g. the more the examiner insists on Physical examination the greater the resistance. Subjects do opposite of what is asked and actively resist efforts to persuade them to comply.
- **Compulsion/Compulsive ritual**: Recurrent actions carried out to relieve the urgency of obsessive thoughts e.g. repetitive hand washing in an attempt to relieve an obsession of dirty hands.
- **Stupor**: Patient lies or sits motionless and doesn't reply to questions or if he does, he gives muttered monosyllabic replies.
- **Waxy flexibility/catatonia**: The examiner encounters plastic resistance like the bending of a wax rod when moving a patient body (or part of it) which is then maintained in an odd position. Very common in catatonic schizophrenia.

F.DISORDERS OF MOOD/AFFECT

- Comprises the most common symptoms of psychiatric disorders.
- Typical in anxiety and depressive disorders. Normal people may also experience them in stress.
- **Mood-**Patient's self-report of the prevailing emotional state. Could be sad, fearful, hopeless etc. Reflects the pt's life situation.
- **Affect-** Pt's apparent emotional tone. The face is the primary tool in getting info about affect.
- **Appropriateness** – congruency with the subject of conversation – appropriate
- **Anxiety (pathological anxiety)**: Feeling of apprehension that is out of proportion to the actual situation. Marked anxiety is called fear & when its acute its called panic.

F.DISORDERS OF MOOD/AFFECT Cont...

- **Euphoria**: Mild unwarranted cheerfulness
- **Elation (pathological elation)**:Pervasive rising of mood accompanied by excessive cheerfulness & even ecstasy(energy/pleasure). Usually used synonymously to mean a feeling of sense of well-being which is exaggerated & inappropriate usually associated with psychomotor acceleration. Common in: Mania/hypomania and Hypothalamic lesions
- **Depression (pathological depression)** ;Pervasive lowering of mood accompanied by feeling of sadness, hopelessness, worthlessness, loss of ability to experience pleasure (anhedonia).
  - ❖ Usually accompanied by slowed thinking, speech and motor activity.
  - ❖ Suicidal ideation may be present. Mainly occur in depressive disorder & other psychiatric disorders.

G. DISORDERS OF MEMORY

- Some characteristics of memory/brain are important to mention:

❖ **Recognition –** feeling of familiarity which accompanies memory.

❖ **Recall –** bringing back specific information to consciousness when desired.

❖ **Registration –** add new item to the memory bank.

❖ **Retention –** capacity to store information in memory.

➢ Memory can be:-Immediate – within hours; Recent – within some months/ days/weeks; Past – distant past.

G. DISORDERS OF MEMORY Cont…

a). Amnesia: This is the loss of memory:- common in organic states or syndromes e.g. delirium/dementia, anxiety states, trauma/epilepsy.

Subtypes of amnesia include**:**

- **Anteretrograde amnesia:** Loss of memory of occurring for events taking place after the incident causing amnesia.

❖ Occur in people involved in accidents.

❖ Occur after a period of unconsciousness.

- **Retrograde amnesia:** Loss of memory for events that occurred before the precipitating event e.g after ECT or head injury

- **Confabulation:** unconscious invention of experiences to cover gaps in memory to recent events.

❖ Gaps in patient's memory filled with fabrications of the patients which he/she nevertheless accepts has facts. Reporting as "memories" of events that didn't take place at the time in question.

❖ Common in KorsaKoffs (Korsakov's) psychosis (syndrome), Dementia, Cerebral trauma, chronic schizophrenics, and Toxic confusion states e.g. alcoholics and Pathological liars.

- -**Jamais vu** – Failure to recognize events that have been encountered before.
- -**Déjàvu** – Recognition of events as familiar when they have never been encountered .Both of these disorders occur in neurological disorders.

H.DISORDERS OF CONSCIOUSNESS

- Consciousness is a state of awareness of one's self and environment. Ranges from full consciousness to coma. Some disorders that may affect consciousness may include:

❖ **Distractibility:** Attention is easily diverted by any sensory stimulus e.g. light voices.

❖ **Inattention:** Difficulty in getting a persons attention. Note that attention is ability to focus on an issue while concentration is the ability to maintain attention.

❖ **Confusion – muddled thinking:** Impaired comprehension, distortion and poor contact with surroundings.

- **Clouding of consciousness** – state of drowsiness. Incomplete reaction to stimuli, impaired attention, concentration & memory, slow & muddled thinking.
- **Delirium:** Clouding of consciousness. Common in organic conditions
- **Confusional state** – muddled thinking associated with impaired consciousness, health, illusions, delusions & anxiety.
- **Stupor:** See motor activity.

I. Disorders of Intelligence/Cognition

- State where the subjects intellectual capacity is impaired.
- Abstract thinking and comprehension can be assessed using a proverb e.g. A penny saved is a penny earned or people in a glass homes shouldn't throw stones. Some problems associated with intelligence/cognition include:

❖ **Dementia** – permanent loss of intelligence due to a coarse brain disease

❖ **Mental retardation –** subnormal mental ability.

J. Disorder of attention & concentration

- Attention is the ability to focus on the matter at hand while concentration is the ability to maintain that focus.
- They both can be impaired in anxiety disorder, depressive, mania, schizophrenia, organic disorders, may not help so much – disease but disability not helps so much

Insight

- Defined as correct awareness of one's mental condition. It is not just absence or presence of insight but a matter of degree. It's described best by use of four criteria:

1) Awareness of oneself as presenting phenomena that other people consider abnormal e.g. being unusually active & elated.
2) Recognition that these phenomena is abnormal
3) Acceptance that these abnormal phenomena is caused by one's own mental illness e.g. rather than e.g. poison.
4) Awareness that treatment is required.
5) Generally, Insight is lost to a greater extent in psychosis than in non-psychotic disorders. Assessment of insight is extremely important in determining a patient's likely cooperation with treatment.

THE END

- **ANY QUESTIONS??**

COMMON MENTAL DISORDERS

Welcome

DEPRESSIVE DISORDERS

Martha Kairu

Objectives

By the end of the lesson, the learner should be able to:-

- Describe the types of depressive disorders in terms of criteria of diagnosis, signs and symptoms, factors associated with each and the management.

Depressive Disorders

- These disorders are commonly characterized by the presence of ***sad, empty, or irritable mood,*** accompanied by ***somatic and cognitive changes*** that significantly *affect the individual's capacity to function*.
- What differs among them are aspects of duration, timing, or presumed etiology.

Depressive disorders according to DSM V can be classified into:

- Disruptive mood dysregulation disorder
- Major depressive disorder
- Persistent depressive disorder (dysthymia)
- Premenstrual dysphoric disorder
- Substance and medication induced depressive disorder
- Depressive disorder secondary to other medical conditions
- Other specified and unspecified

AFFECTIVE/MOOD DISORDERS

- Disorder characterized by mood disturbance usually accompanied by abnormalities in thinking and perception arising from mood disturbance.

Classification

- - Major depressive disorder
- - Bipolar I disorder

MAJOR DEPRESSIVE DISORDER

- **Def** : presence of depressed mood or loss of interest in pleasure with four or more of the following symptoms :-

1. Feeling of worthlessness or guilt
2. Impaired concentration
3. Loss of energy of fatigue
4. Suicidal thoughts
5. Loss or increased of appetite and weight
6. Insomnia or excessive sleep.
7. Psychomotor retardation or agitation.

cont

- The above symptoms are required to be present for atleast 2 weeks.
- Major depression may be present with or without psychotic features like delusions, hallucination or bizarre behaviour.
- Sleep impairment may involve initial insomnia, middle insomnia or terminal insomnia.
- Suicidal ideation may range from passive ideas e,g wishing one was death to active plans on how to kill oneself.

cont

- Psychotic features are most often mood congruent.i.e the content of delusion or hallucination reflects depression.E.G a mood congruent delusion might be the believe that one has committed a terrible crime or sin.
- A mood congruent hallucination might be a voice that tells one to die or that says you have failed life.

Epidemiology

- The life time risk of developing MDD is 15% overall.
- It is more common in women than men in ratio of 2:1
- The range of onset ranges from childhood to old age. The mean age is 4oyrs
- Recurrence is common.50% of people who have one episode of MDD will have one or more additional episode.

Pathophysiology

- Depression result from the low level of mono-amines specifically serotonin and norepinephrine.

Etiology of depression

- The exact cause is unknown however some of the implicated factors include:-
- Genetic factors : the incidence of MDD is higher among relatives of individuals with the disorder than among the general population. 50% of the people with MDD have a first degree relative with mood disorder.

cont

- Biochemical factors : The level of mono-amines Serotonin and Norepinephrine are reduced in individual with major depressive illness
- Cognitive factors ; narrow negative view of self, the environment and future
- Psychosocial factors like: unemployment, loss of loved one, stress,

Predisposing factors to major depressive disorder

- Family history of depression
- Gender : women are twice likely to get depression than men
- Health condition like cancer, heart disease and thyroid disorder
- Violence, physical or emotional abuse such as rape
- Unemployment
- Divorce
- Changes and stressful events such as relationship breakups, starting of a new job.

Somatic symptoms of depression

- Significant decrease in appetite and weight
- Early morning awakening at least 2 or more hours before usual time of waking up.
- Lack of interest and lack of reactivity to pleasurable stimuli.
- Psychomotor agitation or retardation

Forms of depression

- Reactive depression (exogenous depression) : state of depression that people experience in response to external stressor. Caused in reaction to external event or circumstance. e.g death of a family member, divorce or break up.
- Endogenous depression : depression that has no obvious cause. Believed to be originating from within individual. Linked with genetic nature of individual

Treatment modalities

- Antidepressants : SSRIs , TCAs , MOAi,
- Physical therapies : ECT indicated for severe depression with suicidal risk
- Psychotherapy : Emphasizes helping patients gain insight into the cause of their depression
- Cognitive therapy : aims at correcting the depressive negative cognitions like hopelessness and pessimistic ideas

cont

- Supportive psychotherapy : various techniques are employed to support the patient . They are reassurance , occupational psychotherapy ,relaxation
- Group Therapy : sharing experiences to improve expression of their feelings
- Behaviour therapy : includes social skill training .

cont

- 8 . Family therapy : used to reduce or modify stressors.

ACUTE MANAGEMENT

- First line treatment in severe depression is a TCA unless it is contra-indicated. The main contra-indications are coexisting cardiac disease and intolerance to anticholinergic side effects like urine retention

cont

- Main alternatives to TCAs are the SSRIs which do not have side effects ,are not sedating, and are safe in overdose. The main s/e are nausea, diarrhoea and agitation
- If the patient does not respond to 6 weeks of treatment on a therapeutic dose of TCA or an SSRI, consider increasing the dose of current medication or changing to anti-depressant
- Anti-psychotics should be used if the depression is accompanied by psychotic episode

cont

- ECT is indicated in the management of resistant depression and where anti-depressants are contra-indicated or when patients' life may be at risk from suicide or dehydration arising from refusal to eat or drink.
- Relapse prevention
- Anti-depressants should be continued for a minimum of 6 months after the resolution of acute episode

Nursing management of a patient with depression

- Encourage the patient to express emotions. Provide the patient opportunity to cry out and ventilate their anger.
- Assess if there is any suicidal tendency. Take safety measures and keep vigil if patient has suicidal ideas.
- Administer prescribed antidepressants in time and monitor food intake.
- Provide non-intellectual activities e.g cleaning physical exercises provide safe and effective methods of discharging vent up tension.

cont

- Promote sleep and food intake. Most patients have insomnia and lack appetite
- Keep strict record of sleeping pattern. Discourage sleep during the day to promote more restful sleep at night.
- Promote or interact with the patient and focus and not far in future.
- Provide health education to patient and relatives regarding disease and drugs.

Health education shared on drugs

- Take medications regularly and the right dose.
- Teach the patient when therapeutic effects will be seen.Atleast 2 to 3 weeks must elapse before he feels better
- Inform the patient of the side effects of antidepressants
- Teach the patient to avoid alcohol as it causes drug interaction and may cause harm.
- Not to stop medication without medical advice

Health messages shared to family members

- Advice the family to watch for any suicidal ideas or gestures and inform the clinician immediately.
- To give adequate support and encouragement to the patient
- To give accept patient as he is and give him hope and care
- To give medication regularly as prescribed.
- To provide correct history to clinician.

BIPOLAR DISORDER

- Disorder characterized by episodes of mania and depression.

MANIA

- Condition characterized by excessive happiness with inflated self self esteem (grandiosity)
- It is quite common for a patient in manic state to believe that he or she is special. A person may believe that he is on special mission from God.

Presenting features of mania

- Expansive or irritable mood. The person feels extremely high. He or she may describe the experience as feeling on top of the world. Patient may shift from highly elated mood to being angry and irritable if they perceive to have been obstructed.
- Hyperactivity or psychomotor agitation
- Delusions of grandiosity.
- Pressured speech.
- Flight of ideas.

cont

- Easy distractibility. respond to multiple unimportant stimuli
- Dress on bright colors often that do not match
- Excessive make-up and jewelry
- Marked impairment in occupational functioning, social activities or relationships
- Hallucinations most commonly auditory

Etiology

- Genetic factors : Mania run through families.
- Biochemical factors : Mania is considered to be due to excessive biogenic amines (excess norepinephrine and serotonin)
- Psychological factors (stress commonly precedes the 1st episode of of both major depression and mania.

Medical management

- Mood stabilizers : drugs with mood stabilizers properties e.g sodium valproate, carbamazepine ,lamotrigine, and lithium should be instituted early in treatment
- Antipsychotic drugs such as olanzapine, haloperidol of chlorpromazine may be co-administered during the initial period to control behavior and psychosis.
- Benzodiazepines particularly lorazepam may be used to treat mania. They complement antipsychotic dose given in 24hrs reducing EPSEs

Nursing management of manic patient

- Avoid any verbal confrontation as the patient can be easily irritated.
- Maintain therapeutic calm environment. Remove any external stimulation such as noise and lights where possible.
- Observe the patient for fluctuation of mood. Mood fluctuate from excessive happiness to being irritable.
- Administer prescribed mood stabilizers and antipsychotics to reduce restlessness and sleepless caused by over activity.

cont

- Provide the patient with consistent limits on dressing and activities
- Observe the patient for any destructive activities
- that may result in injury.
- Engage the patient in active games, ward occupation and creative work to channel his energy
- Ensure the patient take food for physiological needs. The patient is usually too busy to eat hence may loose weight and dehydration may occur. Meals and fluids should be given under supervision.

Disruptive Mood Dysregulation Disorder

- Characterized by chronic severe and persistent irritability and angry mood manifested by frequent (3-4 times a week) temper outbursts verbally or behavioral in response to frustration.
- These are developmentally inappropriate and occur over at least 1 year both at home and school.
- Associated with familial anxiety disorder and temperamental development.
- There is marked disruption in the child's family and peer relationships as well as school performance.
- Suicidal ideation and attempts may be present.

Premenstrual Dysphoric Disorder

- Significant affective symptoms that emerge in the week prior to menses and quickly disappear with the onset of menses
- At least five symptoms which include marked *affective lability, depressed mood, irritability, or tension* with one or more symptoms of a *major depressive episode*.
- Duration: Present in all menstrual cycles in the past year and documented prospectively for two menstrual cycles.
- It causes clinically significant distress or impairment.
- Treatment: SSRI’s, CBT

PSYCHOTIC DISORDERS : SCHIZOPHRENIA

- **Def**: Most common psychotic disorder characterized by abnormalities in perception ,beliefs and thought processing

Epidemiology

- Life time prevalence is about 1% in the general population.
- First onset is typically between 15-45 years although men exhibit symptoms earlier than men.

Pathophysiology

- Schizophrenia is associated with dopamine hyperactivity in mesolimbic cortex of the brain in basal ganglia.

Clinical features (positive symptoms)

1. ***Hallucinations*** : sensing things while awake that appear to be real, but instead have been created by the mind.

Types of hallucinations

- (a).**Auditory hallucinations** :Hearing voices when no one has spoken (the most common type of hallucination). These voices may be may command someone to do something that may cause harm to themselves or to others. Hearing sounds, such as music, footsteps, windows or doors banging

cont

- (b) **Visual hallucinations** : Seeing patterns, lights, beings, or objects that are not there.
- (c**) Olfactory hallucinations** : Smelling a foul or pleasant odor. Odors are smelled that appear to be coming from specific or unknown place.
- (d). **Tactile hallucinations** : Feeling bodily sensations, such as a crawling feeling on the skin or the movement of internal organs

cont

- 2. ***Delusional beliefs*** very common especially persecutory delusion. Ideas of reference are in which unrelated notices ,signs or remarks are believed to be messages with specific meaning for the patient.
- 3. ***Thought insertion***, thought broadcast and thought withdrawal .Patient believes that other people know what they are thinking either because they can be heard or they are transmitted through TV or Radio
-

cont

- 4. formal thought disorder: individuals have difficulty in expressing their thoughts. Have loosening of associations, word salad or neologism.
- 5. Excitement or agitation
- 6.Hostility or aggressive behaviour
- 7.suicidal tendencies.
- 8. Suspiciousness or ideas of reference

Negative symptoms

- **Alogia**: refers to difficulty with speaking. In some schizophrenic patients, alogia manifests as reduced total speech output, and reduced verbal fluency (the ease with which words are chosen). Patients displaying alogia struggle to give brief answers to questions

- **Asociability** :impairment in social relationships which include little interest in being with other people , poor social skills and few friends

cont

- Avolition/apathy: inability or lack of energy to engage in routine .e.g poor grooming and personal hygiene.
- Anhedonia: inability to feel pleasure. Lack of interest in or enjoyment in activities or relationships.
- Affective blunting : decreased facial expression

Types of schizophrenia

- **Disorganized Schizophrenia-** This is a disorder characterized by incoherence, foolishness and regressive behavior.
- **Paranoid Schizophrenia-** This is a disorder characterized by delusions of persecution or grandeur.
- **Undifferentiated Schizophrenia-** This disorder is characterized by a variety of symptoms found in several of the types of schizophrenia also called simple schizophrenia.

Con’t

- **Hebephrenic schizophrenia-** Characterized by :
  - Silly and childish behaviour
  - Prominent affective symptoms
  - Delusions commons
- **Residual schizophrenia** : absence of prominent delusions ,hallucinations ,disorganized behaviour with presence of odd beliefs or negative symptoms

- **Catatonic schizophrenia** : characterized by marked disturbance of motor behaviour. May take the form of catatonic stupor, catatonic excitement or alternating between stupor and excitement.
- Catatonic excitement presents with:
  - **Increased psychomotor activity i.e. restlessness, agitation and excitement**
  - **Increase in speech production**
  - **Loosening of association**

cont

- Catatonic stupor presents with:
  - **Mutism : lack of speech**
  - **Rigidity : maintenance of posture against efforts to be moved**
  - **Waxy flexibility : parts of the body can be placed in positions that will be maintained for long period of time.**
  - **Stupor : does not react to surrounding and appears to be unaware of them**

Schnederian first rank symptoms of schizophrenia

- Auditory hallucinations
- Delusions of control
- Thought broadcasting
- Thought withdrawal
- Thought insertion.
- Somatic passivity: bodily sensations are experienced as imposed on the body by external force.
- Made volition or acts: one own acts are experienced as being under control of external force

Bleuler's Four A's of schizophrenia

- Eugene Bleuler cited other symptoms called Bleulers Four A's symptoms which include:
- **A**utistic thinking: thought process in which individual is unable to relate with others or environment
- **A**mbivalence: contradictory or opposing emotions. Desires for same person but feels bad about him/her.
- **A**ssociative looseness: inability to think logically.
- **A**ffective disturbance ;inability to show appropriate emotional response

Etiology

- Biochemical imbalances ; over activity of dopamine within mesolimbic cortex.
- Environmental factors e.g. trauma during childhood.
- Genetic causes : high prevalence rates in relatives of schizophrenic
- Differential diagnosis
- Mania ;characterized by prominent affective features like grandiosity, over activity and lability of mood

Con’t

- Depression ; chronic schizophrenia may mimic or coexist with depression.
- Drug induced psychosis present with hallucinations and delusions
- Dementia presents with impairment in thinking
- Schizoid personality disorder present with delusions
- Schizotypal personality disorder presents with delusions.

Medical management

- Acute phase : older or typical antipsychotics e.g. largactil or haloperidol have most effect on positive symptoms of schizophrenia. Chlorpromazine is more sedating
- Patients may benefit from augmentation of antipsychotics with benzodiazepines e.g. diazepam and lorazepam.

cont

- Commonly used Convectional antipsychotics drugs are;
- Chlorpromazine 300-1500mg/day PO,50-100mg/day IM.
- Fluphenazine decanoate 25-50mg every month.
- Haloperidol 5-100mg/day PO,5-20mg/day IM

cont

- Commonly used atypical antipsychotics are:
- Clozapine 25-450mg/day PO
- Risperidone 2-10mg/day PO
- Olanzapine 10-20mg/day PO
- Quetiapine 150-750 mg/day PO
- Ziprasidone 20-80mg/day PO
- Clozapine may cause agranulocytosis-potentially fatal blood disorder marked by low white blood cell count and neutrophil depletion

cont

- Chronic phase : depot antipsychotic injections e.g. modecate (fluphenazine) may be used in patients with poor compliance
- Use of newer antipsychotics e.g. clozapine, olanzapine ,risperidone.
- 3.ECT : is indicated for catatonic schizophrenia and severe depressive symptoms accompanying schizophrenia.

cont

- Psychotherapy : counselling and advise to the patient
- Behaviour therapy : patient is taught appropriate behaviour by direct instruction
- Rehabilitation services to provide opportunities to increase skills in living such as vocational rehabilitation.
- 7.Outpatient treatment to provide aftercare, maintenance therapy, social support programs and medical clinics

Nursing management

- The first priority is to ensure safety of the patient and others. Remove all dangerous objects from surrounding.
- Protect the patient during acute episodes from absconding and suicide attempts
- Administer prescribed antipsychotics and note the progress and side effects
- Provide less stimulating environment e.g. dim light, less noise and comfortable bed.
- Approach the patient with calmness, emphathy and gentle eye contact.

cont

- Observe the patient behavior frequently and note any changes.
- Provide a structured environment with scheduled routine activities of daily living
- Apply mechanical restraints safely if there is a justified need. Mechanical restraints applied too tightly may impair circulation.
- Assess the nature and severity of hallucinations

cont

- Distract the patient from delusions that tend to exacerbate aggressive or potentially violent episodes. Distraction can be done by engaging patient in constructive activities.
- Encourage the patient to express feelings as much as possible.
- Provide food and fluid to the patient to meet the physiological needs of the body.
- Provide assistance with self care activities as required.

End

Organic Psychosis

Martha Kairu

Welcome

Introduction to organic disorders

- Are disorders associated with brain dysfuction.
- Are also called cognitive disorders.
- They include;
  - **Dementia**
  - **Delirium.**

1.DEMENTIA

- A chronic mental disorder characterized by gradual loss of memory and intellectual abilities, impaired reasoning and deterioration of personality with the course being progressive, stationary or reversible.

CLINICAL FEATURES.

- Has early and late signs.

Early signs and symptoms

- Memory impairment for recent events and poor retention of new information.

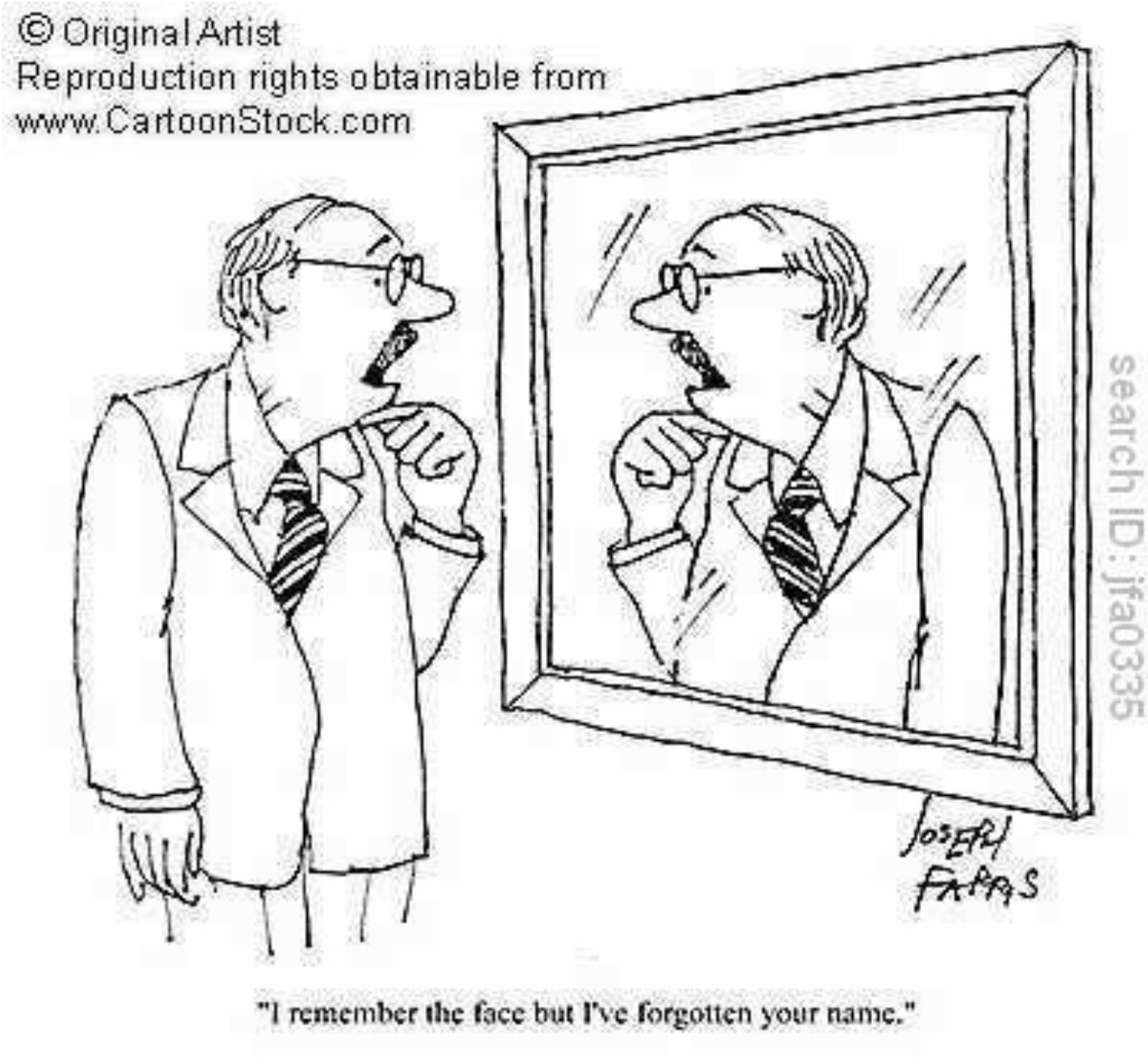
cont

- Reduction in range of interests
- Change in personality: patient may be irritable or aggressive
- Change in mood. Mood may be labile.
- Change in behaviour i.e. restlessness and distractible.
- Poverty of thoughts and persecutory beliefs.

Late signs and symptoms of dementia

- Further memory loss including memory for distant events
- Disorientation especially in time but also in place and later in person which may lead to wandering
- Self neglect and deterioration in self care
- Restlessness especially in afternoon and evening.
- Incoherence and mutism
- Incontinence of urine and feaces

Dementia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search ID: jfa0335
JOSEPH FARRIS
"I remember the face but I've forgotten your name."

Incidence

- Is more common in elderly than middle aged.
- Increases with age from 0.1% from those below 60 years to 15-20% to those who are 80 years.

ETIOLOGY

- Significant loss of neurons and volume in brain regions devoted to memory and mental functioning.
- Damage of the support structures of the nerve cells

cont

- Accumulation of beta amyloid, an insoluble protein which form sticky patches in neurons
- Deficiencies of vitamin B6,B12 and folate
- Infections of the nervous system like encephalitis
- Serious head injuries.
- Excessive metal ions like zinc in the body.

Untreatable or irreversible forms of dementia

- Degenerating disorders of the CNS.
- Huntington's chorea : a hereditary disease marked by progressive degeneration of nerve cells in the brain
- Parkinson disease
- Alzheimer's disease .
- Picks disease

Treatable or reversible forms of dementia

- Vascular or multi-infact dementia
- Dementia resulting from intracranial space occupying lesions
- Dementia resulting from metabolic disorders like hepatic and renal failure.
- Dementia resulting from endocrine disorders like Addison disease.
- Dementia resulting from infections like AIDS ,meningitis and encephalitis.
- Dementia resulting from vitamin deficiency like thiamine
- Dementia resulting from Anoxia

Stages in development of dementia

- Dementia develops in threes stages.

1. **Stage one (2-4)**

- Develop between 2-4 years.
- Characterized by:-
  - **Forgetfulness**
  - **Declining interest in environment**
  - **Poor performance at work.**

2. Stage two: (2-12 yrs)

Characterized by:-

- Progressive memory loss
- Difficulty in following instructions
- Hesitancy in response to questions
- Irritable and anxious
- Wandering
- Neglect personal hygiene
- Social isolation.

Stage 3:Final stage

- Marked loss of weight because of inadequate intake of food.
- Unable to communicate
- Does not recognize family members
- Incontinence of urine and feaces
- Loss of ability to stand and walk

Risk factors for dementia

- Family history of Alzheimer's disease
- Increased age
- Head trauma
- Cardiovascular diseases

INVESTIGATIONS

- Full hemogram
- UECs
- CT scan and MRI

Treatment of dementia

- Treatment of any reversible cause: hydrocephalus, renal failure ,hypothyroidism, brain lesions, subdural hematoma, Vit B6 and B12 ,folate deficiencies.
- Pharmacologic treatment :
- Tacrine (cognex), a cholinergic drug that improves cognitive functioning. However, its use is limited due to liver toxicity.
- Antidepressants, antianxiety, and antipsychotics used to relieve associated symptoms like hallucinations and delusions.
- Antiepileptic drugs for multi-infarct dementia
- Benzodiazepines for insomnia and anxiety.

Nursing management

- Assess the patient level of functioning to formulate appropriate plan of care.
- Provide safety to the patient. Assess the patient level of disorientation to determine specific requirement for safety.
- Maintain daily routines to include drawing up a fixed timetable for patient for waking up, toilet ,exercise and meals,

cont

- Provide additional care during evening due to sun downing. This is a situation where patient condition deteriorates during evening and additional care must be provided.
- Orient the patient to reality in order to decrease confusion. use calendar with large writing and a separate page for each day. Provide newspapers which stimulate interest in events

cont

- Provide a well balance diet rich in protein, higher fiber with adequate amount of calories. Allow plenty of time for meals.
- Provide daily personal hygiene to include brushing of teeth, bathing, keeping the skin clean and dry.
- Provide toilet habits and maintained it as a rigid routine. The patient should be taken to urinate at a fixed interval depending on fluid intake and season

cont

- Prevent accidents from falling, slipping in bathroom and tripping over furniture by providing patients with firmly secured shoes. Any floor covering must be firmly secured.
- Decrease the amount of stimuli to the patient environment so that confusion may be less.
- Help the patient devise methods to reduce memory defects e.g. by asking them to note down the daily activities.

cont

- Use simple explanations and face to face introduction and communication to the patient.
- Provided sufficient fluid during the day and minimum amount of fluid at evening around 6pm
- Keep calm environment with fixed schedules to prevent changes in mood which are unpredictable.
- Provide identification tag for patients with Alzheimer's disease as they are prone to wandering due to disorientation

Multi-infarct dementia

- Condition characterized by an alteration in due brain function due to destruction of brain tissues

Contributing factors

- Advanced age
- Cerebral emboli or thrombosis
- Diabetes
- Heart disease
- High blood cholesterol
- Hypertension

Signs and symptoms

- Confusion
- Wandering or getting lost in familiar places
- Leg or arm weakness
- Problems with recent memory
- Loss of bladder and bowel control
- Inappropriate emotional reaction such as laughing or crying inappropriately
- Problems with recent memory
- Difficulty in following instructions

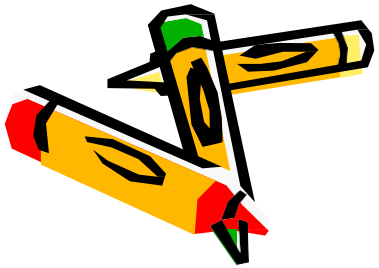
Nursing interventions

- Reduce unnecessary stimulation
- Avoid changing patient room and moving furniture
- Orient patient to the surrounding
- Make environment as stable as possible

Alzheimer's disease

INTRODUCTION

- *Alzheimer's disease is a* degenerative brain disorder of unknown etiology which is the **most common form of dementia**
- Usually starts in late middle age or in old age
- Results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood.



Origin of Alzheimer's Disease

- The disease was first described by Dr. Alois Alzheimer, a German physician, in 1906. Alzheimer had a patient named Auguste D, in her fifties who suffered from what seemed to be a mental illness.
- But when she died in 1906, an autopsy revealed dense deposits, now called neuritic plaques, outside and around the nerve cells in her brain. Inside the cells were twisted strands of fiber, or neurofibrillary tangles.

Auguste D

- Since Dr. Alois Alzheimer's was the first person who discovered the disease, AD was named after him.

Definition

- Alzheimer’s disease is a chronic, **irreversible** disease that affects the cells of the brain and causes impairment of intellectual functioning.
- Alzheimer's disease is a brain disorder which gradually destroys the ability to reason, remember, imagine, and learn.

INCIDENCE

- About 3 percent of men and women ages 65 to 74 have AD, and nearly half of those age 85 and older may have the disease.

CAUSES

- The cause of Alzheimer's disease is not known.

However, several factors are thought to be implicated in this disease e.g.

ENVIRONMENTAL FACTORS

- Cigarette smoking.
- Certain Infections.
- Metals, industrial or other toxins.
- Use of cholesterol lowering drugs (statin).

Signs of Alzheimer's disease

Ten warning signs of Alzheimer's disease

1) Memory loss
2) Difficulty to performing familiar tasks
3) Problems with language
4) Disorientation to time and place
5) Poor or decreased judgment
6) Problems with abstract thinking
7) Misplacing things
8) Changes in mood or behavior
9) Changes in personality
10) Loss of initiative

Symptoms of Alzheimer's disease

- Confusion
- Disturbances in short-term memory
- Problems with attention and spatial orientation
- Personality changes
- Language difficulties
- Unexplained mood swings

DELIRIUM (ACUTE ORGANIC SYNDROME)

- **Defn** :Refers is acute organic mental disorder characterized by;
  - (i) Impairment of consciousness I.E. decreased awareness to surrounding
  - (ii) Disorientation, mostly time, but in severe cases, place and person
  - (iii) Disturbance in perception and restlessness. Has illusions and or hallucinations.
- **Incidence**
- Has the highest incidence among organic mental disorders.
- Account for 10-25% of medical – surgical patients and about 20-40% of geriatric patients

Causes of delirium

- Endocrine and metabolic conditions like diabetic coma, uremia , hyperthyroidism and kidney failure
- Thiamine deficiency
- Traumatic events leading to : Subdural and epidural hematomas
- Vascular problems cerebral arteriosclerosis
- Infections like meningitis and encephalitis

cont

- Withdrawal effects of sedatives
- Neoplasm : space occupying lesions
- Anemia
- Toxins in the brain

Signs and symptoms

- Impairment of consciousness : clouding of consciousness ranging from stupor to coma
- Clouding means loss of clarity ..it means lowered level of consciousness
- Impairment in attention ; difficulty in focusing and sustaining attention
- Illusions and hallucinations esp visual
- Loss of recent and immediate memory

cont

- Hypo activity or hyperactivity characterized by flocculation (aimless picking of bed clothes)
- Disturbances in sleep pattern including insomnia , disturbing dreams or nightmares
- Emotional disturbances including depression , anxiety , fear , irritability euphoria and apathy.

Course and prognosis

- It has abrupt onset
- Duration of episode is brief lasting for about a week

TREATMENT

- Identification of a cause and its immediate correction e.g correction of hypoglycemia and vitamin deficiency.
- Symptomatic treatment : **Benzodiazepines** e.g. lorazepam, Diazepam , and **antipsychotics** e.g. Haloperidol may be given

Nursing management

- Provide safety of the patient as the patient is responding to hallucinatory illusions and delusions
- Restrict environmental stimuli, keep the unit calm and well illuminated
- Keep the room well lighted especially at night
- Provide a caregiver at the bed side of the patient at all times to provide security

cont

- Observe the patient for extreme drowsiness and sleep as it may indicate the patient into coma.
- Reduce fever if present
- Hydrate the patient and maintain intake and output
- Monitor vitals signs
- Orient the patient by :
  - **Repeatedly explaining to the patient where he is and what date ,day and time**
  - **Introduce people with names**
  - **Have a calendar in room and tell the patient what day it is**

ANXIETY DISORDERS

Martha Kairu

Objectives

By the end of the lesson, the learner should be able to:-

- Define anxiety
- Differentiate between anxiety and fear
- Theories explaining anxiety.
- Describe the types of anxiety disorders in terms of criteria of diagnosis, signs and symptoms, factors associated with each and the management.

Introduction

- **Anxiety vs Fear**

- **Fear**: acute, immediate response to suddenly appearing, imminent danger (proximal threats)
- Fear involves subjective feelings of apprehension and objective physiological changes such as rapid heart beat, muscle tremor etc in preparation for flight or fight tendencies.

- **Anxiety**:
- A sustained feeling of uneasiness and apprehension about some undefined threat either physical or psychological with threats to self-esteem, wellbeing or bodily harm.

- Unlike fear, anxiety stems from sources that are not obvious or seems minor to the person who suffers.

Causes of anxiety

Many theories exist since the advent of Freud's pioneering work identifying anxiety as a universal human emotion that directs human behaviour.

The cognitive model attributes anxiety to a disordered thinking (the cognitive triad)

Other causes of anxiety include: Dysfunctional beliefs/rules, Biological basis i.e. the limbic system

Levels of Anxiety

- **Mild:** adaptive day to day tension
- **Moderate:** difficulty focusing with mild somatic complaints such as mild stomach upsets
- **Severe:** unable to focus on problem solving, increased physical discomfort, direction needed to focus attention
- **Panic:** awe, dread, terror, distortion of perception, disorganized personality

Maladaptive coping to anxiety leads to **Anxiety disorders** with a common feature of anxiety**:**

- Generalized anxiety disorder
- Selective mutism
- Separation anxiety disorder
- Specific phobia
- Social anxiety disorder (social phobia)
- Panic disorder
- Agoraphobia
- Substance/medication-Induced Anxiety Disorder.

Generalized Anxiety Disorder

This is an anxiety disorder characterized by excessive anxiety and worry occurring on most days for at least 6 months.

The anxiety is about a number of different events or activities and the individual finds it difficult to control.

The affected person has at least three or more of the following:

- Restlessness or feeling keyed up
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance.

In children just one symptom.

Most common in adults and female.

Panic disorder

- Recurrent unexpected panic attacks.
- A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:
  - Palpitations, pounding heart, accelerated heart rate
  - Sweating
  - Trembling or shaking

- Chest pain or discomfort
- Nausea or abdominal distress.
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Paresthesia (numbness or tingling sensation)
- Sensation of shortness of breath or smothering
- Fear of dying
- Chills or hot flushes
- Feeling of chocking

- At least one of the attacks has been followed by 1 month or more of either :
  - Persistent concern or worry about additional panic attacks or their consequences or
  - A significant maladaptive change in behavior related to the attacks
- Not attributed to substance effect, medical condition or another mental disorder.

Separation Anxiety Disorder

- Essential feature is excessive fear or anxiety concerning separation from home or attachment figures exceeding what may be expected at the given developmental level.

- Individuals with separation anxiety disorder have symptoms that meet at least three of the following criteria: they experience persistent excessive fear when;

- separation from home or major attachment figures
- worry about the well-being or death of attachment figures
- worry about untoward events to themselves
- reluctance or refusal to go out by themselves or being alone
- reluctance or refusal to go to sleep alone
- repeated nightmares
- Physiological features such as headache upon separation

- The disturbance must last for a period of at least 4 weeks in children and adolescents and 6 months or more in adults
- It causes significant distress or impairment in social, academic and occupational life.
- Risk factors include: after life stress, parental overprotection and intrusiveness.
- The most prevalent anxiety disorder in children under 12yrs.

Selective Mutism

- Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations for at least 1 month.

- Such children do not initiate speech or reciprocally respond when spoken to by others except the very close family members or friends.

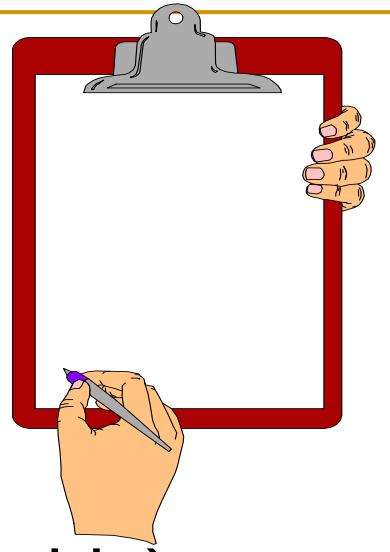
- It interferes with educational or occupational achievement or with social communication.
- The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better explained by a communication disorder

Specific Phobia

- Revolves around specific or single feared objects or situation that is not in fact objectively dangerous
- There's active avoidance of the phobic objects or situations lasting for 6 or more months.
- The fear and anxiety is out of proportion and is the immediate response to the object or situation.

- *Acrophobia* – heights
- *Apiphobia* – bees
- *Ailurophobia* – cats
- *Astrophobia* – lightning
- *Aviophobia* – flying
- *Claustrophobia* – closed spaces
- *Cynophobia* – dogs
- *Entomophobia* – insects
- *Pyrophobia* – fire
- *Gephyrophobia* – bridge crossing
- *Hematophobia* – blood
- *Hydrophobia* – water
- *Microphobia* – germs
- *Monophobia or autophobia* – being alone.
- *Nyctophobia* – night
- *Xenophobia* – strangers

ASSIGNMENT:



- READ AND MAKE NOTES:
  - Social anxiety disorder(social phobia)
  - Agoraphobia

Management of Anxiety Disorders

- CBT : Challenge negative thinking patterns that contribute to anxiety, replacing them with positive, realistic thoughts
- Habituation, flooding and implosive therapies
- Train patient relaxation techniques:
  - Recognize your own feelings of anxiety
  - Mental exercises: crossword puzzle or playing general knowledge games.

- Focusing on a neutral object with as much detail as possible.
- Progressive relaxation 15- 20 minutes. Jacobson 1938(tensing and relax muscles)
- Benson’s meditation (1975) technique
- Develop a set of verbal and nonverbal and environmental manipulation skills

Use of anti-anxiety agents

- Propranolol for physical symptoms of anxiety
- Alprazolam is the treatment of choice for panic disorder; others include clomipramine, fluoxetine, imipramine and phenelzine.
- Others include imipramine and buspirone for generalized anxiety disorder, phenelzine for phobias
- Benzodiazepines sparingly.

Any Question???

PERSONALITY DISORDERS

Martha Kairu

Objectives

By the end of the lesson, learners should be able to:

- Define personality and personality disorder.
- Classify personality disorders and outline the characteristics of each cluster.
- Describe the characteristics of individual personality disorders and their management.

Definition of Personality Disorder

- Enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture:
- Cognition, Affect, Interpersonal Functioning, Impulse Control
- Cross-situation stability – inflexibility
- Leads to impaired functioning, distress

Classifying Personality Disorders

Based on descriptive similarities.

Cluster A:
These persons appear odd or eccentric.
Includes:

- Paranoid,
- Schizoid, and
- Schizotypal

- **Cluster B**:

  These persons appear dramatic, emotional, or erratic.

  Includes: Antisocial, Borderline, Histrionic, and Narcissistic

- **Cluster C**:

  These persons appear anxious or fearful.

  Includes: Avoidant, Dependent, and Obsessive-Compulsive

Etiology of Personality Disorders

Genetics

Monozygotic twins reared apart have nearly same personalities.

Cluster A: more common in the biological relatives of patients with schizophrenia.

Cluster B: Antisocial personality disorder is associated with alcohol use disorders;

Cluster C: obsessive-compulsive traits are more common in monozygotic twins than in dizygotic twins - they also show some signs of depression.

Environmental

Link between fearful children raised by fearful mothers and avoidant personality disorder;
Cultures that encourage aggression may contribute to paranoid and antisocial personality disorders.

Paranoid Personality Disorder

- Characterized by long-standing suspiciousness and mistrust of persons in general.
- Often hostile, irritable, and angry.
- More common in men than in women

- Prevalence - 0.5 to 2.5% of the general population.

- Hallmarks are excessive suspiciousness and distrust of others expressed as a pervasive tendency to interpret actions of others as deliberately demeaning, malevolent, threatening, exploiting, or deceiving.

Management

- Psychotherapy is the treatment of choice
- Pharmacotherapy is useful in dealing with agitation and anxiety.
- Acknowledge mistakes.
- Be open and honest.
- Don’t confront.
- Set limits.
- Clearly explain procedures, medications and results.

Schizoid Personality Disorder

- Display a lifelong pattern of social withdrawal.
- Discomfort with human interaction, their introversion, and their bland, constricted affect
- Eccentric, isolated, or lonely.
- Solitary interests and success at noncompetitive, lonely jobs that others find difficult to tolerate.

- Prevalence is 7.5 % of the general population
- Treatment is similar to that of those with paranoid personality disorder.

Management

- Understand their need for isolation.
- Minimize new contacts and intrusions.
- Maintain a quiet, reassuring, and considerate interest in them.
- Don’t insist on reciprocal responses.

Schizotypal Personality Disorder

- Strikingly odd or strange
- Magical thinking, peculiar notions, ideas of reference, illusions, and derealization
- Occurs in about 3 percent of the population
- Diagnosed on the basis of the patients' peculiarities of thinking, behavior, and appearance.

Management

- Similar to Schizoid PD.
- Misperceptions of physical symptoms and treatment.
- Do not ridicule or judge.
- Respect their need for privacy.

Antisocial Personality Disorder

- An inability to conform to the social norms that ordinarily govern many aspects of a person's adolescent and adult behavior.
- Prevalence is 3% in men and 1% in women.
- Onset of the disorder is before the age of 15.

- Lying, truancy, running away from home, thefts, fights, substance abuse, and illegal activities
- Highly representative of so-called con men
- Notable finding is a lack of remorse for these actions; that is, they appear to lack a conscience.

Management

- Set firm limits.
- Try not to be manipulated.
- Have high level of skepticism.
- self-help groups
- firm limits are essential
- Pharmacotherapy

Borderline Personality Disorder

- Emotionally unstable personality disorder
- 1 to 2 percent of the population
- Twice as common in women as in men
- Almost always appear to be in a state of crisis.

- Mood swings are common.
- Micropsychotic episodes - short-lived psychotic episodes
- Have tumultuous interpersonal relationships.
- Shifts of allegiance from one person or group to another are frequent.

Management

- Be aware of and anticipate defenses.
- Often regress.
- Open and continuous communication with.
- Stable and calm reaction.
- Gently confront.
- Set fair and consistent limits on acting out.

Histrionic Personality Disorder

- Excitable and emotional and behave in a colorful, dramatic, extroverted fashion
- Inability to maintain deep, long-lasting attachments
- Prevalence - 2 to 3%

- High degree of attention-seeking behavior
- Display temper tantrums, tears, and accusations when they are not the center of attention or are not receiving praise or approval.
- Seductive behavior is common

- major defenses are repression and dissociation.
- With age, show fewer symptoms, but because they lack the energy of earlier years, the difference in number of symptoms may be more apparent than real

Narcissistic Personality Disorder

- Characterized by a heightened sense of self-importance and grandiose feelings of uniqueness
- About 1 percent in the general population
- Sense of entitlement is striking

- Handle criticism poorly and may become enraged when someone dares to criticize them
- Interpersonal exploitiveness is common place
- Cannot show empathy, and they feign sympathy only to achieve their own selfish ends.

Management

- Help handle criticism better to avoid becoming easily enraged.
- Reinforce that they are respected and appreciated.
- Set limits on demanding behavior.

Avoidant Personality Disorder

- Show extreme sensitivity to rejection and may lead a socially withdrawn life.
- Not asocial and show a great desire for companionship, but they need unusually strong guarantees of uncritical acceptance.
- Prevalence - 1-10% of the general population

- Most striking aspect is anxiety
- Hypersensitivity to rejection by others is the central clinical feature
- Main personality trait is timidity

Management

- Have patience and understanding.
- Medical illnesses may be embarrassing.
- Minimize new and unfamiliar staff contacts.
- Respond with a calm and reassuring demeanor.
- Do not criticize them.

Dependent Personality Disorder

- Characterized by a pervasive pattern of dependent and submissive behavior.
- Cannot make decisions without an excessive amount of advice and reassurance from others.
- More common in women than in men.

- Pessimism, self-doubt, passivity, and fears of expressing sexual and aggressive feelings all typify the behavior

- An abusive, unfaithful, or alcoholic spouse may be tolerated for long periods to avoid disturbing the sense of attachment.

Management

- Respect their feelings of attachment.
- Be careful when encouraging a patient to change the dynamics of an abusive relationship.
- When medically ill they may become frustrated that they are not being helped, hence show concern.
- Be active in the treatment planning.

Obsessive-Compulsive Personality Disorder

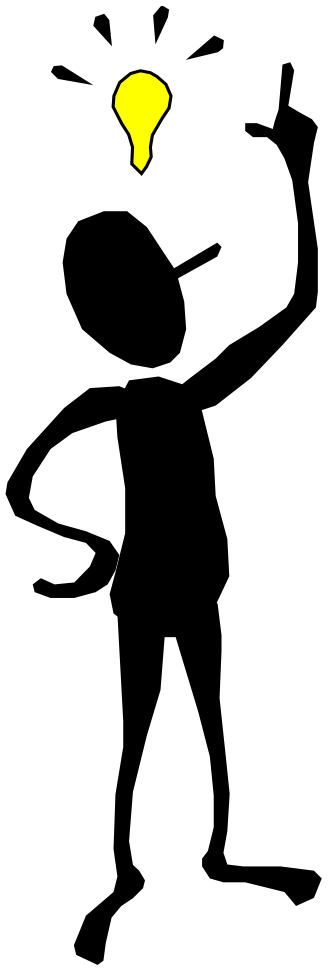
- Characterized by emotional constriction, orderliness, perseverance, stubbornness, and indecisiveness
- Essential feature of the disorder is a pervasive pattern of perfectionism and inflexibility

- Preoccupied with rules, regulations, orderliness, neatness, details, and the achievement of perfection.
- Lack flexibility and are intolerant.
- Capable of prolonged work, provided it is routinized and does not require changes to which they cannot adapt.

Management

- Give precise and rational explanations.
- Value efficiency and punctuality.
- Acknowledge the importance of work, but point out how avoiding treatment may have harmful consequences.
- Allow the patient to control his or her care as much as possible.
- Provide them with information.
- Avoid power struggles.
- Understand their need for order and control.

Any Question???



GOOD..... I AM OUT!!!

SEXUAL DYSFUNCTION DISORDERS

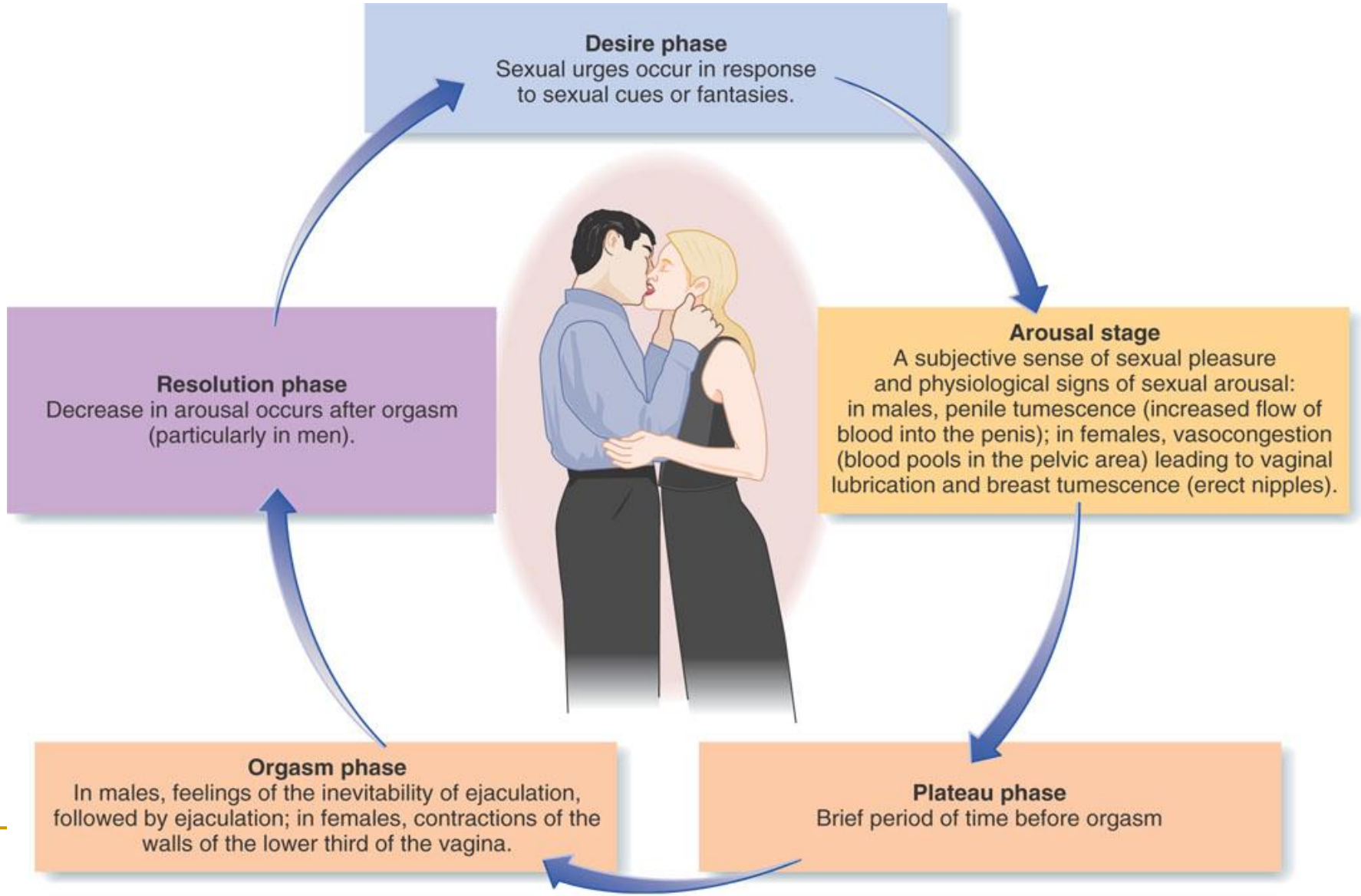
Martha Kairu

Objectives

By the end of the lesson, the learner should be able to:-

- Describe the sexual response cycle
- Describe the types of sexual dysfunction disorders, signs and symptoms, factors associated with each and the management.
- Describe the psychosexual therapy.

Sexual Response Cycle



SEXUAL DYSFUNCTION

- This is characterized by a disturbance in sexual response cycle or by pain associated with sexual intercourse and cause marked distress and interpersonal difficulty:
  - Sexual desire disorders
  - Sexual arousal disorders
  - Orgasmic disorders
  - Sexual pain disorders

Diagnostic Judgement:

- Age, culture, religion and experience of the client
- Chronicity and frequency of the symptom
- Subjective distress and the effect on other areas of functioning.
- If sexual stimulation is inadequate in either focus, intensity or duration, the diagnosis of sexual dysfunction involving excitement or orgasm is not made.

A: Sexual Desire Disorders

- **Hypoactive sexual desire disorder**
  - Persistent or recurrent deficient (or absent) sexual fantasies and desire for sexual activity.
  - The disturbance causes marked distress or interpersonal difficulty.
  - The sexual dysfunction is not better accounted for by another disorder and is not exclusively due to the direct physiological effects of a substance or a general medical condition.

Sexual aversion disorder*

- Persistent or extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual contact.
- The disturbance causes marked distress or interpersonal difficulty.
- The sexual dysfunction is not accounted for by another mental disorder except by another sexual dysfunction.

B. Sexual Arousal Disorder

- **Female sexual interest/arousal disorder**
  - Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.
  - The disorder may result in painful intercourse, sexual avoidance, and the disturbance of marital or sexual relationships.
  - The disturbance causes marked distress or interpersonal difficulty.

Male erectile disorder

- Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.
- Is associated with sexual anxiety, fear of failure, concerns about sexual performance and decreased subjective sense of sexual excitement and pleasure.
- The disturbance causes marked distress or interpersonal difficulty.

C: Orgasmic Disorders

- **Female orgasmic disorder.**
  - Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. This is based on the age, sexual experience and adequacy of sexual stimulation a woman receives.
  - The disturbance causes marked distress or interpersonal difficulty.

Premature/Early Ejaculation Disorder

- Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.
- psychological factors - newly married, fear about performance, stressful relationships etc.
- Physical factors- some men may be tactilely sensitive, responding more intensely to stimulation.

Genito-pelvic pain/penetration Disorder

- **Dyspareunia** (*not due to general medical condition*)
  - Recurrent or persistent pain associated with sexual intercourse in either male or a female.
- **Vaginismus** (*not due to general medical condition*)
  - Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

General Treatment

- Medication
  - Hormone shots, pills, or creams
  - Viagra
- Mechanical aids
  - Penile implants, dilators
- Sex therapy
- Behavioral treatments
- Avoid smoking, drinking, or drug use
- Psychotherapy
  - Manage stress, anxiety, and concerns
- Education and communication
  - About sex and sexual behaviors
  - Create an open dialogue

Management of sexual dysfunction disorders

Assessment

The following are some of the factors to be covered during the assessment interview:

- Adopt Annon's PLISSIT model
- The nature and development of the sexual problem
- Family attitudes towards sexuality – "taboo" element
- Sexual knowledge: how and from where was it gained

- Gender identity and role: did the individual feel safe with the gender identity or role during childhood or adolescent
- Puberty: when did this occur, was it early or late compared with peers, was it traumatic, for the female; ask about the onset and early understanding of menstruation and subsequent patterns.
- Masturbation: if it occurred, was it associated with guilt? Does the individual masturbate now? Enquire about masturbatory fantasies.

- Interest in opposite sex: when did it develop and what was the nature of the first heterosexual relationship?
- Homosexuality: any early homosexuality, but more importantly, is there any current homosexual interests?
- Relationships and sexual contacts prior to meeting the current partner: have there been partners; has sexual activity occurred in these relationships, and if so, were there problems

- Current relationships: when did the couple meet; what attracted them to each other and how did the relationship develop; is there any general discord in the relationship of which sexual difficulty may be merely a symptom; (if so, general marital therapy might be indicated); has the sexual problem undermined general relationship?

- How did the current sexual relationship develop:- was there a problem initially or it suddenly appeared?
- Are there any physical (e.g diabetes, neurological diseases, pelvic pathology, medicines) or psychiatric factors (mood and anxiety disorders) that could account for the problem?
- Physical examination: if indicated to exclude organic causes of the dysfunction.

Therapeutic intervention

- The treatment of sexual dysfunctions altered drastically following Masters and Johnson’s work in 1970. until then, more attempts at RX had involved lengthy psychoanalysis or psychotherapy of an individual; producing only fair outcomes.

Principles of Masters and Johnson approach:

- The couple are helped to communicate both verbally and nonverbally about, and during sexual behaviour.

- Education is provided concerning sexual anatomy and physiology: the couple should concentrate on the uninhibited giving and receiving of sexual stimulation and allow spontaneous physiological reactions (e.g. erections, orgasm) to take care of themselves.

- The “give to get principle” i.e. partners encouraged to give pleasure to receive it.
- Couples are engaged in a very intensive programme of 2 – 3 weeks in which the couple is encouraged to carry out a graduated series of “homework” assignments aimed at establishing a rewarding sexual relationship.
- Therapists work in pairs (one male and one female).

Plan of psychosexual therapy:

- **Formulation**:
  - the couple together is given an explanation of their sexual difficulty in terms of past causes and current factors serving to perpetuate the problems.
  - Agreed ban on sexual intercourse and intimate touching in the early stages of treatment.

Instead the couple engages in:

- **Sensate focus**: involves exploration of each other's bodies in order to give and receive pleasurable sensations with emphasis on communication and giving pleasure in order to receive it.

- **Genital sensate focus:** the couple move to involve the genital and breast areas in their caressing and exploration.

- **Education**: a very important part of therapy which involves providing information on sexual physiology and anatomy and how to engage in effective sexual stimulation. Visual aids are often helpful.

- **Specific techniques**: may be used aimed at correcting specific problems e.g. the “squeeze technique” for premature ejaculation or the use of graded dilators for vaginismus.

- **Gradual return to sexual intercourse**: occurs usually through an intermediate stage of “vaginal containment” with no movement using the female superior or lateral positions. These positions are encouraged because they facilitate continuing use of such techniques as the “squeeze” and may be effective stimulation of the female partner.
- Biological treatment: Viagra (sildenafel), Cialis

SEXUAL DISORDERS
1.PARAPHILIAS

- Paraphilias are recurrent and intense sexual urges or sexually arousing fantasies involving either non-human objects, children or nonconsenting adults.
- TYPES OF PARAPHILIAS
- 1. Frotteurism : recurrent and intense sexual urges to touch and rub against non-consenting adults. Common in men who rub their genitals against non-consenting women esp when getting into and out of car. They can also rub their thighs and breast and achieve maximum satisfaction by doing so.

cont

2. voyeurism : recurrent and strong sexual desire to observe unsuspecting people in secret as they undress or to spy on couples engage in intercourse. The person normally go near bedrooms at the outside of rooms and listen to the ongoing act and if possible watch it.

3.exhibitionism : recurrent sexually arousing fantasies or urges of exposing genitals (male) to another person, Their sexual relationships with their spouses are not satisfactory because they just expose to them without engaging them in act

cont

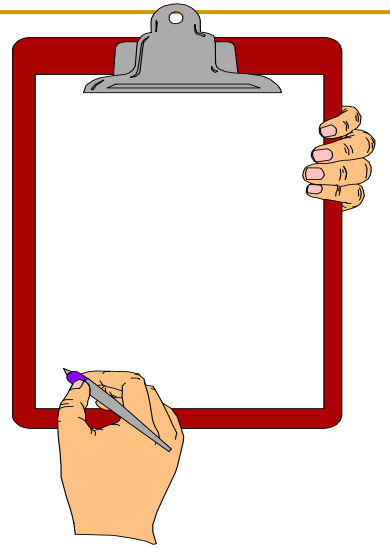
- 4. Fetishism : recurrent intense sexual urges ,sexually arousing fantasies or behaviors that involve use of non-living objects .Fetish objects include women underwear especially with bright colors such as pink , shoes and boots. The objects are worn , touched or smelled and the person achieves satisfaction.
- 5. pedophilia : sexual gratification is obtained by watching ,touching or engaging sexual act with prepubescent children under 13 yrs

cont

6. sexual masochism : a pattern in which a person has intense sexual urges and fantasies that involve being humiliated, beaten bound or made to suffer. They request their partners to restrain ,tie up whip or electrically shock them to achieve sexual satisfaction

7. sexual sadism : a pattern in which a person usually male is intensely sexually aroused by act of inflicting pain to others.they can cut or even strangle others

ASSIGNMENT:



- READ AND MAKE NOTES:
  - Gender Dysphoria (DSM V)

CHILDHOOD MENTAL DISORDERS

Martha Kairu

Introduction

- Group of conditions with onset in the *developmental period*.
- Typically manifest early in development, and are characterized by developmental deficits that produce *impairments of personal, social, academic, or occupational functioning*.
- These disorders frequently co-occur.

AUTISTIC DISORDER

- Autistic disorder is characterized by a **withdrawal of the child into the self and into a fantasy world of his or her own creation.**
- The child has markedly abnormal or impaired development in social interaction and communication.
- Activities and interests are restricted and may be considered somewhat bizarre.

- The prevalence of autism spectrum disorders in the United States is about 1 in 150 children.
- Occurs four to five times more often in boys than in girls.
- Onset of the disorder occurs before age 3, and in most cases it runs a chronic course, with symptoms persisting into adulthood.

Etiology

1. Neurological Implications

- Autism thought to be caused by abnormalities in brain structures or functions.
- Abnormalities have been found in the area of the **amygdala**, which is known to help regulate aspects of social and emotional behavior.
- **Elevated levels of serotonin** have also been found in a number of people with autism.

2. Perinatal influences: Women with asthma and allergies recorded during the second trimester had a greater than two fold elevated risk of having a child affected by autism.

Diagnostic criteria for Autism Spectrum Disorder

A. **Persistent deficits in social communication and social interaction across multiple contexts** as manifested by the following, currently or by history.

1. Deficits in social-emotional reciprocity

2. Deficits in nonverbal communicative behaviors used for social interaction e.g.

- abnormal eye contact and body language or lack of facial expressions
- nonverbal communication.

B. Persistent deficits in social interaction across multiple contexts manifested by the following

1. Deficits in developing, maintaining, and understanding relationships e.g.

- difficulties in sharing imaginative play
- Difficulty in making friends
- absence of interest in peers

C**. Restricted, repetitive patterns of behavior, interests, or activities**, as manifested by at least two of the following

1. Stereotyped or repetitive motor movements, use of objects, or speech e.g.,

- simple motor stereotypies
- lining up toys or flipping objects
- Echolalia
- idiosyncratic phrases

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior e.g.,

- extreme distress at small changes
- difficulties with transitions
- rigid thinking patterns
- greeting rituals
- need to take same route or eat food every day

3. Highly restricted, fixated interests that are abnormal in intensity or focus e.g.

- strong attachment to or preoccupation with unusual objects
- excessively circumscribed or perseverative interest

4. Hyper- or hypo reactivity to sensory input or unusual interests in sensory aspects of the environment e.g.

- apparent indifference to pain/temperature
- adverse response to specific sounds or textures
- excessive smelling or touching of objects
- visual fascination with lights or movement

Note:

- Symptoms must be present in the early developmental period
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

- These disturbances are not better explained by intellectual disability

- Severity is based on social communication impairments and restricted, repetitive patterns of behavior using the **severity scale level 1 to 3**

Assessment

- **Impairment in Social Interaction**
- Children with autistic disorder do not form interpersonal relationships with others.
- They do not respond to or show interest in people.
- As infants they may have an aversion to affection and physical contact.
- As toddlers, the attachment to a significant adult may be either absent or manifested as exaggerated adherence behaviors.

- In childhood, there is failure to develop cooperative play, imaginative play, and friendships.
- Those children with minimal handicaps may eventually progress to the point of recognizing other children as part of their environment, if only in a passive manner.

Impairment in Communication and Imaginative Activity

- Both verbal and nonverbal skills are affected.
- Language may be totally absent, or characterized by immature structure or idiosyncratic utterances whose meaning is clear only to those who are familiar with the child's past experiences.
- Nonverbal communication, such as facial expression or gestures, is often absent or socially inappropriate.

Restricted Activities and Interests

- Even minor changes in the environment are often met with resistance, or sometimes with hysterical responses.
- Attachment to, or extreme fascination with, objects that move or spin (e.g., fans) is common.
- Routine may become an obsession, with minor alterations in routine leading to marked distress.

- Stereotyped body movements (hand-clapping, rocking, whole-body swaying) and verbalizations (repetition of words or phrases) are typical.
- Diet abnormalities may include eating only a few specific foods or consuming an excessive amount of fluids.
- Behaviors that are self-injurious, such as head banging or biting the hands or arms, may be evident.

Nursing diagnoses for the client with autistic disorder

- Risk for self-mutilation related to neurological alterations
- Impaired social interaction related to inability to trust; neurological alterations
- Impaired verbal communication related to withdrawal into the self; inadequate sensory stimulation; neurological alterations
- Disturbed personal identity related to inadequate sensory stimulation; neurological alterations

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

- The essential feature of attention-deficit/hyperactivity disorder (ADHD) is a **persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development**.

- These children are highly distractible and unable to contain stimuli.
- Motor activity is excessive and movements are random and impulsive.
- Onset of the disorder is difficult to diagnose in children younger than age 4 years because their characteristic behavior is much more variable than that of older children.

Etiological Implications

- **Biological Factors**
- Genetics
- A number of studies have revealed supportive evidence of genetic influences in the etiology of ADHD.

Biochemical Theory

- Certain neurotransmitters— dopamine, norepinephrine, and possibly serotonin—are involved in producing the symptoms associated with ADHD, their involvement is still under investigation.
- Abnormal levels of these neurotransmitters may be associated with the symptoms of hyperactivity, impulsivity, mood, and aggression often observed in individuals with the disorder.

Prenatal, Perinatal, and Postnatal Factors

- A recent study is consistent with an earlier finding that links **maternal smoking during pregnancy** and hyperkinetic-impulsive behavior in offspring (Linnet et al, 2005).
- **Intrauterine exposure to toxic substances**, including alcohol, can produce effects on behavior.
- Fetal alcoholic syndrome

- Perinatal influences that may contribute to ADHD are **prematurity**, **signs of fetal distress**, **low birth weight**, **precipitated or prolonged labor**, and **perinatal anoxia.**
- Postnatal factors that have been implicated include **cerebral palsy**, **epilepsy**, and other central nervous system (CNS) abnormalities resulting from trauma, infections, or other neurological disorders

Environmental Influences

- **Environmental Lead**
- Studies continue to provide evidence of the adverse effects on cognitive and behavioral development in children with elevated body levels of lead.
- A possible causal link between elevated lead levels and behavior associated with ADHD is still being investigated.

Psychosocial Influences

- Disorganized or chaotic environments or a disruption in family equilibrium may predispose some individuals to ADHD.
- A high degree of psychosocial stress, maternal mental disorder, paternal criminality, low socioeconomic status, and foster care have been implicated (Dopheide, 2001; Voeller, 2004).

- Other psychosocial influences that have been implicated include family history of alcoholism, hysterical and sociopathic behaviors, and parental history of hyperactivity.

- Prevalence: common in school going children
- Affects male 9 times than females

Symptoms

- Short attention span
- Constant fidgeting
- Inability to sit through activities e.g. meals
- Inability to wait in lines
- Inability to sit still in class
- Failure to stay quiet
- Shunning by peers
- Disobedience
- Frequent fights
- Poor academic performance
- Carelessness
- Poor relationship with others e.g. siblings

Associated problems

- ✓ Low self esteem
- ✓ Mood lability
- ✓ Conduct disorder
- ✓ Leaning disorders
- ✓ Substance abuse
- ✓ School failure
- ✓ Communication problems
- ✓ Physical trauma due to impulsivity

Management

- **Behaviour modification:**
  - Define prominent symptoms
  - Adding structure and stability to both school and home environments
  - Specialized educational techniques
- **Counselling and supportive psychotherapy**

Psychopharmacological Intervention for ADHD

- Central nervous system stimulants , those commonly used include :
- Dextroamphetamine
- Methylphenidate
- Dextroamphetamine / amphetamine composite .
- The actual mechanism by which these medications improve behavior associated with ADHD is not known.

- In most individuals, they produce stimulation, excitability, and restlessness.
- In children with ADHD, the effects include:
  - An increased attention span
  - Control of hyperactive behavior
  - Improvement in learning ability.

- Side effects include :
  - Insomnia
  - Anorexia
  - Weight loss
  - Tachycardia
  - Temporary decrease in rate of growth and development.

- Physical tolerance can occur.
- Atomoxetine , is a medication specific for treating ADHD. Selective norepinephrine reuptake inhibitor.

- The exact mechanism by which it produces its therapeutic effect in ADHD is unknown.
- Side effects include headache, nausea and vomiting, upper abdominal pain, dry mouth, decreased appetite, weight loss, constipation, insomnia, increased blood pressure and heart rate, and sexual dysfunction.

- Antidepressants have been used with some success in the treatment of ADHA.
- Commonly used medications in this category are **bupropion** , **desipramine** , **nortriptyline** , and **imipramine**.
- The tricyclic antidepressants have been useful for some ADHD symptoms, particularly attention and restlessness.

- The major side effects include **sedation**, **dry mouth, increased appetite, changes in atrioventricular conduction of the heart, hypertension or hypotension, arrhythmias,** and **tachycardia**.
- An electrocardiogram should be performed prior to initiation of therapy.

Nursing Implications

- Assess the client's mental status for changes in mood, level of activity, degree of stimulation, and aggressiveness.
- Ensure that the client is protected from injury. Keep stimuli low and environment as quiet as possible to discourage overstimulation.
- To reduce anorexia, the medication may be administered immediately after meals. The client should be weighed regularly (at least weekly) while on therapy with CNS stimulants because of the potential for anorexia and weight loss and the temporary interruption of growth and development.

- To prevent insomnia, administer last dose at least 6 hours before bedtime. Administer sustained-release forms in the morning.
- In children with behavior disorders, a drug “holiday” should be attempted periodically under the direction of the physician to determine effectiveness of the medication and need for continuation.

- A careful personal and family history of heart disease, heart defects, or hypertension should be obtained before these medications are prescribed. Careful monitoring of cardiovascular function during administration must be ongoing.

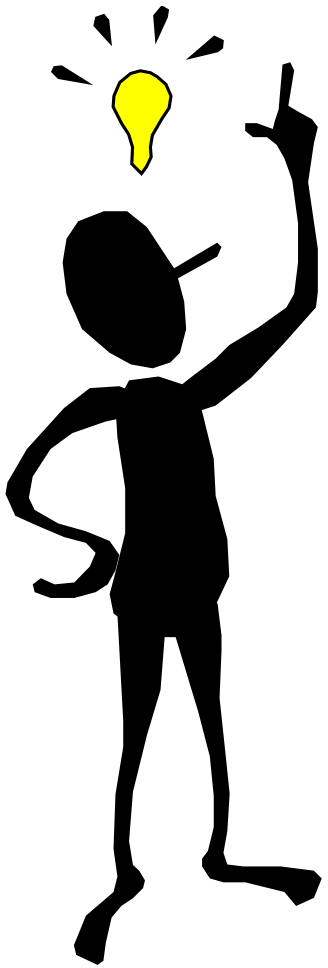
- Severe liver damage has been noted with atomoxetine.
- Any of the following side effects should be reported to the immediately:
- Itching
- Dark urine
- Right upper quadrant pain
- Yellow skin or eyes
- Sore throat
- Fever
- Malaise.

- New or worsened psychiatric symptoms have been noted with CNS stimulants and atomoxetine.
- It is important to monitor continuously for psychotic symptoms (e.g., hearing voices, paranoid behaviors, delusions) and for manic symptoms, including aggressive and hostile behaviors

- Side effects should be reported immediately: shortness of breath, chest pain, jaw/left arm pain, fainting, seizures, sudden vision changes, weakness on one side of the body, slurred speech, confusion, itching, dark urine, right upper quadrant pain, yellow skin or eyes, sore throat, fever, malaise, increased hyperactivity, believing things that are not true, or hearing voices.

- Some OTC medications, particularly cold and hay fever preparations, contain sympathomimetic agents that could compound the effects of the stimulant and create a drug interaction that may be toxic to the child.
- Ensure that parents are aware that the drug should not be withdrawn abruptly. Withdrawal should be gradual and under the direction of the physician.

Any Question???



SUBSTANCE-RELATED
&
ADDICTIVE DISORDERS

Martha Kairu

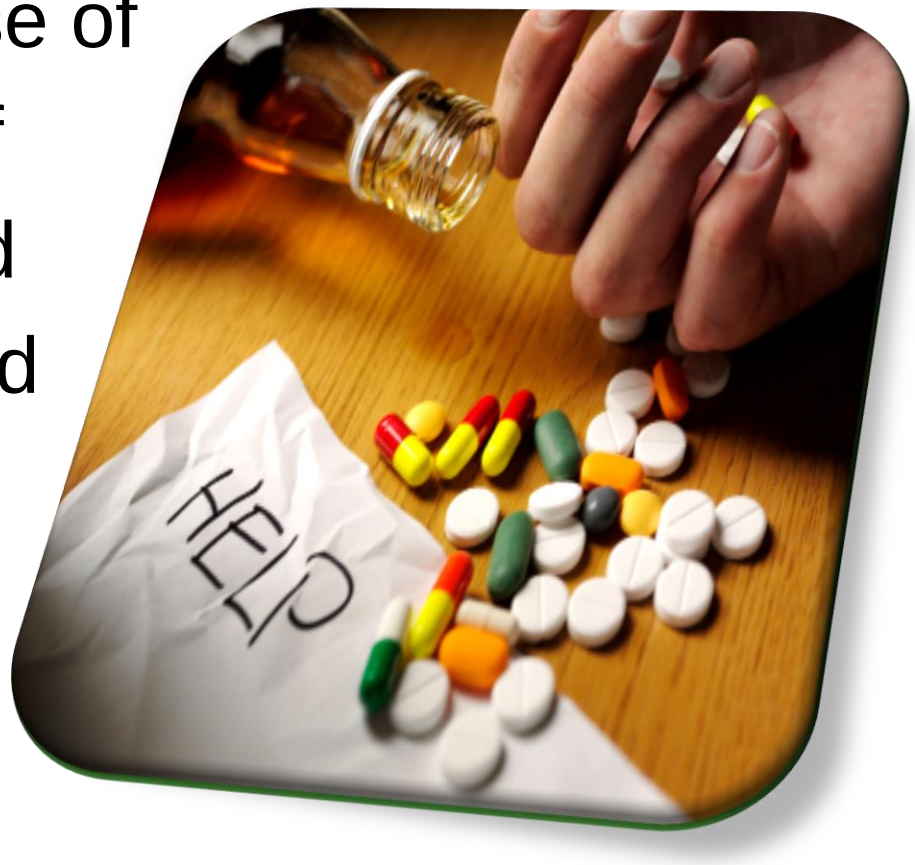
Objectives

By the end of the lesson, the learner should be able to:-

- Define substance withdrawal, intoxication
- Explain social, economic, and medical effects of substance use
- Describe classes of drugs of abuse and their symptoms: intoxication/withdrawal
- Describe addictive disorders and substance related disorders, their diagnostic criteria(DSM V) and management.

Introduction

- Substance use is a major issue in the country with the rise of increased cases of unemployment and wanting parenthood among others.



Substance-Related and Addictive Disorders

Encompasses 10 separate classes of drugs:

1. Alcohol
2. Caffeine
3. Cannabis
4. Hallucinogens
5. Inhalants
6. Opioids
7. Sedatives, hypnotics,& anxiolytics
8. Stimulants
9. Tobacco
10. Other (or unknown) substances

Addictive Disorders

- Includes **Gambling Disorder**

- Other potential behavioral addictions (internet addiction, sex addiction, exercise addiction, shopping addiction, etc.) not included due to “insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions…”

Substance Related Disorders

- Divided into two groups
- **Substance-Induced Disorders:** includes conditions of intoxication or withdrawal and other induced mental disorders
- **Substance-Use Disorders:** relates to pathological patterns of behaviors related to the use of a particular substance

I. Substance-Induced Disorders

- Essential Feature – “the development of a reversible substance-specific syndrome due to the recent ingestion of a substance.”
- Includes intoxication, withdrawal, and other substance/medication-induced mental disorders
- Likely to improve within a month of cessation of use

Substance Intoxication

- Substance intoxication can occur in individuals without a Substance Use Disorder
- Substance intoxication must include problematic behavior
- Substance intoxication does not apply to tobacco. (may explain society's liberal view of use – nonproblematic)

Substance Withdrawal

- Essential Feature – “the development of substance-specific problematic behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use.”

II. Substance Use Disorders

- The Essential Feature – continued use despite significant substance-related problems
- Changes in brain circuits may persist, exhibited in repeated relapses & intense drug cravings
- Criteria include *impaired control*, *social impairment*, *risky use*, and *pharmacological symptoms* (withdrawal/tolerance)

Substance Use Disorders

- 11 diagnostic criteria (some classes of substances have 10 criteria)
- 2 or more within a 12-month period
- Must include a pattern of use leading to clinically significant impairment or distress

Substance Use Disorders: Diagnostic Criteria

1. Substance often taken in larger amounts or over a longer period of time than intended
2. A persistent desire or unsuccessful efforts to cut down or control use
3. A great deal of time spent in activities necessary to obtain the substance, use it, or recover from its effects
4. Craving, or strong desire or urge to use

Substance Use Disorders: Diagnostic Criteria

5. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home
6. Continued use despite having persistent or recurrent social/interpersonal problems caused or exacerbated by use
7. Important social, occupational, or recreational activities given up or reduced because of use

Substance Use Disorders: Diagnostic Criteria

8. Recurrent use in situations which is physically hazardous

9. Use is continued despite knowledge of having a persistent or recurrent physical/psychological problem likely to have been caused or exacerbated by use

Substance Use Disorders: Diagnostic Criteria

10. Tolerance: the need for markedly increased amounts of substance to achieve intoxication or desired effect, or a markedly diminished effect with continued use of same amount

11. Withdrawal: a characteristic syndrome, or use to relieve or avoid withdrawal

Alcohol-Related Disorders

- Prevalence – 12% of males and 4.6% of females 18 and older. Significantly drops after age 65.

- Can lead to persisting neurocognitive disorders

- **Alcohol Intoxication** includes 1 or more symptoms of:
  - slurred speech,
  - incoordination,
  - unsteady gait,
  - nystagmus (involuntary eye movement),
  - attention/memory impairment,
  - stupor/coma

Management of Alcohol Intoxication

- IV fluids and *B-Complex vitamins* for dehydration and as a precaution or treatment for vitamin deficiency.
- Dextrose 10 – 50% can be administered to promote brain metabolism and prevent hypoglycemic crisis.
- In severe cases - those of severe stupor and coma - the person should be intubated to support respirations and to protect the lungs from filling with vomit/secretions.

Other management Strategies

(i) Ensure safety

(ii) Psychotherapy

(iii) Rehabilitation

(iv) Refer to support group e.g. alcohol anonymous

(v) Antidote of alcohol- *Disulfiram*.

(vi) Pharmacology e.g. Antipsychotic agents

- **Alcohol Withdrawal** includes 2 or more of following after cessation of or reduction in alcohol use:
  - Autonomic hyperactivity (sweating or pulse > 100)
  - Increased hand tremor
  - Insomnia
  - Nausea or vomiting
  - Transient visual, tactile, auditory hallucinations
  - Psychomotor agitation
  - Anxiety
  - Seizures

Delirium tremens

- State of withdrawal usually 3-4 days after total cessation manifested by delirium and confusion

- Clinical features include:
  - Insomnia, anxiety, fear, restlessness
  - tremors and convulsions
  - Clouding of consciousness, disorientation, and confusion

- Visual and auditory hallucinations with illusions
- Over-activity of the autonomic NS
- Delusions, agitation and sleep disturbances

- Nutritional deficiencies (Thiamine / Vit B1), lead to Wernicke,s encephalopathy, Korsakoff’s psychosis and alcoholic dementia

Diagnosis for alcohol use problems

- **CAGE:** a simple and effective screening tool that involves asking the following questions
  - Has the patient ever tried to *CUT DOWN* on their drinking?
  - Do they get *ANNOYED* when people talk about their drinking?
  - Do they ever feel *GUILTY* about their drinking?
  - Do they ever take an *EARLY MORNING* drink?

- A positive answer is 2 or more “YES” responses.

- Other screening tools include:
  - Short Michigan alcohol screening test(S-MAST)
  - Laboratory investigations such as blood alcohol concentration (BAC), breath alcohol levels etc

Caffeine-Related Disorders

- Most widely used drug in the world
- Symptoms include tolerance and withdrawal
- No Caffeine Use Disorder (data unavailable yet); only Caffeine Intoxication and Withdrawal
- Taking oral contraceptives decreases elimination of caffeine (Increased risk of intoxication)

Caffeine Intoxication

- Intoxication must be in excess of 250 mg. & cause distress or impairment

- 5 or more of following:
  - Restlessness
  - Nervousness
  - Excitement
  - Insomnia

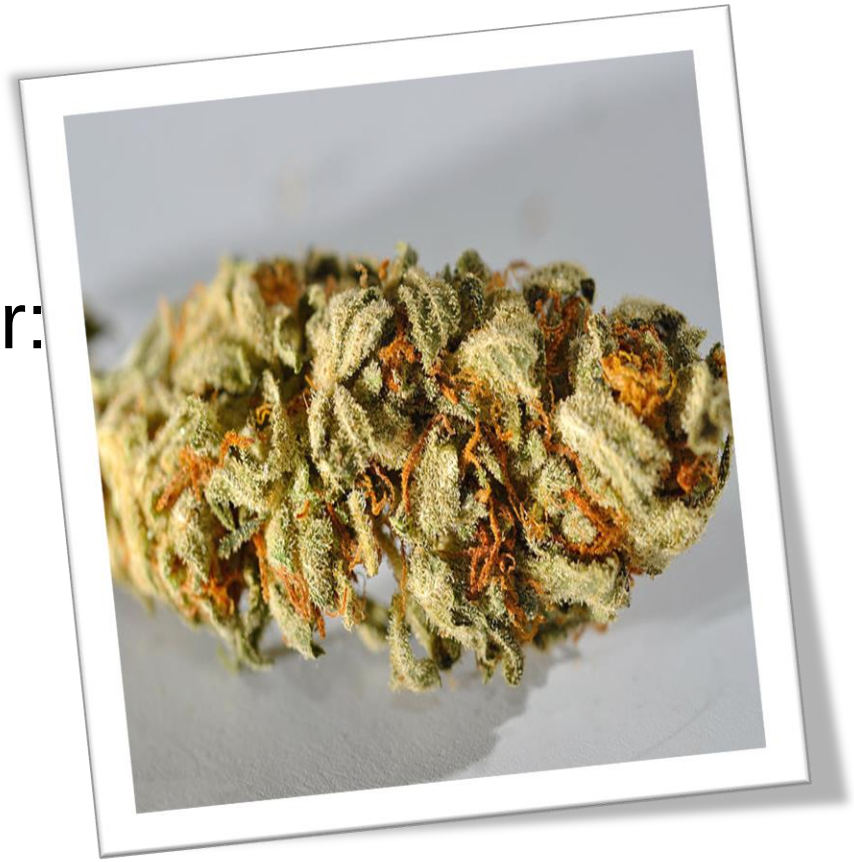
- Flushed face
- Diuresis
- Gastrointestinal disturbance
- Muscle twitching
- Rambling flow of thought and speech
- Tachycardia or cardiac arrhythmia
- Periods of inexhaustibility
- Psychomotor agitation

Caffeine Withdrawal

- Following cessation of or reduction in use within 24 hours by 3 or more of following:
  - Headache (the hallmark feature)
  - Marked fatigue or drowsiness
  - Dysphoric mood, depressed mood, or irritability
  - Difficulty concentrating
  - Flu-like symptoms (nausea, vomiting, muscle pain)

Cannabis Related Disorders

- Common names include: Marijuana, Hashish, “njaga”….
- Smoked, drunk in tea, chewed fresh
- Cannabis Use Disorder:
  - At least 2 of the 11 symptom criteria
  - Includes tolerance and withdrawal



Cannabis Intoxication

- Problematic behavioral or psychological changes (e.g., impaired judgment, motor coordination, social withdrawal, euphoria, anxiety, sensation of slowed time) and,
- 2 or more of the following:
  - Conjunctival injection (red eyes)
  - Increased appetite
  - Dry mouth
  - Tachycardia

Cannabis Withdrawal

- After heavy or prolonged use
- 3 or more of the following developing within a week:
  - Irritability, anger, or aggression
  - Nervousness or anxiety
  - Sleep difficulty (insomnia or disturbing dreams)
  - Decreased appetite or weight loss
  - Restlessness
  - Depressed mood
  - Physical symptoms (sweating, fever, chills, headache, shakiness/tremors, or stomach pain)

Hallucinogen-Related Disorders

- Separate criteria for Phencyclidine Disorders (e.g., “angel dust”, ketamine, cyclohexamine, dizocilpine) and,

- Other Hallucinogen Disorders (e.g., Lysergic acid diethylamide(LSD), psilocybin, mescaline, peyote, morning glory seeds, jimsonweed)

Phencyclidine Use Disorder

- 10 symptom criteria (excludes withdrawal symptoms)
- Previously in the category of Dissociative Anesthetics
- Prevalence primarily in the African-American (49%) and Hispanic (29%) cultures. Only .5% of young Caucasians.

Other Hallucinogen Use Disorder

- 10 symptom criteria (excludes withdrawal symptoms)
- Hallucinogen Use Disorder is one of the rarest. (.5% among adolescents and .2% in adults)
- Those who have this disorder have higher rates of other SUD's as well
- Can lead to psychotic-induced, bipolar-induced, depressive-induced, anxiety-induced disorders and delirium

Phencyclidine Intoxication

- Problematic behavior (e.g., assaultive, impulsive, unpredictable, agitated, impaired judgment) and, 2 or more of the following:
  - Vertical or horizontal nystagmus (involuntary eye movement)
  - Hypertension or tachycardia
  - Numbness or diminished response to pain
  - Ataxia (lack of muscle coordination)
  - Dysarthria (difficulty articulating)
  - Muscle rigidity
  - Seizures or coma
  - Hyperacusis (sensitivity to loud noises)

Other Hallucinogen Intoxication

- Problem behavior or psychological changes (e.g., anxiety, depression, ideas of reference, “losing one’s mind”, paranoia, impaired judgment).
- Perceptual changes (e.g., intensified perceptions, illusions, hallucinations, derealization) and, 2 or more of the following:
- Pupillary dilation, tachycardia, sweating, palpitations, blurred vision, tremors, incoordination

Hallucinogen Persisting Perception Disorder

- Following cessation of hallucinogen use, the reexperiencing of one or more of the perceptual symptoms that were experienced when intoxicated (e.g., trails, color flashes, geometric hallucinations, false perceptions of movement, intensified colors)
- Cause significant distress or impairment in important areas of functioning

Inhalant Related Disorders

- Involves any hydrocarbon-based substances (e.g., toxic gases from glues, fuels, paints, and other volatile substances)
- Standard drug screens do not detect inhalants. Detection is costly
- Prevalence declines after adolescence
- Common with adolescent Conduct Disorder. Adult use strongly associated with suicidality

Inhalant Use Disorder

- 10 of the 11 standard symptom criteria. No withdrawal criteria.
- When possible, name the particular substance involved

Inhalant Intoxication

- Problematic behavioral or psychological changes (e.g., belligerence, assaultive, apathy, impaired judgment)

- 2 or more of following: dizziness, nystagmus, incoordination, slurred speech, unsteady gait, lethargy, depressed reflexes, psychomotor retardation, tremor, muscle weakness, blurred vision, stupor/coma, and euphoria.

Opioid-Related Disorders

- Forms of Opioids include opium, morphine, heroin, codeine and some analgesic opiate derivatives.
- Commonly: *“boy, white lady, brown sugar, muggo….”*
- Consumed through smoking, sniffing, snorting, or direct injection.

Opioid Use Disorder

- Includes all 11 standard, symptom criteria

- Include the specifier “On maintenance therapy” when individual is taking a “prescribed” agonist medication (e.g., methadone, buprenorphine) or antagonist (e.g., naltrexone, Vivitrol)

Opioid Intoxication

- Problem behavior or psychological changes (e.g., euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment)
- Pupillary constriction (or dilation due to severe overdose) and,
- One or more of the following: drowsiness/coma, slurred speech, impairment in attention or memory

Opioid Withdrawal

- 3 or more of the following within minutes to several days after cessation of use or administration of an antagonist:

- Dysphoric mood, nausea/vomiting, muscle aches, lacrimation/rhinorrhea, pupillary dilation, piloerection/sweating, diarrhea, yawning, fever, and insomnia.

Opioid Withdrawal

- Short-acting drugs (e.g., heroin) begin to have withdrawal symptoms within 6-12 hours after last dose
- Longer-acting drugs (e.g., methadone, buprenorphine) may take 2-4 days for symptoms to emerge
- Less acute withdrawal symptoms (e.g., anxiety, insomnia, dysphoria, anhedonia) can last for weeks to months

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

- Includes benzodiazepines, benzodiazepine-like drugs (e.g., ambien, sonata), carbamates, barbiturates (e.g., secobarbital), and barbiturate-like hypnotics (e.g., quaalude/mandrax)
- Also includes all prescription sleeping medications and almost all prescription anti-anxiety medications

- Females appear to be at a higher risk for prescription drug misuse of this class of substances
- Can be detected in toxicological screens for up to a week
- At high doses, can be lethal especially when mixed with alcohol

Intoxication

- Problem behavior or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, and impaired judgment) and,

- One or more of the following: slurred speech, incoordination, unsteady gait, nystagmus, impairment in cognition (attention, memory), stupor/coma

Withdrawal

- Two or more of the following developing within several hours to a few days after cessation:
  1. Autonomic hyperactivity (sweating, pulse rate > 100 bpm)
  2. Hand tremor
  3. Insomnia
  4. Nausea or vomiting
  5. Transient hallucinations or illusions
  6. Psychomotor agitation
  7. Anxiety
  8. Grand mal seizures

- Grand mal seizures may occur in as many as 20-30% of cases undergoing untreated withdrawal
- In severe withdrawal, visual, tactile, or auditory hallucinations or illusions can occur
- Withdrawal from shorter-acting substances can begin within hours, longer-acting within 1-2 days

Stimulant Use Disorder

- Includes cocaine("*snow lady, bazuka, snow dust, crude*")
- Prevalence rate for cocaine use disorder for adults is 0.3%
- Greatest for

  18-29 year-olds

Stimulant Use Disorder

- Stimulant-use disorder is associated with PTSD, ADHD, and gambling disorder
- Hair samples can detect the presence of stimulants for up to 90 days

- Use leading to significant impairment or distress over a 12-month period

Stimulant Intoxication

- Problem behavioral or psychological changes (e.g., euphoria or affective blunting; changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension, or anger; stereotyped behaviors; impaired judgment) &

- 2 or more of the following:
  - tachycardia/bradycardia,
  - pupillary dilation,
  - elevated or lowered BP, perspiration/chills,
  - nausea/vomiting,
  - weight loss,
  - muscular weakness,
  - respiratory depression, chest pain,
  - confusion,
  - seizures, involuntary muscle movements,
  - coma

Stimulant Withdrawal

- Dysphoric mood and 2 or more of the following developing within a few hours to several days after cessation:
  - Fatigue
  - Vivid, unpleasant dreams
  - Insomnia or hypersomnia
  - Increased appetite
  - Psychomotor retardation or agitation

Tobacco-Related Disorders

- Includes daily cigarette use or smokeless tobacco
- Features often include smoking within 30 minutes of waking, daily use, waking at night to smoke
- Nicotine dependence in about 13% of U.S. adults
- Nicotine dependence in about 50% of daily smokers

Tobacco-Related Disorders

- Initiation of smoking after age 21 is rare
- Those who quit usually do so after age 30
- Non-daily smoking has become more prevalent in the past decade especially among younger individuals
- More common among those with AD/HD, conduct d/o, mood, anxiety, personality, psychotic or other SUD's

Tobacco-Related Disorders

- Individuals with low incomes and low educational levels are more likely to initiate tobacco use and less likely to stop
- 50% of smokers who do not stop using tobacco will die early from a tobacco-related illness
- There is no Tobacco Intoxication Disorder

Tobacco Use Disorder

- Problematic pattern of use leading to significant impairment or distress as manifested by 2 or more of the 11 symptom criteria
- Includes the specifier “on maintenance therapy” for those taking a nicotine replacement aid or a tobacco cessation medication

Tobacco Withdrawal

- Cessation or reduction followed within 24 hours by 4 or more of the following:
  - Irritability, frustration, or anger
  - Anxiety
  - Difficulty concentrating
  - Increased appetite
  - Restlessness
  - Depressed mood
  - Insomnia

Other (or Unknown) Substance Use Disorder

- Problematic use of an “intoxicating substance” not able to be classified within the other categories
- Meets at least two or more of the 11 symptom criteria within a 12-month period

Other (or Unknown) Substance Use Disorder

- Other includes anabolic steroids; non-steroidal anti-inflammatory drugs; cortisol; antiparkinsonian medications; antihistamines; nitrous oxide; amyl-, butyl-, or isobutyl-nitrates; betel nut; kava; and khat
- Unknown – when a substance is unknown
- Also, includes the categories Intoxication and Withdrawal

Gambling Disorder

- Previously known as “Pathological Gambling” and was in category of *Impulse Control Disorders*
- Problematic gambling leading to significant impairment or distress
- Leading to four or more of the following symptoms over a 12-month period

Gambling Disorder Diagnostic Criteria

1. Needs to gamble with increasing amounts of money for desired excitement
2. Is restless or irritable when attempting to cut down or stop gambling
3. Repeated unsuccessful efforts to control, cut back, or stop gambling
4. Often preoccupied with gambling
5. Gambles when feeling distressed (helpless, guilty, anxious, depressed)

Gambling Disorder Diagnostic Criteria

6. After losing money gambling, often returns another day to get even
7. Lies to conceal the extent of involvement with gambling
8. Jeopardized or lost a significant relationship, job, or career opportunity due to gambling
9. Relies on others to provide money to relieve financial situations caused by gambling

Gambling Disorder Diagnostic Criteria

- Removal of the criteria “has committed acts of forgery, fraud, theft, or embezzlement to finance gambling”
- Can be specified as either “Episodic” or “Persistent” and “In early remission” or “In sustained remission”

Gambling Disorder Severity Rating

- Mild: 4-5 criteria
- Moderate: 6-7 criteria
- Severe: 8-9 criteria

Gambling Disorder

- About 0.2%-0.3% of general population
- 3x more likely in males
- Highest in African Americans (0.9%), whites (0.4%), Hispanics (0.3%)
- For females, the progression is more rapid
- About 17% commit suicide
- Often associated with SUDs and impulse –control disorders (males) & mood/ anxiety D/O (females)

Any Question???

Psychiatric Emergencies

Martha Kairu

Welcome *

PSYCHIATRIC EMERGENCIES

- **DEF** : Psychiatric emergency is a condition where the patient has disturbance of thought , affect and psychomotor activity leading to a threat to his existence or threat to people in the environment
- Requires immediate intervention to safeguard the life of the patient.

Approaches to psychiatric emergencies

- Quick evaluation to identify the nature of the condition and to institute care on basis of seriousness
- Patients condition and plans of management should be explained in simple language to the patient and family members
- History and clinical findings should be clearly recorded in the emergency file

Types of psychiatric emergencies

- Suicidal threat
- Suicidal tendency
- Violent/aggression/excitement
- Panic attacks
- Catatonic stupor
- Hysterical attacks
- Delirium tremens
- Drug induced extrapyramidal symptoms
- Victims of disaster
- Neuroleptic malignant syndrome

SUICIDE AND DELIBERATE SELF HARM

Welcome

Definitions

- **Suicide:**
  - Act of taking ones life
- **Deliberate self harm:**
  - Act of intentionally inflicting harm or injury on one self
- **Para-suicide:**
  - A mere cry for help without the intention of killing one self
- **Suicidal attempt:**
  - An unsuccessful suicidal act with a non-fatal outcome

TYPES

- Egoistic-lack of sense in society
- Altruistic-self sacrifice for society
- Anomic- loss of direction in life
- Fatalistic-under oppressive situations

Methods used to commit suicide

- Overdose of drugs
- Shooting
- Strangulation
- Starvation
- Suffocation
- Inhalation of poisonous fumes
- Jumping from a height
- Driving and crashing vehicle
- Burning
- Drinking corrosive substances
- Electrocution

Risk factors

- Previous suicide attempt
- Mental disorders—particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol/substance abuse d’drs.
- Family history of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss

Risk factors cont’

- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- Influence of significant people—family members, celebrities, peers who have died by suicide.
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide that have a contagious influence
- Isolation, a feeling of being cut off from other people

Protective factors

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help seeking.
- Restricted access to highly lethal methods of suicide.
- Family and community support.
- Support from ongoing medical and mental health-care relationships.
- Learned skills in problem-solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Characteristics evaluated in the psychiatric assessment of patients with suicidal behavior

- 1. Current presentation of suicidality
  - Suicidal/self harming thoughts, plans, b/vr and intent
  - Specific methods considered for suicide & their lethality
  - Evidence of hopelessness, impulsiveness, axiety etc
  - Reasons for living and plans for the future
  - Alcohol/substances associated with current presentation
  - Thoughts, plans or intentions of violence towards others.

2. Psychiatric illnesses

- Current s/s of psychiatric disorders esp. mood disorders
- Substance use disorders, anxiety disorders and personality(borderline & antisocial).
- Previous psychiatric dx and treatments and prognosis

3. History

- Previous suicide attempts, aborted suicide attempts or other self harming behaviors
- Previous or current medical Dx and Rx including surgeries/hospitalizations
- Family Hx of suicide/attempts or mental illness including substance abuse

4. Psychosocial situation

- Acute psychosocial crises and chronic psychosocial stressors-losses, finances, family…….
- Employment status, living situation(whether or not having children in the home) & presence or absence of external supports.
- Family constellation and quality of family relationships
- Cultural/religious beliefs about death and suicide
- Individual strengths and vulnerability

5. Coping skills

- Personality traits
- Past responses to stress
- Capacity for reality testing
- Ability to tolerate psychological pain and satisfy psychological needs

Assessment of suicidal risk

- Use of different scales which assess for potential risk factors to suicide among others.
  - ‘SADCHILDREN’ SCALE
  - ‘SAD PERSONS’ SCALE
  - IS PATH WARM?

Sad persons(Patterson et al, 1983) Adapted sad persons' scale(Juhnke,1996)

- **S**: Sex.
  - Male: female=4:1 but females attempt more
- **A**: Age.
  - High in Youth 15-24, males>75 & females 45-54 yrs
- **D**: Depression.
  - Depressed are 20x than general population due to hopelessness
- **P**: Prior history.
  - Approx 80% of completed suicides are preceded by a prio attempt.
- **E**: Ethanol abuse.
  - Alcohol and/or drug abuse increase risk

SAD PERSONS CONT’

- **R**: Rational thinking loss.
  - Psychosis (I had a voice telling me to kill myself)
- **S**: support system loss.
  - Loss of support e.g. lover, relative, parent etc increase risk
- **O**: Organized plan.
  - Having a method in mind creates more risk
- **N**: No significant other
  - See ‘s’ above
- **S**: Sickness.
- Terminal illness e.g. AIDS, cancer etc=20x

Scoring system

- 1 point for each positive answer on the above
- Score & risk
- 0-2: no real problem keep watch
- 3-4: send home but check frequently
- 3-6: consider hospitalization
- 7-10: definitely hospitalize involuntarily or voluntarily

‘SADCHILDREN SCALE’(adapted from Di Vasto, West & Cristy 1979)

- **S**: support systems
- **A**: alcohol/assault
- **D**: depression/delusion
- **C**: communication/change in behavior
- **H**: hostility/hallucinations/history
- **I**: impulsiveness/illness
- **L**: lethality
- **D**: demography
- **R**: reaction of the evaluator
- **E**: events leading to suicide attempt
- **N**: no hope.

IS PATH WARM?

- Suicide **I**deation:
  - Does client report active suicidal ideation?
  - Written about suicide/death?
  - Client report desire to kill self?
  - Desire to purchase a weapon e.g. gun?
  - Intention to use car, gun etc to kill self?
- **S**ubstance abuse:
  - Client Excessively use alcohol or substances?
- **P**urposelessness:
  - Does s/he voice lack/loss of purpose in life?
  - Little or no reason to continue living?

- **A**nger:
  - Client express feelings of range or uncontrolled anger?
  - Seek revenge against others thought to have wronged or faulted him/her?
- **T**rapped:
  - Does client feel trapped?
  - Believe no way out of h/her current situation?
  - Believe death is preferable to a painful living?
  - Believe no other choice remaining in life?
- **H**opelessness:
  - Negative sense of self, others and future?
  - Future appears hopeless with little chance for positive change?

- **W**ithdrawing:
  - Indicate a desire to withdraw from family, friends etc
  - Has s/he already began withdrawing?
- **A**nxiety:
  - Feel anxious, agitated or unable to sleep?
  - Report inability to relax?
  - Report sleeping all time?
- **R**ecklessness:
  - Act recklessly or engage in risky activities?
- **M**ood change:
  - Report experiencing dramatic mood shifts or states.

Specific interventions

- Psychopharmacology, especially the SSRIs.
- Psychotherapy/CBT/ECT
- Substance abuse treatment; treatment of pain disorders
- Treatment of medical disorders
- Involvement in outside activities/avoid isolation – join outside groups, bereavement groups, organizations……
- etc

Nursing Management of suicidal patients

- Include;-
- Assess the patient’s suicidal potential.
- Observe the patient for 24 hours.
- Make sure the windows and electrical bulbs should not be access to the patients.
- Remove all the dangerous objects such as, glass container, ashtrays, matches, cigarettes, ties, string, razor, blades, scissors or metal pins.
- Stay with the patient and meet the physical needs of the patient.

Nursing care cont’

- Check the patient at frequent, irregular intervals during the night and ascertains safety and whereabouts.
- All psychotropic drugs should be kept locked.
- Ensure that the patient swallows prescribed medication.
- Observe, record and report any changes in the client mood, elation, withdrawal in all the shifts.
- Promote adequate nutrition, hydration and elimination.
- Promote an adequate rest, sleep and activity.

Nursiing care cont’

- Do not joke about death, make sensitive remark such as " Everybody really want to live ".
- Do not argue about the patient’s feelings.
- Help the patient to identify positive aspects about him or herself and life situation.
- Give the patient support to interact with others clients or to attend activities.
- Give family psychotherapy for maintains of good inter-personal communication with the patient.

SUMMARY

- NOTES:……
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VIOLENCE AND AGRESSION

Introduction

- Violence and aggression are common psychiatric emergencies
- Many psychiatric patients are not always violent or aggressive but these behaviors do occur during acute phases of psychiatric illnesses.
- Health professionals should be well equipped with knowledge and skills to handle violent and/or aggressive patients.

Causes

- Organic and non-organic psychiatric conditions
- Mania
- Depression
- Drug and alcohol dependence
- Epilepsy
- Acute stress reaction
- Neurotic disorders
- Impulsive violent behavior
- Reactive psychosis

Assessing and predicting violent behavior

- Signs of impending violence:-
  - Very recent acts of violence including damage to property
  - Verbal or physical threats(menacing)
  - Carrying weapons that may be used to cause harm
  - Progressive psychomotor agitation
  - Alcohol or drug intoxication
  - Paranoid features in a psychotic patient
  - Command violent auditory hallucinations

Cont’

- Catatonic excitement
- Certain patients with mania
- Certain patients with agitated depression
- etc

Assessing the risk of violence

- Considerations:
- Violent ideations and plans: idea, wish, intention, plan, availability of means, implementation of plan and wish for help.
- Demographics:-sex(males), age(15-24), socioeconomic status(low), social supports(few/absent).
- Past history:-violence, non-violent antisocial acts, impulse dyscontrol e.g. Gambling, substance use etc
- Overt stressors:-marital conflicts, losses-real or symbolic, weaknesses etc

Management.

- 4 progressive strategies:-
- De-escalation(defusing/talking down)
- Environmental manipulation
- Rapid tranquilization
- Restrains and seclusion

Common drugs used for rapid tranquillization

- A mixture of benzodiazepines with antipsychotics offer the best results.
- Diazepam:5-10 mg po/iv, max 30mg/event
- Lorazepam: 2mg iv, max 10mg/24hrs
- Olanzepine:5-10mg im, max 30mg/event
- Haloperidol: 5-10mg im, max 20mg/event

Precautions to take

- Speak with the patient in a calm voice
- Do not argue with them
- Approach them in an open posture
- Always approach the from the side
- Call them by their names
- Do not put on dangling attires like scuffs, ties, necklaces etc
- Remove any dangerous item that they may use to cause harm

What to do in case of attempted attacks

- Hold their hands from behind
- Throw a heavy cloth e.g. blanket on the patient then restrain
- Call for help (ensure enough staff back-up)
- Make use of exit points

Guidelines for self protection when handling an aggressive patients

- Be prepared to move, a violent patient can strike out suddenly.
- Keep comfortable distance away from the patient
- Never see a potentially violent patient alone
- Maintain a clear exit route for both the staff and patient
- Be sure the patient has no weapons in his/her possessions
- Administer prescribed anti-psychotic nedications

CATATONIC STUPOR

- Stupor is a clinical syndrome of akinesia and mutism with preservation of consciousness.

MANAGEMENT

- Ensure patent airway
- Administer IV fluids
- Collect hx and perform physical examinations
- Draw blood for investigations before starting any treatment

Case scenario.

- You are alone in the psychiatric nursing station doing documentations while your two colleagues are outside attending to patients. All of a sudden, Kamwenja, a manic patient known to exhibit violent behavior enters the room holding a dart on his right hand, he closes the door behind him and smilingly tells you; “your day has finally come! Kwisha!”
- **Quiz**: **what will you do?**

END^^^^

- **QUESTIONS?**

THERAPIES IN MENTAL HEALTH

Martha Kairu

Objectives

By the end of the lesson, learners should be able to:

- Describe and apply the therapeutic nurse-client relationship.
- Describe the various therapies including cognitive behavioral, social support, occupational, group, environmental, community based rehabilitation and electroconvulsive therapies.
- Review pharmacological therapy.

THERAPEUTIC NURSE-CLIENT RELATIONSHIP

- Therapeutic relationships are goal- oriented and directed at learning and growth promotion.

- Such require:
  - Rapport, Self understanding, Acceptance, Consistency, Trust, Genuineness, Respect, Empathy

Phases of a Therapeutic Nurse-Client Relationship

- Pre-interaction phase
- Orientation/Introductory Period
- Working
- Termination

PSYCHOTHERAPY

- Psychotherapy includes treatments of emotional, behavioral, personality and psychotic disorders based primarily on verbal and non-verbal communication with patients and their environmental, occupational and community support based needs.

- Recovery of mentally ill patients is not dependent on biological treatment alone!

MILIEU THERAPY

- Also referred to as ‘therapeutic environment’ or ‘therapeutic community’.
- The environment is structured to effect behavioral changes and improve psychological health and functioning of the individual.

Conditions Promoting a Therapeutic Environment

- Basic physiological needs should be met.
- Physical facilities are conducive to achievement of therapy goals e.g. space
- Participates in decision making and problem solving.
- Responsibilities assigned according to client capabilities.
- Structured program of social and work related activities.
- Community and family are involved.

Role of the Nurse

- Ensures basic needs for the client are met
- Assessing physical and psychosocial status
- Administering medications
- Helping clients develop trusting relationships
- Setting limits on unacceptable behaviors
- Educating clients

GROUP THERAPY

- Involves treatment of an individual within a group through support and encouragement for the group members and the therapist.
- It is a learning and problem solving process in which each individual is involved with his ‘own self’ and the group is involved as a ‘collective self’.

Classification of groups

- There are a number of group classifications:
  - Open and closed
  - Structured and non-structured
  - Heterogeneous and homogeneous

- The classification that is of significance is one that distinguishes groups according to the method used:

1. Didactic – inspirational groups

Emphasizes the educational experiences of its members and promotes intellectual and emotional changes while reflecting ethical, religious or societal values.

Examples:

- Alcoholics anonymous
- Sex/relationship education
- Discharge planning
- Diet group

2.Conversation/exploratory groups

- Exploration and verbalization of its member's emotional and psychological problems within the context of their past and present relationship and their interpersonal relationships in the group.

Examples:

  - Personal growth group
  - Family therapy
  - Psychodrama
  - Marriage therapy.

3. Activity groups

- Uses a particular activity as the structure around which the interaction of the group members is built, encouraging the development of ego strengths and control.

Examples:

- Music therapy
- Play therapy
- Exercise group
- Reality orientation

Curative factors in group therapy

- **Shared information**:

  Because of similar backgrounds and problems the group members get the opportunity to share very important information.

- **Altruism**:

  An opportunity to help members of the group who may feel worthless and useless boost their ego.

- **Universality**:

  - Sharing of experiences and finding that others respond positively lead to the discovery that problems, feelings and behaviour are not unique but are shared by others.

- **Group cohesion:**

  - A feeling of belonging and empathy develops and the group becomes an important source of support.

- **Hope**:

  - Observing how members progress and overcome their problems gives the other group members hope.

  - Confidence in therapeutic process is engendered and group members begin to have confidence that their conditions will improve.

- **Interpersonal learning**:

  - Group members not only learning from others but also analyze their personal feelings and behaviour in the group.

- **Ventilation:**

  - This encompasses active, verbal participation in the group process by means of self disclosure and self-examination and helps in the release of negative feelings.

- **Socialization:**

  - Group members learn new, socially acceptable behavioural pattern. They receive frank feedback in a supportive environment about an acceptable behaviour and are encouraged to try new patterns.

Phases of Group Development

- **I. Initial or orientation phase**

- objectives, selection of members, the type of group, consultation with members, logistics and establishment of roles.

- **II. Middle/working phase**

- problem solving and decision making phase.

- **III. Final/Termination phase**

- after the groups objectives have been met, then it has to be terminated as required.

Tasks of group therapist during the sessions

- Preparation
  - Set the objectives of the sessions.
  - Selection of group members.
  - Selection of the type of the group.
  - Consultation with the team: logistics arrangements.
  - Preparation of the group members.

Maintenance and goal achievement

The group leader is responsible for the group survival and achievement of its objectives through:

- Creation of therapeutic group norms such as confidentiality, frank as possible about feelings
- Creation of a focal point: help all the members focus in a well planned activity (in the case of activity group).

- Management of problem behavior: such as people who monopolizes the group, people who all talk at the same time, late arrivals, losing contact with reality or becoming aggressive.
- Creation of group cohesion: show respect, warmth and empathy to all the members and teach all of them to do the same by example.

Termination

- Members are usually very dependent on one another and resistant to termination.
- Feelings of anger, loss, and affection should be verbalized and members encouraged to evaluate the entire group experience.
- Group leader to allow enough time for this phase.

OCCUPATIONAL THERAPY

- Treatment through active participation in purposeful activities
- It also emphasizes development of ones' occupational interests, skills and abilities.
- Aim:
  - To rehabilitate patients for their return home and help them overcome anxiety at work or deal with a difficult working relationship.

- Depending with the available resources various activities may be incorporated such as:
  - Gardening
  - Cooking/washing
  - Carpentry
  - Recreational activities e.g games
  - Intellectual activities: Group discussions, reading magazines

- The therapist role in this case involves:
  - Assessment

    - this helps in planning adequate occupational therapy programs
  - Rehabilitation

    - through the use of purposeful activities and attainment of satisfying personal relationships by encouraging new skills

COGNITIVE - BEHAVIORAL THERAPY (CBT)

- Involves changing one's attitudes and behavior by focusing on the automatic thoughts, images, beliefs and attitudes that are held and how these processes relate to the way a person behaves, as a way of dealing with emotional problems.

- The general goals in cognitive - behavioral therapy are:
  - To obtain symptom relief as quickly as possible,
  - to assist the client in identifying dysfunctional patterns of thinking and behaving,
  - to guide the client to evidence and logic that effectively tests the validity of the dysfunctional thinking.

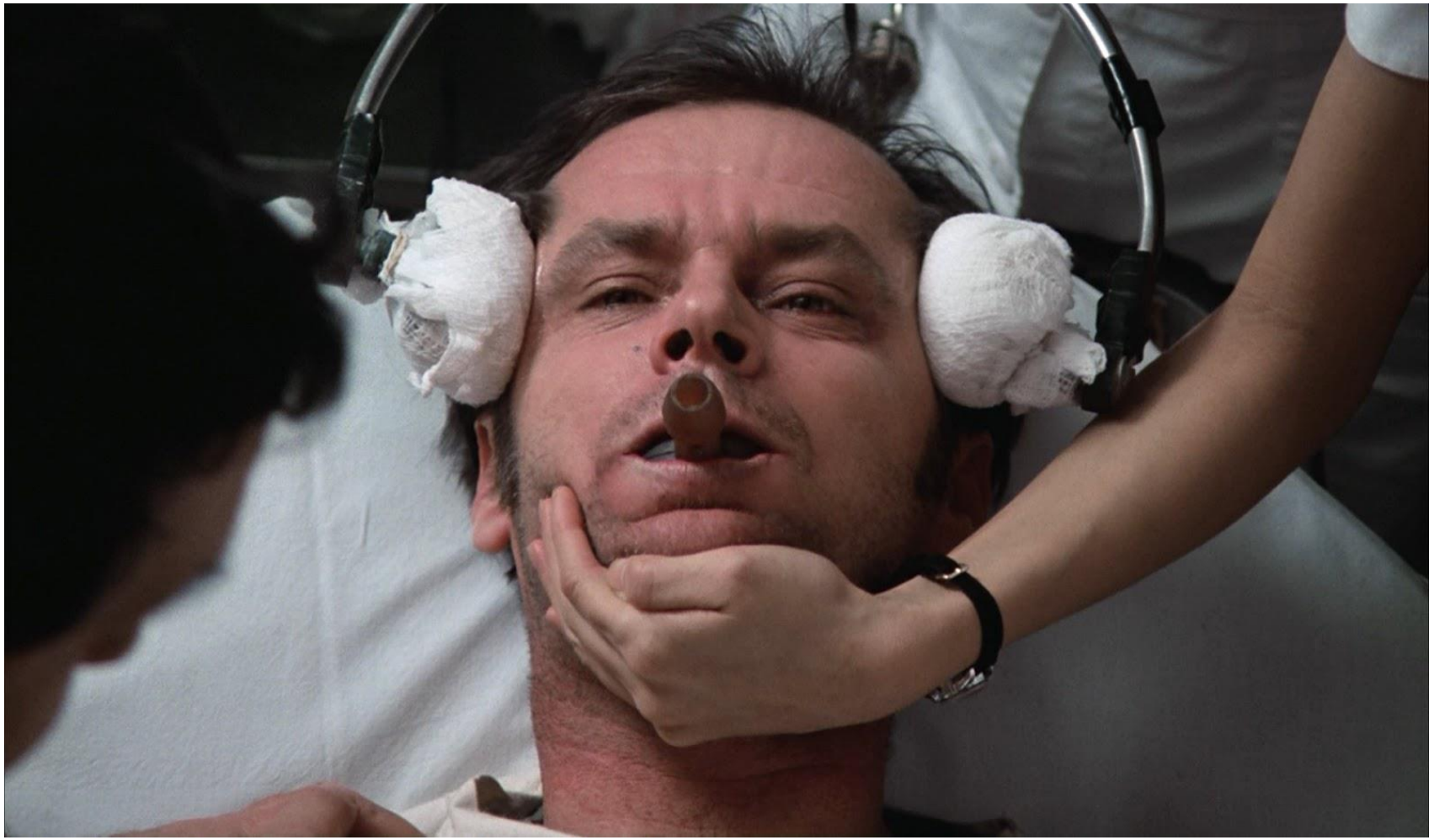
- The client is asked to describe evidence that both supports and disputes the distorted thought. The logic underlying the inferences is then reviewed with the client.
- Evaluation and discussion of the clients thoughts and the implication of their consequences.

- CBT can be used in the management of:
  - Anger, anxiety and panic attacks
  - Depression
  - Drug or substance abuse disorders
  - Eating disorders
  - Phobias
  - Obsessive – compulsive disorder
  - Child and adolescents problems
  - Post – traumatic stress disorders
  - Sexual and relationships problems etc.

ELECTROCONVULSIVE THERAPY(ECT)

- Induction of a grand mal seizure by means of an electrical pulse through the brain of an anaesthesized patient.

- The mechanism of ECT is not clear, however it has been shown to affect neurotransmitters including GABA, norepinephrine, serotonin, dopamine and endogenous opiates.



- It is given in doses ranging from 70 to 130 volts via electrodes placed on the temporal lobes.
- The frequency of treatment depends upon the severity of the patient’s mental disorder to a maximum of 8 to 12 sessions.

Pre-treatment Evaluation

- Informed consent
- Medical history and physical examination
- Investigations such as full haemogram, UECs, EEG, ECG, chest and spinal x-ray if possible
- Pre-medications and NPO.

Indications for ECT

- All mood disorders
- Major depressive episodes
- Acute schizophrenic presentations
- Catatonic excitement

- its merely suggested in: delirium and several medical conditions such as parkinsons disease

Contraindications

- There are **no absolute contraindications;** Relative contraindications include;
  - Increased intracranial pressure
  - Recent history of myocardial infarction
  - High-risk conditions e.g. bleeding (or otherwise unstable), vascular aneurysm or malformation, intracerebral haemorrhage, acute or impending retinal detachment, pheochromocytoma, or high anaesthetic risk

Side Effects of ECT

- Anxiety and apprehension
- Confusion
- Memory loss
- Headaches, which respond to acetaminophen or NSAIDS
- Transient muscle aches

- Less Common Side Effects:
  - Weight gain, possibly due to treatment of anorexia
  - Amenorrhea or other menstrual changes lasting up to several months
  - Transient systemic hypertension
  - Apnea or laryngospasms
  - Burns from poor contact with electrodes
  - Cardiac arrhythmias
  - Prolonged (usually defined as >3 minutes) seizure or a "late" seizure

Nursing Care in ECT

- Electroconvulsive therapy is treated like a minor surgical procedure that requires preoperative and postoperative care:
  - Providing educational and emotional support
  - Pre-treatment planning and assessment
  - Preparing and monitoring the patient during the actual procedure
  - Post-treatment care and evaluation

Providing Educational and emotional support

- Explain the procedure to the patient
- Obtain an informed consent from the patient and the guardian.
- Respond to patient’s concerns and feelings.
- Educate the patient concerning the procedure and explain to the patient the necessary tasks associated with ECT.

Pre-treatment Nursing care

- Preparation of treatment room for the ECT procedure
- Complete the pre-treatment check list.
- Patient’s identity is checked and the patient wears an identity bracelet.
- Safekeeping of the patient’s valuables.
- NPO for minimum 4 hours before treatment.
- The patient’s hair should be clean and dry to allow for electrode contact.

- Empty bladder before treatment.
- Prostheses, dentures, glasses, hearing aids, contact lenses should be removed.
- Minimise anxiety through anxiety management techniques, ensuring short waiting time and offering reassurance and support.
- Standard practices should be practiced regarding general anaesthesia care

Nursing Care during ECT Procedure

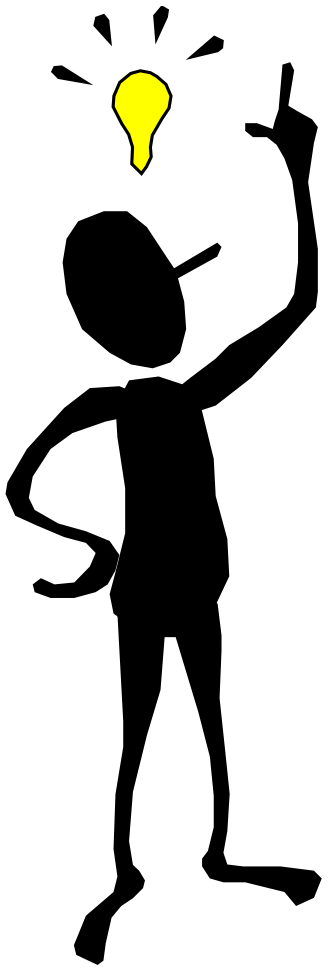
- Patient in a well padded bed and placed in a comfortable dorsal position or supine position. A small pillow is placed under the lumber curve.
- Apply ECG electrodes, BP cuff, and pulse oximetry sensor.
- Give a short acting anesthetic agent.

- Support the shoulder and arms of the patient. Restraint the thigh with the help of a sheet.
- Hyperextension of the head with support to the chin.
- Administer oxygen
- Apply jelly to the electrodes
- Make the observations of the convulsions, suction and O_2 if necessary.

Post-ECT Care

- Observe and record the vital parameters ¼ hourly until stable
- Place the patient on side lying position, clean the secretions
- Allow the patient to sleep for 30 min to one hour
- Reassure the client and reorient to the ward
- Allow the patient to have tea or any drinks
- Record the procedure

Any Question???



REVIEW PHARMACOLOGICAL THERAPY FOR MENTAL DISORDERS.

PHARMACOTHERAPY

Psychotropic drugs can be classified according to their uses:

- Antidepressants
- Mood stabilizers
- Antipsychotics
- Anxiolytics and Hypnotics
- Anticonvulsants
- Psychostimulants.

Anti Depressants

- Antidepressant medication should always be tailored to the needs of individual patients titrating the dose against the clinical effect and side effect profile.
- Treatment be introduced at the lowest dose possible and gradually increasing so as to reduce the severity of the initial side effects.
- About 5 -10% of depression becomes chronic and requires regular follow up and continuous antidepressant medication.

Classification of antidepressants

1. **Heterocyclics:** block the uptake of noradrenalin or serotonin into presynaptic nerve terminals hence increasing their availability.
   - **Bicyclics:** Dothiepine
   - **Tricyclics(TCA):**
     - Amitriptyline (Tryptanol): →25-150mg/24hrs.
     - Others include: Maproptiline, Nortryptyline, Desipramine and Lofepramine, Trimipramine, Imipramine, Clomipramine
   - **Tetracyclics:**
     - Mianserine (Lantanon): →10-60mg/24hrs (nocte, start slow and increase slowly).

Side effects of heterocyclics

- Lethality in overdose except in mianserin, doses of over 1g can result in death, due to seizures, arrythmias or hypotension.
- Sedation
- Anticholinergic side effects such as:
  - Blurred vision
  - Dry mouth
  - Urinary hesitancy and retention.
  - Tachycardia
  - Aggravation of glaucoma and constipation

Cont'd…

- Seizures e.g. with clomipramine.
- Cardiovascular: Hypotension and orthostatic hypotension (alpha 1 receptor blockage).
- Hematological: Leucopenia
- Sexual: Decreased libido, Orgasmic dysfunction in females, delayed or occasional absence of ejaculation in males.
- Weight gain resulting from an increased appetite
- Depersonalization/ derealization.
- Use in the first trimester of pregnancy should be avoided. Excreted into breast milk.

Contraindications

- Acute myocardial infarction
- Pregnancy
- Breast feeding
- Alcoholism
- Glaucoma
- Epilepsy

2. Selective Serotonin Re-uptake Inhibitors (SSRIs)

- Selectively inhibits serotonin reuptake, alleviating depression and imparting some anti - anxiety effect.
- Has got fewer side effects than Tricyclics.

  Examples:
  - Fluoxetine (prozac): →20-80mg/24hrs
  - Paroxetine (aropax):→20-80mg/24hrs
  - **Others**: citalopram, fluvoxamine, sertraline.

Cont'd…

- Side effects of SSRIs:
  - Nausea and vomiting, Diarrhea
  - Tremors, Restlessness
  - Dizziness, headache, Insomnia
  - Excessive sweating
  - Ejaculation delay and reduced libido
  - Suppression of cytochrome p450 just like the tricyclics thus increasing the blood concentration of antipsychotic and other antidepressants if combined.

Monoamine oxidase inhibitors (MAOIs)

- These drugs act by inhibiting the MAO enzyme, thereby causing an increase in biogenic amines such as noradrenaline, dopamine and serotonin in the storage sites throughout the central nervous system.
  - Phenelzine (Nardil).
  - Tranylcypromine (Parnate).
- Precautions: Pregnancy, Peadiatrics, Breastfeeding and Geriatrics

Side effects of MAOIs

- Dizziness, tiredness and weakness
- Diarhoea
- Swelling of the feet and lower limbs
- Unusual excitement or nervousness
- Tachycardia
- Dark urine, difficulty urinating,
- Headaches
- Skin rash
- Blurred vision, constipation
- Decreased libido
- Difficulty sleeping.

Contraindications

- Cardiovascular disease
- Severe liver and renal functioning impairment

Patient information

- Morning administration to avoid sleep disturbance
- Food and beverages containing Tyramine to be avoided during treatment or 14 days after completion of treatment:
  - Alcohol (beer and chianti wine), avocado, broad beans, chocolate, cream and yoghurt, meat or fish preserved through smoking or pickling, yeast products, cheese.

Factors influencing the choice of antidepressants

- Previous response
- Family history of response
- Agitation or retardation
- Cost.
- Co-morbid disorders.
- History of cardiac disease (avoid heterocyclics, except for mianserine).
- Epilepsy (avoid heterocyclics particularly clomipramine and maprotiline).
- Glaucoma (avoid heterocyclics which are more anticholinergics).

Mood Stabilizers

Lithium carbonate

Indications:

- Bipolar mood disorder: acute phase of mania for maintenance or prophylaxis.
- Cyclothymic disorder
- Schizoaffective disorder: bipolar type.
- Other uses: psychosis due to tricyclis, organic brain syndrome, aggression, postpartum mania.

Treatment principles:

- Prior to the beginning of treatment, inform the patient about:
  - Side effects and dangers
  - The possibilities that diuretics and anti-inflammatory drugs may increase lithium serum levels to dangerous limits.
  - Avoiding alteration in sodium intake and dehydration.

Pharmacokinetics

- Lithium taken by mouth is well absorbed from the intestine.
- It is not bound to plasma.
- Lithium absorption is linked to Na+ balance in the body; lithium decrease sodium re-absorption in the proximal and distal convoluted tubules causing natriuresis and sub-clinical sodium depletion.
- If Na+ intake is lowered or loss increased (diuretics, diarrhea, sweating) there is an increased tubular uptake of lithium in place of Na+ with an added risk of toxicity.

Mechanism of action

- Lithium inhibits presynaptic alpha and post synaptic beta adrenergic mechanisms. It replaces intracellular Na+ and by doing so decreases cellular excitability.

Patient monitoring

1. **Before starting lithium**
   - Complete medical hx and physical examination
   - Laboratory determination of:
     - Full blood count
     - Urea and electrolytes
     - Thyroid function tests
     - Electrocardiogram (those with hx of heart disease)
2. **After starting lithium**
   - Coz of narrow therapeutic and toxic levels, do regular lithium serum levels (0.6 – 1.2mmol/liter). Dosages are therefore based on the lithium serum levels.
3. **Administration of the medicine**
   - With food to avoid gastric irritation
   - Drink plenty of fluids in hot weather or when exercising.
   - Diet to contain enough Na+ otherwise toxic symptoms develop on lower dosages of lithium.
   - If a dose is missed, take as soon as possible unless it is within six hours of the next scheduled dose. Do not increase the next dose.

4. Side effects

Side effects of lithium are increased if a person is dehydrated; if side effects occur try giving the person one or two glasses of water. Carbonated soft drinks are high in caffeine and may worsen the side effects.

Common side effects

- Weight gain
- Stomach ache
- Diarrhoea
- Nausea
- Vomiting
- Increased thirst
- Increase micturation
- Fine hand tremor
- Tiredness, weakness, dizziness and headache.

Occasional side effects

- Low thyroid functioning or goitre
- Acne
- Skin rashes
- Hair loss
- Change in blood sugar
- Metallic taste in the mouth
- Irritability

Uncommon but potentially serious side effects (stop the lithium and inform the psychiatrist)

- Seizures
- Confusion

Signs that the lithium level may be too high

(inform the psychiatrist immediately and do not give lithium for at least 24hrs).

- Vomiting or dirrhoea morre than once
- Sever trembling
- Weakness
- Lack of coordination
- Extreme sleepiness or tiredness
- Severe dizziness
- Trouble speaking or slurred speech

Serious toxic side effects (admit to general hospital immediately)

- Irregular heart beat
- Fainting
- Staggering
- Blurred vision
- Ringing or buzzing sound in the ears
- No urination
- Muscle twitches, high fever, convulsions, unconsciousness

5. Precautions

- Some drugs increase lithium levels e.g. indocid and thiazide diuretics.
- Do not take more than the prescribed dose
- Do not drink large amounts of coffee, tea or carbonated drinks because of their diuretic effects
- Lithium should never be taken during pregnancy because it can cause birth defects.

Carbamazepine (Tegretol).

- Is an anticonvulsant used to treat complex – partial and tonic clonic seizures. It has a mild mood stabilizing effect of patients.

Indications of use:

- Bipolar disorder: acute mania. Effective in lithium - resistant bipolar disorder.
- Affective symptoms secondary to seizure disorders
- Impusive control problems: aggression,
- Schizoaffective disorder.
- Schizophrenia (not as a first line treatment).
- Alcohol withdrawal (not as a first line treatment).

Dosage of carbamazepine

- Start with low dose (e.g. 100mg bd). The average therapeutic dose is 200mg tds but can be higher depending on clinical response and side effects.

Side effects of carbamazepine

- Most common: sedation, vertigo, blurred vision, ataxia
- Nausea, vomiting, slowing of cardiac conduction, rash may occur.
- Serious side effects such as hepatitis, exfoliative dermatitis (steven-johnson's syndrome) and blood dyscrasias are extremely rare.

ANTIPSYCHOTICS

Introduction

- ***Antipsychotic drugs*** are also called major tranquillizers or neuroleptics used in the treatment of psychoses like schizophrenia, bipolar disorders (manic phase) and alcohol withdrawal disorder.

GENERIC NAME	TRADE NAME	DAILY DOSES(RANGE)
Low Potency Drugs		
Chlorpromazine	Largactil	300-1000mgs
Sulpride	Domatil,Sulparex	200-2400mg
Thioridazine	Melleril	50-800mg
High Potency Drugs		
Haloperidol	Haldol,Serenace	1-20mg
Thiothixene	Navane	6-60mgs
Zoxapine	Loxitane	60-250mgs
Molindone	Lidone	50-400mgs
Flupenthixol	Depixol	6-18mg
Fluphenazine	Moditen	2.5-20mg

Trifluoperazine	Stelazine	5-30mg
Zuclopenthixo	Clopixol	20-150mg
Pimozide	Orap	2-10mg

Mechanisms of Action

- The drugs are thought to work by blocking dopamine receptors causing a decrease in psychotic symptoms.
- metabolised in the liver and excreted by the kidneys. For one to get the desired effects, one must maintain the patient on the lowest dose possible and initial therapy should be on divided doses so that the patient can be monitored.

- For acutely psychotic patients:
  - Give intramuscular haloperidol, for example, 5mg every 30 to 60 minutes over a two to six hour period. Peak level is attained 20 to 40 minutes after injection.
  - Monitor blood pressure before each dose and withhold if the systolic blood pressure is 90mm Hg or below.
  - Sleep state should be monitored to ensure six to seven hours of sleep.
  - Dystonia occurring 1 hour to 48 hours after starting treatment should be treated with an antiparkinsonism drug.
  - To decrease the danger to the patient themselves and others, the patient needs to be monitored for possible adverse reactions to the medication.

- Drugs should be given using the following time frame:
  - Six months for first psychotic episode.
  - One year period for second psychotic episode.
  - Indefinite period for third and later psychotic episodes.
- The drug should be discontinued through tapering the dosage to avoid dyskinesia.

Side effects of antipsychotics

- There are several side effects that may be experienced by patients. These include drowsiness and orthostatic hypotension, especially after im injections.
- The patient may also experience ***extra pyramidal symptoms*** like:
  - Dystonia, that is, spasms of muscles of face, neck, back, eye, arms and legs.
  - Oculogyric crisis, presenting as fixed upward gaze from spasm of oculomotor muscles.
  - Torticollis, that is, pulling of the head to the side from spasm of cervical muscles.

Extrapyramidal side effects of antipsychotics cntd...

- Opisthotonus, which refers to the hyperextension of the back from spasm of back muscles.
- Akathisia or continuous motor restlessness.
- Akinesia or lack of body movement especially arms.
- Pseudoparkinsonism, which presents with a shuffling gait, mask-like facial expression, tremor, rigidity and akinesia.

SIDE EFFECTS CNTD…

- The patient may also experience tardive dyskinesia, that is, a wormlike movement of the tongue, frequent blinking, and involuntary movement of tongue, lips and jaw. They may experience convulsive seizures or allergic or toxic effects (some of which are rare and serious).These include:
  - Aggranulosis
  - Oral monoliasis
  - Dermatitis
  - Jaundice

Side effects of antipsychotics cntd...

- The patient may also exhibit other side effects including endocrine or metabolic effects like weight gain or decreased libido, impotence, impaired ejaculation in males. They may also have decreased thermoregulatory ability and as a result might complain of being too cold or too hot.
- Adjusting the dosage of antipsychotic drugs, and giving antiparkinsonian drugs can often be quite effective in treating side effects.

Contraindications

- Comatose, glaucoma, prosthetic hyperplasic, acute myocardial infarction are contraindications to the use of these drugs

Nurse's Responsibility for a Patient Receiving Antipsychotics

- Instruct the patient to take sips of water frequently to relieve dryness of mouth. Frequent mouth washes, use of chewing gum and applying glycerine.
- A high-fiber diet, increased fluid intake and laxatives if needed, help to reduce constipation.
- Advise the patient to get up from the bed or chair very slowly. Patient should sit on the edge of the bed for one full minute dangling his feet, before standing up.

- Check BP before and after medication is given as a measure to prevent falls and other complications resulting from orthostatic hypotension.
- Differentiate between akathisia and agitation. A change of drug may be necessary if side-effects are severe.
- Administer antiparkinsonian drugs as prescribed.
- Observe the patient regularly for abnormal movements.
- Take all seizure precautions.
- Patient should be warned about driving a car or operating machinery when first treated with antipsychotics.

- Giving the entire dose at bedtime usually eliminates any problem from sedation.
- Advise the patient to use sunscreen measures (use of full sleeves, dark glasses etc) for photosensitive reactions.
- Teach the importance of drug compliance, side-effects of drugs and reporting if too severe, regular follow-ups.

Anxiolytics and hypnotics

- The distinction between anxiolytics and hypnotics is artificial: most anxiolytics in higher doses given at night have sleep inducing actions and many hypnotics in divided doses during the day are useful anxiolytics.
- Anxiolytics are those drugs whose main purpose is to decrease anxiety.
- Hypnotic drugs have a calming effect, decrease arausal and promote sleep.
- Hypnotics are often anxiolytics but not all anxiolytics have hypnotic properties.

Classification

- There are many chemical groups of drugs that have sedative-hypnotic properties but just a few are used in modern psychiatry on a regular basis:
- These are:
  - Benzodiazepines
  - Cyclopyrolones
  - Azapirones
- Other less commonly used groups are: barbiturates, carbamates, cyclic esters, chloral hydrate and alcohol.
- Antidepressants are often used in certain anxiety states as drugs of first choice.

Anxiolytics and hypnotics

Mode of action

- Both benzodiazepines and cyclopyrones act primarily on GABA – benzodiazepine receptor complex facilitating the effect of GABA.
- Buspirone the only available azapirone is a 5HT1A partial agonist and a non-sedating, non-hypnotic anxiolytic.
- BDZ are powerful potentiators of GABA activity:
  - Muscle relaxation both pre and post synaptic influences in the spinal cord.
  - Anticonvulsant effects by general inhibiting effect
  - Ataxia by a cerebellar effect.
  - Sedation by the effects on the reticular activating system.

Anxiolytics and hypnotics

For clinical purposes, benzodiazepines and relared compounds are classified as follows:

- Short acting (half life less than 24hrs).
- Intermediate acting (half life between 24 and 48 hrs).
- Long acting (half life more than 48 hrs).

Anxiolytics

- Short acting e.g. diazepam (valium), od.
- Intermediate acting e.g. clozabam (Urbanol) bd.
- Long acting e.g Lorazepam (ativan) tds.

Hypnotics

Short acting, strongly sedative e.g. Temazepam (Normison)

CLINICAL USE OF ANXIOLYTICS AND HYPNOTICS

- Treatment of choice in the management of anxiety, insomnia and stress.
- Patients with fluctuating anxiety may prefer shorter acting oxazepam or lorazepam.
- Alprozolam has been found to be useful in anxiety and depression.
- Oxazepam penetrates BBB too slowly for a hypnotic effect, hence temazepam and lormetazepam are more appropriate.
- BDZ are useful in the management of alcohol withdrawal syndrome: there is however a danger of substitution.
- Diazepam has been used in the treatment of spasticity, tetanus and rabies.
- Diazepam IV is used for status epilepticus.
- Adverse effects of benzodiazepines are high potential for dependence and abuse.

Anticonvusants and psychstimulants

- Please study the following:

Anticonvulsants:

- Phenytoin (hydantoin)
- Carbamazepine
- Barbiturates (phenobarbitone)
- Succinamides (zarontin, celontin and milontin).
- Benzodiazepines
- Sodium valproate (epilim)

Psychostimulants:

- Methylphenidate
- Disulfirum

Please study the following:

- Agents used to treat extrapyramidal syndromes:
  - Anticholinergic drugs: biperiden, benzhexol, ophenadrine
  - Amantadine
  - Propranolol

END

COMMUNITY MENTAL HEALTH

BY Martha Kairu

Introduction

- Community as a client
- Populations in the community are at risk of many mental problems
- Risks are associated with the crises they undergo in life
- Both maturational and situational crises apply.

Role of the nurse in cmh

- ✓Identification of mentally ill persons in the community
- ✓Provide first aid in psychiatric emergency care
- ✓Follow-up
- ✓Mental health education

Public health model

- Primary prevention
- Secondary prevention
- Tertiary prevention

Primary prevention

- Services aimed at reducing the incidence of mental disorders within the population.

- Focus on:-

1. Assisting individuals to increase their ability to cope effectively with stress.
2. Targeting and diminishing harmful forces (stressors) within the environment

Primary interventions

Teaching :

- Parenting skills and child development to prospective new parents
- Physical and psychosocial effects of alcohol/drugs
- Techniques of stress management
- Groups of individuals ways to cope with the changes associated with various maturational stages

Cont'

- Teaching concepts of mental health to various groups within the community
- Providing education and support to unemployed or homeless individuals
- Providing education and support to other individuals in various transitional periods (e.g. ***widows and widowers, new retirees, and women entering the work force in middle life)***

Settings

- Community social institutions e.g.:-
  - Churches
  - Schools/colleges
  - Community centers
  - Workplaces
  - Meetings of women/youth groups
  - Civil society organizations
  - Etc

Secondary prevention

- Interventions aimed at minimizing early symptoms of psychiatric illness and directed toward reducing the prevalence and duration of the illness.

- Focus:
  1. Recognition of symptoms
  2. Provision of treatment
  3. Referral for treatment.

Secondary interventions

- Ongoing assessment of individuals at high risk for illness exacerbation
- Provision of care for individuals in whom illness symptoms have been assessed
- Referral for treatment of individuals in whom illness symptoms have been assessed.
- ***Nb: application of the nursing process***

Tertiary prevention

- Services aimed at reducing the residual defects that are associated with severe and persistent mental illness.

- Focus:
  1. Preventing complications of the illness
  2. Promoting rehabilitation that is directed toward achievement of each individual’s maximum level of functioning

Tertiary interventions

- Consideration of the rehabilitation process at the time of initial diagnosis and treatment planning
- Teaching the client daily living skills and encouraging independence to his or her maximum ability
- Referring clients for various aftercare services like support groups

Cont’

- Monitoring effectiveness of aftercare services
- Making referrals for support services when required.

Settings

- ✓Inpatient setups
- ✓Out patient departments
- ✓Home based care
- ✓Group homes
- ✓Nursing homes
- ✓Community mental health centers.

Summary

- Prevent
- Control
- Rehabilitate

THE END

- THANK YOU