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MENTAL HEALTH AND PSYCHIATRIC NURSING II

COURSE GUIDE

NSC 412
MENTAL HEALTH AND PSYCHIATRIC NURSING II

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MODULE 1: HEALTHY MENTAL HEALTH ENVIRONMENT, SOURCES AND CAUSES OF MENTAL DISORDERS

UNIT 1: HEALTHY MENTAL HEALTH ENVIRONMENT

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1.0 INTRODUCTION

The last unit was on factors affecting mental health where several factors were looked into. This unit will take you through healthy mental health environments.

2.0 OBJECTIVES

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

- examine the impact of the home front on the mental health of individual members of the family
- state how a child's school environment can either make or mar his mental health
- explain how a person's working environment can affect his mental health.

3.0 MAINCONTENT

3.1 Healthy Mental Health Environments

There are three settings which provide for a healthy mental health environment, namely, the home, the school for students and the workplace or place where one earns a living for the adult worker. For the purpose of this discuss, the school age child or adolescent not in school for economic or any other reasons and who engages in activities directed towards earning a living is considered a worker. The student spends a good part of his time in the house and in the school, while those not in schools such as adults and drop-outs also spend most of their time at home and at the place they earn a living. Time spent in other places within the community is usually less than time spent in any of the above primary settings.

We are going to consider factors within each of these settings which can either positively or adversely affect the mental health status of an individual of whatever age, sex or social status. We have previously classified environment into physical, mental and social environment. The emphasis in this unit is on mental/emotional health environment, we must not lose sight of the fact that the various forms of environment influences one another The type of atmosphere generated by either physical or social environment influences an individual's mental/emotional environment.

3.2 Mental Health Environment at Home

The concept of home connotes a place where a father, mother and siblings reside. This is a place where they all converge after each has returned from the day's activities outside the home. A home is a place where the inmates interact as members of the same family. In a restricted sense, the home is a place where a mother and a father are present except where the absence of one is either temporary and by mutual understanding as in the case of transfer, study leaves, short trips or by the demise of one of the spouses. Even under a death situation, the home could not be considered complete because each member has a role to play. It is not an easy task to attempt to play the role of both father and mother to siblings successfully by a single parent.

Influence of home environment on a child's mental health development

In order to ensure that a child grows in a healthy environment, there has always been a need to move a child who has suffered the death of one of the parents to a home where he can live in an environment that promotes not only his physical and social growth, but also mental growth.

A home is a fortress to which a child can always for sympathy, protection, love security, food, understanding and acceptance. A home that a child can look up to, for the satisfaction of the basic needs, such as those enumerated above constitute an environment which engenders good mental health. By contrast, a home torn by strife,

quarrel, fighting, swearing and a home where there is constant hunger, fighting, lack of care, lack of love and security, lack of understanding, etc. constitutes an environment which generates frustration, fear, insecurity, delinquency and anti-social behaviours in a growing child.

A conducive emotional home environment for the child is one in which parents not only provide the child's basic needs, but also provide discipline and guidance. While over-strictness can generate negative feelings in the child, over-permissiveness is equally dangerous. Parents must provide appropriate balance between being very harsh or over-permissive.

A growing child needs independence and freedom, but he needs also guidance in order to use his freedom and independence with great responsibility. A child needs friendship of his parents, to share the day adventures, to seek opinion and advice and to communicate. Parents should therefore make themselves available for family interactive sessions often. An environment that makes it possible for children to talk freely, but with respect to their parents will promote good mental health.

Importance of health home environment to parents

It is not only the siblings that need a wholesome mental environment. The behaviour of the adult members of the family towards one another not only influences/affects their attitude to their children, but also to themselves. A wholesome home environment has a positive influence on adult mental health and an unfavorable environment generates mental emotional distress.

There are many factors which can influence the behaviour of a husband towards the wife and vice versa. The way these factors are managed often determines the kind of relationship that may exist between them. We shall examine two of these factors and you should think of numerous others. The two singled out in this lecture – money and sex issues – are considered the foremost issues which have caused untold disasters in matrimonial relationships.

Influence of money in maintenance of wholesome home environment

Traditionally, the man is considered the breadwinner. He is expected to provide money for family sustenance. Even though in these austere days, when it has become expedient more than ever before for the woman to take on some job either to fulfill her professional goal or to supplement family income, the man is still expected to carry the bulk of the family sustenance bill. Where this responsibility is not being carried out, it is the danger signal especially if the woman is incapable of making substantial contribution to family income.

This danger becomes even more serious if the woman believes the man makes enough money but fails to provide sufficient amount to feed the family. As a result, the woman

naturally nags. She complains even in the presence of the children and inadvertently drops the hints that their father has failed in his duty and therefore useless. The inevitable follow- up of abuses, quarrelling and even fighting thus creates poor emotional health environment for everyone in the home. The couple may now be cohabiting rather than really living together as a family. Love and respect is lost for one another.

They may begin to seek outside ways to compensate for what is lacking in the home, – love, caring, understanding, fellowship etc. The situation ultimately gets into a chain of reactions which boomerangs on the entire family. The woman begins to find other means of finding money to feed her and the children, and then the man begins to stay out more and more seeking comfort in other women and/or outside interest. The final thing there may be the complete breakdown of communication in the family, with the woman leaving home or being kicked out and the children dangling in-between.

On the other hand, a positive environment for good mental health is created when the breadwinner gives out money regularly and both the breadwinner and housekeeper sit down to discuss their problems and agree on how they can jointly tackle them. Even where very little money is coming to the woman for food and housekeeping bills, with love, understanding, communication and friendship, the family can remain cohesive. Most women do not mind making substantial contribution to providing family sustenance needs as long as the breadwinner does not completely abrogate his responsibility to the family. Women are generally proud and respectful of husbands who can accept their responsibility to the family. Situations in which a woman is proud of the husband and respects him; in which there is harmonious relationship, creates an environment for positive mental health growth and the children tend to imbibe those attributes of their parents which have enabled them to live harmoniously.

Influence of sexual relationship on healthy home environment

By nature, the males sexual feelings are more easily aroused although it is known that some women are highly strong sexually, but these seem far and between, when compared with men. A man reaches his state of readiness for sexual act several minutes ahead of the woman. The woman must therefore be led on gradually to the level where she is physiologically and psychologically prepared for sexual intercourse. If a woman is compelled to have sexual intercourse when she is not physiologically and psychologically ready, she is left in a state of mental and physical torture long after the man has attained the ecstasy of the act and is soundly asleep.

When this woman is constantly compelled to have sexual intercourse when she is not ready, she gradually becomes frigid or physically resists having any intercourse that will end up leaving her unsatisfied and sleepless every night the experience takes place. For a violent husband who will always want to satisfy his sexual urge, every night creates fear for the woman. This type of situation affects the mental health of the woman adversely and this could manifest itself physically and socially, especially if the woman then seeks for sexual satisfaction outside the matrimonial home.

A woman has sexual feelings and needs to satisfy these feelings as much as the man does. But her physiological make-up must be understood and appropriate allowance made for this by the man. The act of sexual intercourse must begin several hours before he actual act with loving words, appreciation of what the woman has done during the day, intimate conversation about the day's „goings and comings", sharing individual activities of the day. Then while in bed, the tender feelings continue to set the foreplay until the woman is gradually led to a point where she is ready for the sexual act. The man has to learn to hold himself until the woman is ready. Once the habit of helping the woman to reach a level at which both arrive at the plateau of the act at the same time or very close to each other, is established, the woman looks forward to having sex rather than being afraid; and rather than being frigid in bed, she would participate actively in the act of making it pleasurable for the man as she herself enjoy sit.

Another point of importance is that of lack of consideration for the physical state of a woman. Being a mother, worker and home-maker, she is often tired at the end of the day. When this happens, all she needs is a good rest and sleep. A husband must realize this need and respects it, if there is going to be a good sexual relationship. A tired body can hardly function effectively or efficiently in anything including sexual act.

An important point about sexual relationship is that both husband and wife must have consideration for the needs and feelings for each other. No one should deny the other sex, and at the same time, no one should compel the other to have sex when one of the partners is not in the mood. The decision to have sexual intercourse should be mutual. It is the constant lack of consideration for each other's needs and feelings that creates an unwholesome home environment. A healthy home environment is a pre-requisite for a happy matrimonial home.

3.3 Influence of School Environment on a Child's Mental Health

An important component of the school health programme is the provision of healthful school living environment, which embraces all the efforts made to provide at school physical, emotional/mental and social conditions which are beneficial to the health and safety of students. While the importance of maintaining a healthful physical environment is acknowledged, the major concern here is the promotion or otherwise of healthy social and emotional environment. The tone of the school can have either positive or adverse effects on students" desire to learn and to identify themselves with their institution.

Tragedy of unwholesome school environment

The tragedy of unhealthy emotional environment generated by the school is not that students" performance is most likely to be poor but that the impact is likely to lead to anti-social behaviour such as delinquency, lack of respect for constituted authority, destruction of public or private properties, frustration, aggression and such behaviours.

School authorities, administrators and other school personnel must be aware of the implications in a situation where an institution at whatever level of learning does not provide a healthy mental health environment.

Students are happy when they have an attractive school and when the school is well organized. They are happy to be in school where everyone is treated with respect and dignity; they are happy when the teachers can be relied upon and are fair in all their interactions with students. Beautiful scenery, clean and orderly environment, contributes to healthy emotional well-being. The inescapable conclusion is that students who attend institutions that provide healthy mental health environments are more likely to do much better than their peers who attend institutions that do not provide a conducive teaching-learning environment.

3.4 Influence of Workplace Environment on Mental Health of Workers

The joy a person derives from his workplace or a place he earns his living depends largely on the type of atmosphere that exists in the place. Such an atmosphere naturally affects the mental health status of the person. There are factors which determine the kind of mental health environment a workplace possesses. These include job satisfaction, job security, promotion or advancement prospects, job schedules, inter- personal relationship etc. The kind of environment generated by the above factors is directly related to whether or not the worker is having a good or bad time in the workplace.

Job satisfaction and mental health

A job that gives satisfaction promotes good mental health. To some people, their job is drudgery and they derive no joy in what they are doing, but they work just to live. For some persons, they work on monotonous schedules, doing the same thing day in day out sometimes without thought. They are simply robots. In contrast, a job that is challenging and meaningful to the worker generates a healthy emotional environment which leads to job satisfaction. A job that offers workers opportunities for initiatives, for constructive idea and for experimentation founded on well thought out hypothesis creates an environment which is mentally stimulating and challenging and emotionally satisfying.

Job security and mental health

Initially a person without a job will grab on anything that come his way. But later he begins to think of the job security. Unless he is assured of job security, he becomes almost as insecure as he was when he had no job. The uncertainty of job security creates fear and apprehension both of which detract from mental health. Even when tenure of job has been established, constant harassment from superior officers can also create job insecurity with the attendant mental health consequences.

Job prospects and mental health

Advancement in one's job means more money or pay. It does not matter how long it takes one to advance from one stage to the other, but there is that satisfaction so long as the criteria for advancement is clearly outlined and that there is justice and fairness in the interpretation of the guidelines. Lack of job prospects and advancements generates a climate which dampens the spirit of workers and this leads to low productivity.
More importantly, it kills morale and reduces mental health status.

Influence of inter-personal relationships on mental health

The relationship between management and workers, between workers and their immediate supervisors or among workers themselves goes a long way to determine the mental health disposition of workers while at work. A cordial and friendly relationship creates a most congenial climate which in its wake promotes positive mental health. Workers‟ morale is improved by discussion groups and case conferences on matters relating to the working conditions in the organization.

4.0 CONCLUSION

Indeed, there exist a delicate relationship between mental health and the environment of man. Observations have shown that the more the environment of man stimulating the more mental health is enhanced and vice versa.

5.0 SUMMARY

We have examined conditions which can promote positive mental health environment at home. For a child to grow and develop well, he must be provided with the basic human needs, namely food, shelter, clothing, security, love and affection. He needs self-esteem and a sense of belonging. All these will generate in an atmosphere in which the child can grow and develop optimally. For the two principal adults in the home (father and mother, husband and wife), understanding, cooperation, love and affection, sharing and faithfulness and carrying out individual responsibilities creates an environment which promotes positive mental health at home.

Healthy mental environment in the school leads to effective teaching and learning process. A good school setting in terms of excellence in academics and sports, good organization of school programmes, good inter-personal relationship between teachers and students which engenders mutual trust and respect culminate in providing conducive mental health environment in which to teach and learn.

6.0 TUTOR-MARKED ASSIGNMENT

Interactions between environment and mental health are crucial to man.
Discuss.

7.0 REFERENCES/FURTHERREADING

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SELF ASSESSMENT EXERCISE I

1. List three environments that promote health mental health
2. Discuss any of the mentioned environments in detail

ANSWER

1. The Home ii. The School and iii. The workplace
2. a. Mental Health Environment at Home

The concept of home connotes a place where a father, mother and siblings reside. This is a place where they all converge after each has returned from the day's activities outside the home. A home is a place where the inmates interact as members of the same family. In a restricted sense, the home is a place where a mother and a father are present except where the absence of one is either temporary and by mutual understanding as in the case of transfer, study leaves, short trips or by the demise of one of the spouses. Even under a death situation, the home could not be considered complete because each member has a role to play. It is not an easy task to attempt to play the role of both father and mother to siblings successfully by a single parent. In order to ensure that a child grows in a healthy environment, there has always been a need to move a child who has suffered the death of one of the parents to a home where he can live in an environment that promotes not only his physical and social growth, but also mental growth. A home is a fortress to which a child can always for sympathy, protection, love security, food, understanding and acceptance. A home that a child can look up to, for the satisfaction of the basic needs, such as those enumerated above constitute an environment which engenders good mental health. By contrast, a home torn by strife, quarrel, fighting, swearing and a home where there is constant hunger, fighting, lack of care, lack of love and security, lack of understanding, etc. constitutes an environment which generates frustration, fear, insecurity, delinquency and anti-social behaviours in a growing child. A conducive emotional home environment for the child is one in which parents not only provide the child's basic needs, but also provide discipline and guidance. While over-strictness can generate negative feelings in the child, over-permissiveness is equally dangerous. Parents must provide appropriate balance between being very harsh or over- permissive.

b. Influence of School Environment on a Child's Mental Health

An important component of the school health programme is the provision of healthful school living environment, which embraces all the efforts made to provide at school physical, emotional/mental and social conditions which are beneficial to the health and safety of students. While the importance of maintaining a healthful physical environment is acknowledged, the major concern here is the promotion or otherwise of healthy social and emotional environment. The tone of the school can have either positive or adverse effects on students‟ desire to learn and to identify themselves with their institution. The tragedy of unhealthy emotional environment generated by the school is not that students‟ performance is most likely to be poor but that the impact is likely to lead to anti-social behaviour such as delinquency, lack of respect for constituted authority, destruction of public or private properties, frustration, aggression and such behaviours. School authorities, administrators and other school personnel must be aware of the implications in a situation where an institution at whatever level of learning does not provide a healthy mental health environment. Students are happy when they have an attractive school and when the school is well organized. They are happy to be in school where everyone is treated with respect and dignity; they are happy when the teachers can be relied upon and are fair in all their interactions with students. Beautiful scenery, clean and orderly environment, contributes to healthy emotional well-being. The inescapable conclusion is that students who attend institutions that provide healthy mental health environments are more likely to do much better than their peers who attend institutions that do not provide a conducive teaching-learning environment.

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there is that satisfaction so long as the criteria for advancement is clearly outlined and that there is justice and fairness in the interpretation of the guidelines. Lack of job prospects and advancements generates a climate which dampens the spirit of workers and this leads to low productivity. More importantly, it kills morale and reduces mental health status. The relationship between management and workers, between workers and their immediate supervisors or among workers themselves goes a long way to determine the mental health disposition of workers while at work. A cordial and friendly relationship creates a most congenial climate which in its wake promotes positive mental health. Workers‟ morale is improved by discussion groups and case conferences on matters relating to the working conditions in the organization.

UNIT 2: SOURCES OF MENTAL HEALTH PROBLEMS IN YOUTHS

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4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR-MARKED ASSIGNMENT
7.0 REFERENCES/FURTHER READING

1.0 INTRODUCTION

In our previous units, we examined factors which affect mental health and identified them as heredity and environment. The home, school and community were also considered as places where individuals including youths interact with significant others with consequent influence on their social and emotional health. This unit will examine some of the sources of mental and social health problems of youths in our society.

2.0 OBJECTIVES

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

- explain why some youths give up family relationships
- describe how inability to adjust socially and emotionally impinges on the mental health of youths
- explain how an unwholesome social and emotional climate at school can affect the mental health of youths
- list the causes of loneliness and the consequences to mental health of youths.

3.0 MAIN CONTENT

3.1 Common Mental Health Problems of Youths

Youths are generally classified as those who are in the senior secondary schools and in the tertiary institutions (colleges of education, polytechnics and universities) and other similar institutions. Age-wise, this period can be placed between 15years or earlier, to perhaps 30years. For this lecture, youths under consideration are not limited to only those who are schooling. They include also those not only in schools but are within the student's age range. Students and other youths are confronted by a considerable number of social and economic problems which impinge on their mental health. It is not possible to discuss or examine the gamut of mental health problems which confront young persons. Attempts have been made in this lecture to discuss briefly some of these problems which have been highlighted by John, Sutton and Cooley (1957) and Bryd (1957). Some may appear very trivial, but you should be aware of the fact that the seriousness or the triviality of a problem depends largely on the capacity of an affected youth or a person concerned to cope with the situation. These problems are by no means exhaustive. They include:

3.1.1 Inability to Give Up Home and Family Relationships

Every person is expected to develop some emotional attachment to his family and home – to think of the home and family members with love and affection, to want to meet with the members as often as it is possible and to interact meaningfully and happily with them. All these feelings are products of how the family, as an institution has been held together and sustained. Unfortunately however, some families bring up their children in such a way that they are not helped to be independent outside the family. They do not encourage the children to move out and interact with their peer while growing up. The children are over-protected to the point that they become docile. Such children grow up without learning that life exists outside the home and the world could be very rough and trying and that it is only the tough that keeps going when the going gets tough.

Lack of encouragement to children to explore the world comes from over protectiveness creating situations which ultimately affect the children's mental health. Not being prepared for the world outside the home, they meet with so much frustration which generates stress. Their only solution is to constantly fall back to their home – a kind of defence mechanism employed to avoid facing reality. Inability to face the realities of life outside the home or to adjust and find a satisfactory way
to cope with them creates such psychological and mental problems such as which does not enhance mental health development.

3.1.2 Rejection of Parental and Home Standards

We have examined the case of some youths who by their upbringing are unprepared for independent existences outside the home and therefore cling to the home whenever they are threatened or confronted with any type of problems. There are however other youths who may have been over-protected and/or over-restricted and who therefore, cannot wait to leave home in order to gain freedom to do things their own way. The moment they move out of their homes, they tend to renounce parental and home standards. Deep down,

parental love and affection is still there, but the young adult refuses to accept the standard of the parents. He may in fact be confronted with two or more different standards – standards within the home and those outside the home environment. The youth thus passes through a period of decision-making: "Which standards do i adopt, the home or the outside standards?" During this period of decision-making, which is also the period of conflict for the youth, he goes through a period of stress which may be short-lived or long-lasting, depending on which way he resolves the conflict. More often than not, the youth takes the opposite end from the home situation. The fact of the issue at hand is that the rejection of familiar situations creates a wedge in the relationship of parent and the youth and this must occasionally generate some stresses, for the youth is torn between his love and affection for his parents, and rejection of their standards. This situation thus impinges on the mental health of the youth.

3.1.3 The Search for Identity and a Purpose in Life

Parents can give their children protection, security as well as attend to their other physiological needs. They can give them a sense of belonging: they may sometimes attempt to give them identity by letting their own names, success and reputation rub off on them. But these are often times borrowed garments that may wear out with time. The real identity must be found, discovered and/or built for oneself. Coupled with the discovery of one's own identity is also the discovery of one's purpose in life.

The search for identity and purpose in life goes beyond the emotional and social dimensions of humans. It operates on the non-physical level; that is on the spiritual and psychic level. The search may be enhanced bone's upbringing simply by familiar modeling, or the youth may be left to grope in darkness until he finds something he can hang unto. Although there are a variety of reasons why youths in the secondary and tertiary institutions join the many religious sects in their campuses, The real purpose may in fact be that many of them go into these ventures in order to discover for themselves the meaning of their existence and the purpose of their living. Believing that they have found what they are searching for, some of them become fanatical, while others balance their belief with reality. Some never succeed in finding solutions to the question bugging their minds: Who am I? While this search and discovery lasts, the youth's mental health status is deeply involved.

3.1.4 Lack of Social and Emotional Adjustment

Inability of some youths to adjust to social and emotional situation when they step into the wider world reflects on the social interaction and emotional climate in the home. Feelings of superiority and/or inferiority are both manifestations of lack of social adjustment. Youths from more affluent homes which believe that their affluence gives them a right over every other person, naturally grow up to see themselves as special beings. Such persons lack humility and consequently do not find it easy to interact with other persons except those who are willing to accept inferior positions to them. In the same manner, some youths from the less affluent homes in which the family members are

content to accept anything that comes to them are more likely to accept inferior positions in their social interaction with others. They have not learned to exert themselves in social situations. These situations are unhealthy. But on the other hand, a youth from a home-whether affluent or not-where members are proud of what they are; are humble even in the midst of affluence; respect other people's views and rights, demand their own rights no matter from whom and are not afraid to speak up when the occasion demands, is more likely to interact well in the wider world.

Many youths who leave their homes for the first time may appear to be matured physically but may be emotionally immature Such emotional immaturity derived from poor emotional home climate is often expressed in over-stimulation which leads to responding to situations with irrational fear and other anxieties, both of which affect the status of mental health adversely.

3.1.5 Scholastic Difficulties

Students are constantly on the move from classrooms, lecture halls, library to dining halls or food canteens. Some live through the hassle quite comfortably, but there are some of these who do not seem to achieve the desired result in spite of all their efforts. Every grade counts towards the class of degree, so some students are constantly on edge. The thought of failing a course is a threat to their peace of mind. The fear of failing a course dangles like an axe over them because It implies
a „re-sit examination", or having to offer the course „at the next available opportunity" depending on the institution.

3.1.6 Harassment from Teachers

Student harassment in educational institutions in Nigeria never came to the limelight until the issue of sexual harassment in our educational institutions became an issue of public concern within the decade. Student harassment and sexual harassment have always existed in our educational institutions and they have often gone together. Students have been subject of victimization by their teachers for reasons best known to the harasser and often unknown by the harassed. Some students have been excluded from lectures by teachers, deservedly for misdemeanors which needed to be curbed before they spread. However, several instances exist where students have been verbally battered in class or excluded from lectures for no apparent reasons. The number of students who may experience the type of unwanted display of authority by their lecturers may be few, nevertheless the matter of student harassment is real and it is a source of constant worry to those students who see themselves as victims. Student harassment may degenerate into poor making and return of very low scores for harassed students" test and examination, or in fact deliberately withholding harassed students" scores. This also compounds the student's problems which ultimately affects his or her mental health status.

3.1.7 Poor Sexual Adjustment

Some youths are uneasy in the presence of the opposite sex, with the result that they behave as if they actually hate them. They find it extremely difficult to relate or interact with them in a meaningful way. They probably feel inadequate in a number of ways, including inferiority complex. Some, especially males, speak so much about their escapades with the female sex, but never have the courage to speak or lack a substance of conversation when they meet with the opposite sex. This is generally due to the failure to make necessary adjustments to the female sex in their childhood days. Such youths may probably have no sisters with whom to interact at home. Familiar attitudes towards boy-girl relationships may also implant on the youth a negative attitude towards women. There are other male youths who do not recoil in the presence of the female sex. Rather they would want to treat them as objects rather than persons that should be treated with respect and dignity. This attitude may also have been learned in the home where the father believes in the absolute supremacy of the male sex and the subservience of the female.

The females also have their own inadequacies. Some may avoid interactions with male, because they have been branded evil right from the time the girls began to show some interest in the male. These young girls have been brought up to believe that all male advances are geared towards establishing relationships based on purely physical gratifications. Under this type of upbringing the girl grows up, full of distrust and suspicion both of which undermine any meaningful sexual relationship. On the other side of the coin too are categories of adolescents who wear a constant air of superiority and importance that create a barrier between them and any healthy and meaningful boy-girl relationship.

These types of boys and girls described above may appear to be in good mental health but deep down they are actually under some mental stress unknown to them which they unconsciously attempt to cover with some of the several defence mechanisms.

3.1.8 Search for Future Life Partner

Colleges and universities are settings where the population is largely made up of young men and women. Here youths, particularly women look forward to getting young men with whom they can share their future together. The search for a husband becomes more desperate in the third or final year of study such that it could constitute a serious mental health problem. College and university days are most likely to be the most interesting period of their lives; they are also likely to have the largest number of eligible young men in the same community. Some girls are more subtle in their search while others are more aggressive with such behaviours as showing up at every social gathering such as campus parties, sophisticated dressing, manner of speaking and manner of walking, some girls even give the impression of being reserved, with the hope to be noticed by a serious-minded male student who is also searching for a future partner. If an impression that worrying about marriage is only found on the doorsteps of female students had been created, it is because female students are more mentally affected. There are reports of incidents of near suicides and actual suicides on account of alleged jilting.

3.1.9 Problems of Drug Abuse

Drug abuse and misuse are both mental health problems which are common in Nigeria, particularly among the youths in our tertiary institutions. A normal person would neither misuse nor abuse drugs on a regular basis. However, there are some legitimate reasons and cases why one may need to use drugs. Under certain situations the use of drugs becomes legitimate especially when used under medical instructions.

Our concern here is in the fact that misuse and abuse of drugs have adverse effects on mental health as well as the socio-psychological situations that make youths turn to drugs to solve their problems. Such socio-psychological problems include search for identity which is a common reason given among youths; the desire to reduce tension and anxiety or to remove fatigue and boredom. Other reasons given include the desire to change one's mood, activity level, or to improve social interactions and relationships; the desire for group conformity as well as the desire to „just feel good". The fact of the matter is that there are several other positive actions or behaviour that can produce a more positive and healthy result.

3.1.10 Inadequacy of Basic Services and Facilities

Nigerian youths in colleges and universities, like the other persons in the large community encounter problems emanating from lack of essential services and facilities. For instance, inconsistency in water supply and electricity, lack of adequate library space, poor environmental sanitation in halls of residence and classrooms, overcrowding in lecture halls of residence and classrooms which over-stretch the meager facilities – all affect the productivity and effectiveness of the students. Since most students want to do well in their studies, any situation as those mentioned above will undermine their mental health.

4.0 CONCLUSION

There are some mental health problems which affect youths in our society and some of these youths attempt to solve these problems psychologically through habits which further land them into more serious psychological and physical problems. There are those that turn to drugs and some other solutions that seem fit for their problems.

5.0 SUMMARY

We have examined some of the mental health problems which impinge on the youths. A considerable number of the problems emanate from inability of youths to handle satisfactorily socio-psychological problems such as those related to boy-girl relationships, peer group relationships.

6.0 TUTOR-MARKED ASSIGNMENT

What is loneliness? How can it affect mental health?

Explain how the social and emotional adjustment at home can influence the mental health development of the youth.

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SELF ASSESSMENT EXERCISE II

Enumerate and briefly discuss any five common mental health problems of the youths in Nigeria

ANSWER

1. Inability to give up home and family relationships
2. Rejection of Parental and Home Standards
3. The Search for Identity and a Purpose in Life
4. Lack of Social and Emotional Adjustment
5. Scholastic Difficulties
6. Harassment from Teachers
7. Poor Sexual Adjustment
8. Search for Future Life Partner
9. Problems of Drug Abuse
10. Inadequacy of Basic Services and Facilities

1. Inability to Give Up Home and Family Relationships

Every person is expected to develop some emotional attachment to his family and home – to think of the home and family members with love and affection, to want to meet with the members as often as it is possible and to interact meaningfully and happily with them. All these feelings are products of how the family, as an institution has been held together and sustained. Unfortunately however, some families bring up their children in such a way that they are not helped to be independent outside the family. They do not encourage the children to move out and interact with their peer while growing up. The children are over-protected to the point that they become docile. Such children grow up without learning that life exists outside the home and the world could be very rough and trying and that it is only the tough that keeps going when the going gets tough.

2. Rejection of Parental and Home Standards

There are however other youths who may have been over- protected and/or over-restricted and who therefore, cannot wait to leave home in order to gain freedom to do things their own way. The moment they move out of their homes, they tend to renounce parental and home standards. Deep down, parental love and affection is still there, but the young adult refuses to accept the standard of the parents. He may in fact be confronted with two or more different standards – standards within the home and those outside the home environment. The youth thus passes through a period of decision-making: "Which standards do i adopt, the home or the outside standards?"

3. The Search for Identity and a Purpose in Life

The search for identity and purpose in life goes beyond the emotional and social dimensions of humans. It operates on the non-physical level; that is on the spiritual and psychic level. The search may be enhanced by one's upbringing simply by familiar modeling, or the youth may be left to grope in darkness until he finds something he can hang unto. Although there are a variety of reasons why youths in the secondary and tertiary institutions join the many religious sects in their campuses, the real purpose may in fact be that many of them go into these ventures in order to discover for themselves the meaning of their existence and the purpose of their living.

4. Lack of Social and Emotional Adjustment

Inability of some youths to adjust to social and emotional situation when they step into the wider world reflects on the social interaction and emotional climate in the home. Feelings of superiority and/or inferiority are both manifestations of lack of social adjustment. Youths from more affluent homes which believe that their affluence gives them a right over every other person, naturally grow up to see themselves as special beings. Such persons lack humility and consequently do not find it easy to interact with other persons except those who are willing to accept inferior positions to them. In the same manner, some youths from the less affluent homes in which the family members are content to accept anything that comes to them are more likely to accept inferior positions in their social interaction with others. They have not learned to exert themselves in social situations. These situations are unhealthy.

5. Scholastic Difficulties

Students are constantly on the move from classrooms, lecture halls, library to dining halls or food canteens. Some live through the hassle quite comfortably, but there are some of these who do not seem to achieve the desired result in spite of all their efforts. Every grade counts towards the class of degree, so some students are constantly on edge. The thought of failing a course is a threat to their peace of mind. The fear of failing a course dangles like an axe over them because It implies a "re-sit examination", or having to offer the course "at the next available opportunity" depending on the institution.

6. Harassment from Teachers

Student harassment in educational institutions in Nigeria never came to the limelight until the issue of sexual harassment in our educational institutions became an issue of public concern within the decade. Student harassment and sexual harassment have always existed in our educational institutions and they have often gone together.

Students have been subject of victimization by their teachers for reasons best known to the harasser and often unknown by the harassed. Some students have been excluded from lectures by teachers, deservedly for misdemeanors which needed to be curbed before they spread. However, several instances exist where students have been verbally battered in class or excluded from lectures for no apparent reasons.

7.Poor Sexual Adjustment

Some youths are uneasy in the presence of the opposite sex, with the result that they behave as if they actually hate them. They find it extremely difficult to relate or interact with them in a meaningful way. They probably feel inadequate in a number of ways, including inferiority complex. Some, especially males, speak so much about their escapades with the female sex, but never have the courage to speak or lack a substance of conversation when they meet with the opposite sex. This is generally due to the failure to make necessary adjustments to the female sex in their childhood days. Such youths may probably have no sisters with whom to interact at home. Familiar attitudes towards boy-girl relationships may also implant on the youth a negative attitude towards women. There are other male youths who do not recoil in the presence of the female sex. Rather they would want to treat them as objects rather than persons that should be treated with respect and dignity. This attitude may also have been learned in the home where the father believes in the absolute supremacy of the male sex and the subservience of the female. The females also have their own inadequacies. Some may avoid interactions with male, because they have been branded evil right from the time the girls began to show some interest in the male. These young girls have been brought up to believe that all male advances are geared towards establishing relationships based on purely physical gratifications. Under this type of upbringing the girl grows up, full of distrust and suspicion both of which undermine any meaningful sexual relationship. On the other side of the coin too are categories of adolescents who wear a constant air of superiority and importance that create a barrier between them and any healthy and meaningful boy-girl relationship.

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9. Problems of Drug Abuse

Drug abuse and misuse are both mental health problems which are common in Nigeria, particularly among the youths in our tertiary institutions. A normal person would neither misuse nor abuse drugs on a regular basis. However, there are some legitimate reasons and cases why one may need to use drugs. Under certain situations the use of drugs becomes legitimate especially when used under medical instructions. Our concern here is in the fact that misuse and abuse of drugs have adverse effects on mental health as well as the socio-psychological situations that make youths turn to drugs to solve their problems.

10. Inadequacy of Basic Services and Facilities

Nigerian youths in colleges and universities, like the other persons in the large community encounter problems emanating from lack of essential services and facilities. For instance, inconsistency in water supply and electricity, lack of adequate library space, poor environmental sanitation in halls of residence and classrooms, overcrowding in lecture halls of residence and classrooms which over-stretch the meager facilities – all affect the productivity and effectiveness of the students. Since most students want to do well in their studies, any situation as those mentioned above will undermine their mental health.

UNIT 3: CAUSES OF MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
    3.1 Causes of Psychiatric Disorders
    3.2 Predisposing Causes
    3.3 General Causes
    3.4 Precipitating Causes
    3.5 Mental (or Psychological) Causes
    3.6 Prevention of Mental Illness
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR-MARKED ASSIGNMENT
7.0 REFERENCES/FURTHER READING

1.0 INTRODUCTION

This unit will expose the learner to various causes of mental illness.

2.0 OBJECTIVES

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

- identify the causes of mental illness
- discuss the identified causes.

3.0 MAINCONTENT

3.1 Causes of Psychiatric Disorders

No single set of facts can be considered separately when seeking the causes of mental illness. In most cases, it is impossible to ascribe a mental illness to one particular cause and for the most part a possible aetiology must be recognized.

Causes of psychiatric illness come either: (1) The predisposing causes, or (2) The Exciting (or Precipitating) causes. The Predisposing causes are conditions which exist in the individual and render him liable to a mental breakdown. The exciting causes are those conditions which give rise to the actual breakdown. The exciting cause is, as it were the match which sets fire to the trail of gunpowder which represents the predisposing cause.

3.2 Predisposing Causes

Heredity

It has been shown by the study of twins that heredity plays an important part in certain mental illnesses. Monozygotic twins (identical) are born with the same genetic makeup whereas dizygotic twins are no more closely related genetically than other brothers and sisters.

In Schizophrenia 65 per cent of the Uniovular twins showed similar features mentally. For instance, both were completely normal or both had Schizophrenia or both showed mild abnormalities. This only occurs in 15 per cent of binovular twins. In manic depressive illness the figures for Uniovular twins was 70 per cent and for binovular twins 15 per cent. This emphasizes the importance of heredity at any rate in the forms of mental illness.

Another method by which the degree of heredity plays a part can be estimated by comparing the frequency of a particular form of mental illness in the relatives of the patient suffering from it with the frequency of its occurrence in the general population. Obviously the higher the incidence among the patient's relatives the greater is the hereditary factor.

Faulty upbringing

The over-anxious, fussy parent may cause a child to be anxious and lacking in confidence while permissive may lead to an undisciplined child who may show tantrums, jealousy.

3.3 General Causes

Age

In old age there is a decline in both the mental and physical spheres as a result of natural wear and tear. Also women during the child bearing period of their lives have to face the added stresses of pregnancy and puerperium. Thus, as a result of child birth, few women suffer from Puerperal Psychosis; and at old age, they suffer from Senile Psychosis, Senile Dementia.

Sex

Males do suffer from certain psychiatric problems more than the females. For example, males get more indulged in Indian hemp smoking than the females. Whereas females get more worried, they react badly to situations and easily develop mental illness. Paranoid states are common in women than in men.

3.4 Exciting (or Precipitating) Causes

Physical factors

These include infections, intoxications, endocrine, circulatory, nutritional disturbances and trauma.

Infections and toxins

Any generalized infection may produce a mental illness usually of the confusional or delirious type. The level of the temperature does not seem to be any criterion as to when mental symptoms will occur, but probably these depend more on the predisposition of the patient. (For example patients with hyperpyrexia do talk irrationally if the temperature is not controlled ontime).

Such mental illnesses may be found with pneumonia, typhoid, scarlet fever, influenza, septicaemia and syphilis.

Trauma

Trauma is a major cause of psychiatric illnesses. This could be as a result of a fall from a height, forceps delivery or road traffic accident in which results in direct damage to the brain thus impairing the normal function of the brain or as a result of rape, natural disaster or loses.

3.5 Mental (or Psychological) Causes

Some social factors are of great importance and may lead to mental breakdown. Unemployment leads to reduction in income which may cause malnutrition through lack of food. A predisposed individual develops mental illness, whereas in the individual who shows no predisposition, apart from a natural depression and anxiety regarding his family, no symptoms may occur. Environmental stresses resulting from industrialization, mechanization, and increased competition for jobs contribute to the incidence of mental illness. Sudden stress e.g. grief of dead person, business worry etc. could be a contributing factor.

3.6 Prevention of Mental Illness

Until there is a clear definition of mental illness, it will be difficult to know exactly what preventive measures are required. However, there are some clues that suggest that a child needs to be provided with emotional warmth, support and security to provide for the emotional and social growth of his personality.

One approach to preventing mental illness in individuals living in a community is to improve the environmental and social conditions existing in the community. A stable, secure, loving family life assists individuals to develop attitudes about self and others that make it possible to adjust to the pressures of adulthood and to live a satisfying and productive life.

Many authorities believe that prevention of mental illness will not be achieved on a widespread scale until efforts are directed at improving the quality of life for all persons in our society. These authorities conclude that many of our social problems such as poor housing, racial, religious and sexual discrimination and unavailability of quality healthcare to all are major elements in the cause of mental illness. Therefore, these persons support broad social reform programs designed to alter the basis of these social ills.

Prevention of mental illness has been an important goal of epidemiologists in public health. Preventive psychiatry is characterized by three types of prevention (Caplan, 1964). Primary Prevention reduces or eliminates the incidence of symptoms and signs of mental disorders; it stops illness (morbidity) and perhaps mortality before it occurs. Secondary prevention reduces the prevalence of mental illness without directly altering its incidence by early treatment of acute cases, reducing the duration of illness and its associated morbidity and mortality. Tertiary prevention reduces the morbidity and mortality rates associated with mental disorders by rehabilitation, the incidence and prevalence of the disorders are not affected, although pain and suffering may be relieved.

Effective prevention requires specifying the disorder or problem to be prevented, demonstrating risk factors and identifying and evaluating proposed interventions. Psychiatric epidemiology provides the specific basis of preventive psychiatry.

Primary prevention of organic mental disorders and mental retardation has benefited from epidemiological data. Some investigators have expanded the concept of primary prevention to include Health Prevention through activities that improve the quality of life and prepare individuals in a general way for adapting to life stresses.

4.0 CONCLUSION

The various causes of psychiatric disorders are interrelated, so no single cause can be considered as an entity when seeking the cause of mental disorder. Thus, the learner must explore all the causes and proper understanding of these causes will assist in no small measure in the prevention of mental illness in our society.

5.0 SUMMARY

In this unit, we looked at causes of mental illness such as predisposing and exciting causes with the preventive measures. It is hoped that you have increased your knowledge by going through this unit.

6.0 TUTOR-MARKED ASSIGNMENT

Differentiate between predisposing and exciting causes of mental illness.

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SELF ASSESSMENT EXERCISE III

Discuss the psychological causes of mental illness

ANSWER

Some social factors are of great importance and may lead to mental breakdown. Unemployment leads to reduction in income which may cause malnutrition through lack of food. A predisposed individual develops mental illness, whereas in the individual who shows no predisposition, apart from a natural depression and anxiety regarding his family, no symptoms may occur. Environmental stresses resulting from industrialization, mechanization, and increased competition for jobs contribute to the incidence of mental illness. Sudden stress e.g. grief of dead person, business worry etc. could be a contributing factor.

MODULE 2 PSYCHIATRIC EMERGENCIES AND DISORDER OF CHILDHOOD PSYCHIATRIC

UNIT 1 PSYCHIATRIC EMERGENCIES

CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
    3.1 Introduction – Psychiatric Emergencies
    3.2 Common Psychiatric Emergencies
        3.2.1 Suicidal Attempt
        3.2.2 Violent, Aggressive Behaviour and Excitement
        3.2.3 Panic Attacks
        3.2.4 Stupor and Catatonic Syndrome
        3.2.5 Hysterical Attacks
        3.2.6 Transient Situational Disturbances
    3.3 Organic Psychiatric Emergencies
        3.3.1 Delirium Tremens
        3.3.2 Epileptic Furor
        3.3.3 Acute Drug Induced Extra pyramidal Syndrome
        3.3.4 Drug Toxicity
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR-MARKED ASSIGNMENT
7.0 REFERENCES/FURTHER READING

1.0 INTRODUCTION

This unit will expose the learners to a number of psychiatric emergencies in which the patient requires immediate intervention.

2.0 OBJECTIVES

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

- list some psychiatric emergencies
- describe five of the identified psychiatric emergencies
- explain the organic psychiatric emergencies.

3.0 MAIN CONTENT

3.1 Introduction – Psychiatric Emergencies

Psychiatric emergency is a condition wherein the patient has disturbances of thought, affect and psychomotor activity leading to a threat to his existence (suicide), or threat to the people in the environment (homicide). This condition needs immediate intervention

to safeguard the life of the patient, bring down the anxiety of the family members and enhance emotional/physical security to others in the environment.

3.2 Common Psychiatric Emergencies

3.2.1 Suicidal Attempt

In psychiatry a suicidal attempt is considered to be one of the commonest emergencies. Suicide is a type of deliberate self-harm and is defined as an intentional human act of killing oneself.

Etiology

The following are some of the possible causes of suicide:

- Psychiatric disorders
- Major depression
- Schizophrenia
- Drug or alcohol abuse
- Dementia
- Delirium
- Personality disorder
- Patients with incurable or painful physical disorders like cancer and AIDS.
- Psychological factors
- Failure in examination
- Dowry difficulties
- Marital difficulties
- Loss of loved ones/object
- Isolation and alienation from social groups
- Financial and occupational difficulties.

Risk factors for suicide

- Age

males above 40 years of age
females above 55 years of age

- Sex

men have greater risk of completed suicide osuicide is 3 times more common in men than women
women have higher rate of attempted suicide

Being unmarried, divorced, widowed or separated

Having a definite suicidal plan

History of previous suicidal attempts

Recent losses.

Management

1. Be aware of certain signs which may indicate that the individual may commit suicide, such as:

- Suicide threat
- writing fare well letters
- giving away treasured articles
- making a will
- closing bank accounts
- appearing peaceful and happy after a period of depression
- refusing to eat or drink, maintain personal hygiene.

Monitoring the patient's safety needs:

- take all suicidal threats or attempts seriously and notify a psychiatrist
- search for toxic agents such as drugs/alcohol
- do not leave the drug tray within reach of the patient, make sure that the daily medication is swallowed
- remove sharp instruments such as razor blades, knives, glass
- bottles
- remove straps and clothing such as belts, neckties
- do not allow the patient to bolt his door on the inside, make sure that somebody accompanies him to the bathroom
- patient should be kept in constant observation and should never be left alone
- have good vigilance especially during morning hours
- spend time with him, talk to him, and allow him to ventilate his feelings
- encourage him to talk about his suicidal plans/methods
- if suicidal tendencies are very severe, sedation should be given as prescribed.

Encourage verbal communication of suicidal ideas as well as his/her fear and depressive thoughts. A „no suicidal" pact may be signed, which is a written agreement between the patients and the nurse, that client will not act on suicidal impulses, but will approach the nurse to talk about them.

Enhance self-esteem of the patient by focusing on his strengths rather than weaknesses. His positive qualities should be emphasised with realistic praise and appreciation. This fosters a sense of self-worth and enables him to take control of his life situation.

3.2.2 Violent, Aggressive Behaviour and Excitement

This is a severe form of aggressiveness. During this stage, patient will be irrational, uncooperative, delusional and assaultive.
Etiology

Organic psychiatric disorders like delirium, dementia, and Wernicke-Korsakoff's psychosis.

Other psychiatric disorders like schizophrenia, mania, agitated depression, withdrawal from alcohol and drugs, epilepsy, acute stress reaction, panic disorder and personality disorders.

Management

- An excited patient is usually brought tied up with a rope or in chains. The first step should be to remove the chains.
- Talk to the patient and see if he responds. Firm and kind approach by the nurse is essential.
- Usually sedation is given. Common drugs used are: diazepam 10- 20mg, IV; haloperidol 10-20mg; chlorpromazine 50-100mgIM.
- Once the patient is sedated, take careful history from relatives; rule out the possibility of organic pathology. In particular check for history of convulsions, fever, recent intake of alcohol, fluctuations of consciousness.
- Carry out complete physical examinations.
- Send blood specimens for hemoglobin, total cell count etc.
- Look for evidence of dehydration and malnutrition. If there is severe dehydration, glucose saline drip may be started.
- Have less furniture in the room and remove sharp instruments, ropes, glass items, ties, strings, match boxes, etc. from patient's vicinity.
- Keep environmental stimuli, such as lighting and noise levels to a minimum; assign single room; limit interactions with others.
- Remove hazardous objects and substances; caution the patient when there is possibility of an accident.
- Stay with the patient as hyperactivity increases to reduce anxiety level and foster a feeling of security.
- Redirect violent behaviour with physical outlets such as exercise, out door activities.
- Encourage the patient to „talk out" his aggressive feelings, rather than acting them out.
- If the patient is not calmed by talking down and refuses medications, restraints may become necessary.

- Following application of restraints, observe patient every 15 minutes to ensure that nutritional and elimination needs are met. Also observe for any numbness, tingling or cyanosis in the extremities. It is important to choose the least restrictive alternative as far as possible for these patients.

Guidelines for self-protection when handling an aggressive patient:

- never see a potentially violent personal one
- keep a comfortable distance away from the patient (arm-length)
- be prepared to move, a violent patient can strike out suddenly
- maintain a clear exit route for both the staff and patient
- be sure that the patient has no weapons in his possession before approaching him
- if patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away
- keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon
- distract the patient momentarily to remove the weapon (throwing water in the patient's face, yelling etc.)
- give prescribed antipsychotic medications.

3.2.3 Panic Attacks

Episode of acute anxiety and panic can occur as a part of psychotic or neurotic illness. The patient will experience palpitations, sweating, tremors, feelings of choking, chest pain, nausea, abdominal distress, and fear of dying, paresthesias, chills or hot flushes.

Management

- Give reassurance first.
- Search for causes.
- Diazepam 10mg or Lorazepam 2mg may be administered.

3.2.4 Stupor and Catatonic Syndrome

Stupor is a clinical syndrome of alkinesis and mutism but with relevant preservation of conscious awareness. Stupor is often associated with catatonic signs and symptoms (catatonic withdrawal or catatonic stupor). The various catatonic signs include mutism, negativism, stupor, ambitendency, echolalia, echopraxia, automatic obedience, posturing, mannerisms, stereotypies etc.

Management

- Ensure patent airway.

- Administer I. V.fluids.
- Collect history and perform physical examination.
- Draw blood for investigations before starting any treatment.
- Other care is same as that for an unconscious patient.

3.2.5 Hysterical Attacks

A hysteric may mimic abnormality of any function, which is under voluntary control. The common modes of presentation may be:

- Hysterical fits
- Hysterical ataxia
- Hysterical paraplegia.
- All presentations are marked by a dramatic quality and sadness of mood.

Management

- Hysterical fit must be distinguished from genuine fits.
- As hysterical symptoms can cause panic among relatives, explain to the relatives the psychological nature of symptoms. Reassure that no harm would come to the patient.
- Help the patient to realise the meaning of the symptoms and help him find alternative ways of coping with stress.
- Suggestion therapy with I.V Pentothal may be helpful in some cases.

3.2.6 Transient Situational Disturbances

These are characterized by disturbed feelings and behaviour occurring due to overwhelming external stimuli.

Management

- Reassurance.
- Mild sedation if necessary.
- Allowing the patient to ventilate his/her feelings.
- Counseling by an understanding professional.

3.3 Organic Psychiatric Emergencies

3.3.1 Delirium Tremens

Delirium tremens is an acute condition resulting from alcohol withdrawal from alcohol.

Management

- Keep the patient in a quiet and safe environment.
- Sedation is usually given with diazepam 10mg or Lorazepam 4mg IV, followed by oral administration.
- Maintain fluid and electrolyte balance.
- Reassure patient and family.

3.3.2 Epileptic Furor

Following epileptic attack patient may behave in a strange manner and become excited and violent:

Management

Sedation: Inj. Diazepam 10mg IV [or] Inj. Luminal 10mg I. V.
followed by oral anti-convulsants.

Haloperidol 10mg I. V. helps to reduce psychotic behaviour.

3.3.3 Acute Drug-Induced Extrapyramidal Syndrome

Antipsychotics can cause a variety of movement related side-effects, collectively known as extrapyramidal symptoms (EPS). Neuroleptic malignant syndrome is rare but most serious of these symptoms and occurs in a small minority of patients taking neuroleptics, especially high potency compounds.

Management

The drug should be stopped immediately. Treatment is symptomatic and includes cooling the patient, maintaining fluid and electrolyte balance and treating inter current infections. Diazepam can be used for muscle stiffness. Dantrolene, a drug used to treat malignant hyperthermia, bromocriptine, amantadine and L-dopa have been used.

3.3.4 Drug Toxicity

Drug over-dosage may be accidental or suicidal. In either case all attempts must be made to find out the drug consumed. A detailed history should be collected and symptomatic treatment instituted.

A common case of drug poisoning is lithium toxicity. The symptoms include drowsiness, vomiting, abdominal pain, confusion, blurred vision, acute circulatory failure, stupor and coma, generalized convulsions, oliguria and death.

Management

- Administer Oxygen.

- Start I.V line.
- Assess for cardiac-arrhythmias.
- Refer for haemidialysis.
- Administer anti-convulsants.

4.0 CONCLUSION

Both common psychiatric emergencies and organic psychiatric emergencies are subjects of concern to the mental health service providers, the family members and the society at large. So adequate understanding and pragmatic approach of the service providers will go a long way in assisting the affected individuals.

5.0 SUMMARY

The unit has taken the learners through both common and organic psychiatric emergencies and it is our hope that the knowledge of the learners has been enhanced.

6.0 TUTOR-MARKED ASSIGNMENT

Differentiate between common psychiatric emergencies and organic psychiatric emergencies.

7.0 REFERENCES/FURTHER READING

Morrison, M. (1997). *Foundations of Mental Health Nursing*. Philadelphia: Mosby.

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SELF ASSESSMENT EXERCISE IV

1. Enumerate at least 10 causes of suicide in Nigeria
2. List five (5) common psychiatric emergencies

ANSWER:

1. Causes of suicide in Nigeria
   - Psychiatric disorders
   - Major depression
   - Schizophrenia
   - Drug or alcohol abuse
   - Dementia
   - Delirium
   - Personality disorder

- Patients with incurable or painful physical disorders like cancer and AIDS.
- Psychological factors
- Failure in examination
- Dowry difficulties
- Marital difficulties
- Loss of loved ones/object
- Isolation and alienation from social groups
- Financial and occupational difficulties.

2. Common psychiatric emergencies
    a. Suicidal Attempt
    b. Violent, Aggressive Behaviour and Excitement
    c. Panic Attacks
    d. Stupor and Catatonic Syndrome
    e. Hysterical Attacks
    f. Transient Situational Disturbances
    g. Delirium Tremens
    h. Epileptic Furor
    i. Acute Drug Induced Extra pyramidal Syndrome
    j. Drug Toxicity

UNIT 2 DISORDERS OF CHILDHOOD PSYCHIATRY I

CONTENTS

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    3.1 Introduction
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7.0 REFERENCES/FURTHERREADING

1.0 INTRODUCTION

The next three units will expose the learners to a field of child psychiatry which is new to the 20th century. This unit will cover the classification of childhood psychiatric disorders, mental retardation and disorders of psychological development.

2.0 OBJECTIVES

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

- classify childhood psychiatric disorders
- explain the concept of mental retardation
- describe the care and rehabilitation of the mentally retarded
- list the disorders of psychological development.

3.0 MAIN CONTENT

3.1 Introduction

The field of child psychiatry is new to the 20th century and child psychiatric nursing evolved gradually as the therapeutic value of nurses‟ relationships with children began to be realised. In 1954, the first graduate programme in child psychiatric nursing was opened. Advocates of Child Psychiatry (ACPN), which is the professional organisation for this nursing specialty was established in 1971 and the first ANA certification of child psychiatric nurses took place in 1979. The ANA‟s Standards of child and adolescent psychiatric and mental health nursing practice were published in 1985.

The child psychiatric nurse uses a wide range of treatment modalities, including milieu therapy, behaviour modification, cognitive behaviour therapy, therapeutic play, group

and family therapy and pharmacological agents. Child psychiatric nursing is different from adult psychiatric nursing in the following ways:

It is seldom that children initiate a consultation with the clinician. Instead, they are brought by adults, usually the parents, who think that some aspects of behaviour or development are abnormal.

The child's stage of development determines whether behaviour is normal or abnormal. For instance, bedwetting is normal at the age of three years but abnormal when the child is seven. Thus, greater attention should be paid to the stage of development of the child and the duration of the disorder.

Children are generally less able to express themselves in words; therefore evidence of the disturbance is based more on the observations of behaviour made by parents, teachers and others.

The treatment of children makes use of less medications or other method of individual treatment. Main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with family and coordinating the efforts of others who can help children especially at school.

3.2 Classification

Mental retardation (F7)

Disorders of psychological development (F8)

- Specific developmental disorders of speech and language.
- Specific developmental disorders of scholastic skills.
- Specific developmental disorders of motor function.
- Pervasive developmental disorders.

Behavioural and emotional disorders with onset occurring in childhood and adolescence (F9)

- Hyperkinetic disorders.
- Conduct disorders.
- Emotional disorders:
  - Separation anxiety disorder of childhood
  - Phobic anxiety disorder of childhood
  - Social anxiety disorder of childhood
  - Sibling rivalry disorder.
- Disorder of social functioning:
  - Elective mutism.
- Tic disorders.

- Other behavioural and emotional disorders in childhood and adolescence:
  - Non-organic enuresis
  - Non-organic encopresis
  - Feeding disorders of infancy and childhood
  - Stereotyped movement disorders
  - Stuttering.

3.3 Mental Retardation

Definition

"Mental retardation refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period" (American Association on Mental Deficiency, 1983).

"General intellectual functioning" is defined as the result obtained by the administration of standardised general intelligence tests developed for the purpose, and adopted to the conditions of the region/country.

"Significant sub average" is defined as an Intelligence Quotient (IQ) of 70 or below on standardised measure of intelligence. The upper limit is intended as a guideline and could be extended to 75 or more, depending on the reliability of the intelligence test used.

"Adaptive behaviour" is defined as the degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The expectations of adaptive behaviour vary with the chronological age. The deficits in adaptive behaviour may be reflected in the following areas:

During infancy and childhood in:

- sensory and motor skill development
- communication skill (including speech and language)
- self-help skills
- socialisation.

During childhood and adolescence in:

- application of basic academic skill to daily life activities
- application of appropriate reasoning and judgment in the mastery of the environment
- social skills.

During late adolescence in:

- vocational and social responsibilities and performance

"Developmental period" is defined as the period of time between conception and the 18th birthday.

Etiology

Genetic Factors

Chromosomal abnormalities

- Down syndrome
- Fragile X syndrome
- Trisomy X syndrome
- Cat-cry syndrome
- Prader-willi syndrome

Metabolic disorders

- Phenylketonuria
- Wilson's disease
- Galactosemia

Cranial malformation

- Hydrocephaly
- Microdephaly

Gross disease of brain

- Tuberculosis scleroses
- Neurofibromatosis
- Epilepsy

Prenatal Factors

Infections

- Rubella
- Cytomegalovirus
- Syphilis
- Toxoplasmosis, herpes simplex

Endocrine disorders

- Hypothyroidism
- Hyperparathyroidism
- Diabetes mellitus

Physical damage and disorders

- Injury
- Hypoxia
- Radiation
- Anemia
- Emphysema

Intoxication

- Lead
- Certain drugs
- Substance abuse

Placental dysfunction

- Toxemia of pregnancy
- Placenta previa
- Cord prolapsed
- Nutritional growth retardation

Perinatal Factors

- Birth asphyxia
- Prolonged or difficult birth
- Prematurity (due to complications)
- Kernicterus
- Instrumental delivery (resulting on head injury, intraventricular hemorrhage)

Postnatal Factors

- Infections
  - Encephalitis
  - Measles
  - Meningitis
  - Septicemia
- Accidents
- Lead poisoning

Environmental and Sociocultural Factors

- Cultural deprivation
- Low socio-economic status
- Inadequate caretakers
- Child abuse

Classification

Mental retardation is classified into the following levels based on the intelligent quotient of individuals.

Intelligent Quotient (IQ)

Mild (Educable)	50-70
Moderate (Trainable)	35-50
Severe (Dependent retarded)	20-35
Profound (Life support)	<20

Behavioural Manifestations
Mild Retarded (I.Q.50-70)

This is commonest type of mental retardation accounting for 85 to 90 percent of all cases. These individuals have minimal retardation in sensory-motor areas. They often progress up to Primary six of formal education can achieve vocational and social self-sufficiency with a little support. They can develop social and communication skills, but have deficits in cognitive function like poor ability for abstraction and egocentric thinking.

Moderate Retardation (I.Q. 35-50)

About 10 per cent of the mentally retarded come under this group. Communication skills develop much slowly in these individuals. They can be trained to support themselves by performing semiskilled or unskilled work under supervision.

Severe Retardation (I.Q. 20-35)

Severe mental retardation is often recognised early in life with poor motor development and absent or markedly delayed speech and communication skills. There is a possibility of teaching some skills in ADL skills with long-term consistent behaviour modification. But most of them require a great deal of assistance and structured living arrangements.

Profound Retardation (I.Q. <20)

This group account for one to two per cent of all mentally retarded. The achievement of developmental milestones is markedly delayed. They require constant nursing care/supervision. Associated physical disorders are common.

Diagnosis

- History collection from parents and caretakers
- Physical examination
- Neurological examination
- Assessing milestones development
- Investigations
  - urine and blood examination for metabolic disorders
  - cultural for cytogenic and biochemical studies
  - amniocentesis in infant chromosomal disorders
  - chorionic villi sampling
- Hearing and speech evaluation
- EEG, especially if seizures are present
- CT scan or MRI brain e.g. in tuberculosis

- Thyroid function tests when cretinism is suspected
- Psychological tests like Stanford Binet Intelligence Scale and Wechsler Intelligence Scale For Children (WISC), for categorising the child's disability.

Through psychological testing, the child's mental age is estimated. The Intelligence Quotient is then determined using the formula:

$$\frac{\text{Mental Age (M.A.)}}{\text{Chronological Age (C.A.)}} \times 100$$

Prognosis

The prognosis for children with mental retardation has improved and institutional care is no longer recommended. These children are mainstreamed whenever feasible and are taught survival skills. A multidimensional orientation is used when working with these children, considering their physiological, cognitive, social and emotional development.

Primary Prevention

Preconception

- Genetic counseling, which is an attempt to determine risk of occurrence or recurrence of specific genetic or chromosomal disorders; parents can then make an informed decision as to the risks of having a retarded child.
- Immunisation for maternal rubella.
- Adequate maternal nutrition can lay a sound metabolic foundation for later childbearing.

- Family planning in terms of size, appropriate spacing and age of parents can also affect a variety of specific causal agents.

During Gestation

Two general approaches to prevention are associated with this period:

a. Prenatal care
b. Analysis of foetus for possible genetic disorders.

a. Prenatal care

- Adequate nutrition, foetal monitoring and protection from disease.
- Avoidance of teratogenic substances like exposure to radiation and consumption of alcohol and drugs.

b.Analysis of foetus

- By amniocentesis, fetoscopy, foetal biopsy and ultrasound.

At delivery

- Delivery conducted by expert doctors and staff, especially in the cases of high-risk pregnancy (e.g. maternal conditions of diabetes, hypertension, etc.)
- Apgar scoring done at one and five minutes after the birth of the child.
- Close monitoring of mother and child.
- Injection of gamma globulin, which can prevent Rh-negative mothers from developing antibodies that might otherwise affect subsequent children.

Childhood

- Proper nutrition throughout the developmental period and particularly during the first six months after birth.
- Dietary restrictions for specific metabolic disorders until no longer needed.
- Avoidance of hazards in the child's environment to avert brain damage from causes such as lead poisoning, ingestion of chemicals or accidents.

Secondary Prevention

- Early detection and treatment of preventable disorders. For example, phenylketonuria and hypothyroidism can be effectively treated at an early stage by dietary control or hormone replacement therapy.
- Early recognition of presence of mental retardation. A delay in diagnosis may cause unfortunate delay in rehabilitation.

- Psychiatric treatment for emotional and behavioural difficulties.

Tertiary Prevention

This includes rehabilitation in vocational, physical and social areas according to the level of handicap. Rehabilitation is aimed at reducing disability and providing optimal functioning in a child with mental retardation.

Care and Rehabilitation of the Mentally Retarded

The main elements in a comprehensive service for mentally retarded individuals and their families include:

- the prevention and early detection of mental handicaps
- regular assessment of the mentally retarded person's attainments and disabilities
- advice, support and practical measures for families
- provision for education, training, occupation or work appropriate for each handicapped person
- housing and social support to enable self-care
- medical, nursing and other services for those who require them as outpatients, day patients or inpatients
- psychiatric and psychological services.

General provision

The general approach to care is educational and psychosocial. The family doctor and pediatrician are mainly responsible for the early detection and assessment of mental retardation. The team providing continuing healthcare also includes psychologists, speech therapists, nurses, occupational therapists and physio-therapists.

The mildly retarded

A few mildly retarded children require fostering, boarding school placements or residential care, but usually specialist services are not required. Mildly retarded adults may need help with housing, employment or with the special problems of old age.

The severely retarded

In case of children, some require special services throughout their lives, which may include a sitting service, day respite during school holidays, or overnight stays in a foster family or residential care. In case of adults, provisions are required for work, occupation, housing, adult education, etc. The main principle now guiding the provision of resources

is that the retarded person should be given sufficient help to be able to use the usual community services, rather than to provide specialist segregated services.

Education and training: The aim is that as many mentally retarded children as possible are educated in ordinary schools either in normal classes or in special classes. There is now an increasing use of more specialist teaches and a variety of innovative procedures for teaching language and other methods of communication. Before leaving school, these children require reassessment and vocational guidance.

Hints for successful skill training:

- Divide each training activity into small steps and demonstrate.
- Give the mentally retarded person repeated training in each activity.
- Give the training regularly and systematically: Do not let parents get impatient.

- Start the training with what the child already knows and then proceed to the skills that need to be trained. By this the child will have a feeling of success and achievement.
- Reward his efforts even if the child attains near success, by appreciation or with something that he likes.
- Reduce the reward gradually as he masters a skill and takes up another skill for training.
- Use the training materials which are appropriate, attractive and locally made.
- Remember, children learn better from children of the same age. Therefore, try and involve normal children of the same age in training the mentally retarded child, after orienting the normal child appropriately.
- Remember, there is no age limit for training a mentally retarded person.
- Assess the child periodically, preferably once in four or six months.
- Remember, a mentally retarded child learns very slowly. Tell the parents not to be dejected at the slow process, nor feel threatened by the child's failure.

Vocational training

The activities included in vocational training are working preparation, selective placement, post placement and follow up.

MITRA Special School and Vocational Training Centre for the Mentally Retarded, is an example of vocational training.

Help for families: Help for families is needed from the time that the diagnosis is first made; adequate time must be allowed to explain the prognosis; indicate what help can be provided and discuss the part that the parents can play in helping their child to achieve full potential. When the child starts school, the parents should not only be kept informed about his progress, but should feel involved in the planning and provision of care.

Families are likely to need extra help when the child is approaching puberty or leaving school; both day and overnight cares are often required to relieve caregivers and to encourage the retarded person to become more independent.

Stages in Parent Counselling

Stage 1: Impart information regarding the condition of the mentally retarded child. Avoid giving misleading information or building false hopes in the parents.

Stage 2: Help the parents to develop right attitudes towards their mentally retarded child (to prevent overprotection, rejection, pushing the child too had). Handle guilt feelings in parents.

Stage 3: Create awareness in the parents regarding their role in training the child. The parents should be made to realise that training a mentally retarded child does not need complex skills and with repeated training in simple steps, the child can learn.

Parents are taught behaviour modifications techniques to decrease or eliminate problematic behaviours, increase adaptive behaviours and develop new skills. Some of these techniques include positive reinforcement, shaping, prompting, modelling, extinction procedures etc.

Parents should demonstrate how their training has helped their child to acquire new skills. This will give them a sense of achievement, thus making them more involved in the care.

Some questions parents ask

1. **Is mental retardation same as mental illness?**

No. Mentally retarded persons are not mentally ill. The mentally retarded person is just slow in their development.

2. **Is mental retardation curable?**

No. Mental retardation is a condition which cannot be cured. But timely and appropriate intervention can help the mentally retarded person to learn several skills.

3. **Can marriage solve the problems of mental retardation?**

No. Many people think that after marriage, the mentally retarded person will become active and responsible, or sexual satisfaction will cure the person. That is not so. Marriage will only further complicate the problem. When it is known that a mentally retarded person cannot be totally independent, it will not be possible for him/her to look after his/her family.

4. **Do mentally retarded persons become normal as they grow older?**

No. The mentally retarded person's mental development is slower than that of a normal person. Therefore, when their actual age increases with time, the mental development does not occur at the same pace to catch up with the actual age.

5. Is mental retardation an infectious disease?

No. Many people think that by allowing normal children to mix, eat or play with mentally retarded children, the normal children will also develop mental retardation. This is wrong. Interaction between mentally retarded children and normal children on the other hand, helps in the improvement of mentally retarded children.

6. Is it true that the mentally retarded persons cannot be taught anything?

No. Mentally retarded persons can be taught many things, but they need to be trained systematically. They can perform many jobs under supervision.

7. Is it true that mental retardation is due to karma and hence nothing can be done about it?

No. Believing that mental retardation is due to their karma helps the parents to be free from the feelings of guilt. Parents must be told that whatever may be the cause, training the child will improve the condition. And the earlier the training, the better the chances of improvement.

Residential Care: Parents should be supported in caring for their retarded children at home, or if the work is too heavy a burden for them, the child should be cared for in daycare centres, half way homes etc.

Specialist medical services: Retarded children and adults often have physical handicaps or epilepsy for which continuing medical care is needed.

Psychiatric services: Expert psychiatric care is an essential part of a comprehensive community service for the mentally retarded.

Nursing Management

Assessment

- Assessment of early infant behaviours to indicate a cognitive disability among high-risk children should be closely observed (e.g. children born to elderly primips, birth trauma etc.); early infant behaviours that may indicate a cognitive disability include non-responsiveness to contact, poor eye contact during feeding,

slow feeding, diminished spontaneous activity, decreased responsiveness to surroundings, decreased alertness to voice or movement and irritability.

- Documentation of daily living skills.
- A careful family assessment for information on:
- the family's response to the child
- presence of other members with impaired cognition in the family
- degree of independence encouraged at home
- stability of the family unit.

- **Psychological assessment:** This is directed at the interaction between the individual and people who are closely involved in care and determining the correct needs and wishes for the future. It should examine opportunities for learning new skills, making relationships, and achieving maximum choice about the way of life.

Intervention

- The long-term goals for these children are highly individualized and are dependent on the level of mental retardation. Parents should be involved in establishing realistic goals for their mentally retarded child. Some of these goals can be:
  - the child dresses himself
  - the child maintains continence of stool and urine
  - the child demonstrates acceptable social behaviours
  - the adolescent participates in a structured work programme.
- Early intervention programmes are essential to maximise the children's potential development. This necessitates early recognition and referral. Nurses have an opportunity to evaluate children in the nursery, in the clinic during well-child healthcare, in schools and during acute management. The potential of each child will vary according to the degree of mental retardation. The key for success is that the child's strengths and potential abilities are emphasised rather than deficits.
- The nurse can participates in programmes that teach infant stimulation, activities of daily living and independent self-care skills. A successful technique in the treatment of the mentally retarded is operant conditioning. It focuses on changing or modifying the individual's response to the environment by reinforcing certain desirable patterns of behaviour or eliminating undesirable patterns.
- In addition, learning social skills and adaptive behaviours assist the child in building a positive self-image. For older children and adolescents assistance is needed to prepare them for a productive work life.
- Sexuality becomes a major concern, as these children may form emotional attachment to those of the opposite sex and have normal sexual desires. However, their decision making skills are limited.
- In all instances, it is important for the nurse to maintain a non- threatening approach. Very often these children do not understand why physical assessment, therapeutic approaches and evaluative measures are needed. Proper explanation and relevant information should be given to the parents and their help should be

enlisted in bringing out the best out of the child. Close collaboration with all members of the team involved in the care of the child is highly essential for a successful outcome. To a large extent the nurse is responsible for the emotional climate of the setting in which she is employed

3.4 Disorders of Psychological Development

Specific developmental disorders of speech and language

These are disorders in which normal patterns of language acquisition are disturbed from the early stages of development. The conditions are not directly attributable to neurological or speech mechanism abnormality or mental retardation. It includes developmental language disorder or dysphasia, developmental articulation disorder or phonological disorder or dyslalia, expressive language disorder, receptive language disorder and other developmental disorders of speech and language.

Specific developmental disorders of scholastic skills

Specific developmental disorders of scholastic skills are divided further into specific reading disorder, specific spelling disorder and specific arithmetic disorder.

Specific reading disorders (dyslexia) should be clearly distinguished from general backwardness in scholastic achievement resulting from low intelligence or inadequate education. It is characterised by a slow acquisition of reading skills, slow reading speed, impaired comprehension, word omissions and distortions and letter reversals.

The main feature of the *specific spelling disorder* is significant impairment in the development of spelling skills in the absence of a history of specific reading disorder. The ability to spell orally and to write out words correctly is both affected.

Specific arithmetic disorder involves deficit in basic computational skills of addition, subtraction, multiplication and division.

Specific development disorders of motor function

Children with this disorder have delayed motor development, which is below the expected level on the basis of their age and general intelligence. The main feature of this disorder is a serious impairment in the development of motor coordination, which results in clumsiness in school work or play.

Pervasive developmental disorders

The term Pervasive Developmental Disorders (PDD) refers to a group of disorder characterised by abnormalities in communication and social interaction and by restricted repetitive activities and interests. These abnormalities occur in a wide range of situations,

usually development is abnormal from infancy and most cases are manifest before the age of five years. PDD includes childhood autism, a typical autism, Rett's syndrome, Asperger's syndrome, childhood disintegrative disorder and other pervasive developmental disorders.

Epidemiology

Prevalence is 4-5/10, 000 in children under 16 years of age. Male to female ratio is 4 or 5 to 1. The disorder is evenly distributed across all socio-economic classes.

Childhood autism

In 1908, Heller from Australia reported six cases of disintegrative psychoses with onset in the third or fourth year of life in children whose development was normal. Kenner (1943) identified a relatively homogenous group of children with onset of psychoses in the 1st and
2nd year of life that he designated early "infantile autism" and "autistic disturbances of affect contact". Lauretta Bender first used the term "childhood schizophrenia" to characterise psychotic children. Now all these terms have been replaced and the condition is currently known as Childhood Autism in ICD10, or Autistic Disorder in DSM IV.

Etiology

Genetic factors The higher concordance rate in monozygotic than dizygotic twins (36% vs 0%) suggests a genetic factor. Siblings of autistic children show a prevalence of autistic disorder of two per cent (50 times over expected prevalence).

Biochemical factors At least 1/3rd of patients with autistic disorder have elevated plasma serotonin.

Medical factors There is an elevated incidence of early development problems such as post-natal neurological infections (meningitis, encephalitis), congenital rubella and cytomegalovirus, phenylketonuria and rarely perinatal asphyxia. The other inborn errors of metabolism associated with autism are tuberous sclerosis and neurofibromatosis. About two to five per cent appears to have Fragile X chromosome syndrome. Neurological abnormalities are present in about one-quarter of cases.

Perinatal factors During gestation maternal bleeding after the first trimester and meconium in the amniotic fluid have been reported in the histories of autistic children. There is also a high incidence of medication usage during pregnancy in the mothers of autistic children.

Psychodynamic and parenting influences and social environment Some of the specific causative factors proposed in these theories are parental rejection, child

responses to deviant parental personality characteristics, family break up, family stress, insufficient stimulation
and faulty communication patterns (Schreibman & Charlop, 1989). Kanner (1973) in his studies, describe the parents of autistic children as educated upper class individuals, involved in career and intellectual pursuits, who were aloof, obsessive and emotionally cold. The term „refrigerator parents", was coined to describe their lack of warmth and affectionate behaviour. Mahler and associates (1975) suggested that the autistic child is fixed in the pre-symbiotic phase of development. In this phase, the child creates a barrier between self and others. The normal symbiotic relationship between mother and child followed by the progression to separation/individualisation does not occur. Ego development is inhibited and the child fails to achieve a sense of self.

Theory-of-mind in autism: Theory-of-mind describes the developmental process whereby the child comes to understand others" mind or to anticipate what others may be thinking, feeling or intending.
Children with autistic disorder are sometimes said to be „mind-blind", in that they lack the ability to put themselves in the place of another person.

Electrophysiological changes Brain stem auditory evoked responses (BASRS) of autistic children showed impairment in sensory modulation at brain stem level.

Neuroanatomical studies These studies have shown an enlargement of lateral ventricles and cerebellar degeneration.

Behavioural characteristics

- Autistic aloofness (unresponsiveness to parent's affectionate behaviour, by smiling or cuddling).
- Gaze avoidance or lack of eye-to-eye contact.
- Dislikes being touched or kissed.
- No separation anxiety on being left in an unfamiliar environment with strangers.
- No or abnormal social play. Failure to play with peers and unable to make friends.
- Failure to develop empathy.
- Marked lack of awareness of the existence or feelings of others.
- Anger or fear without apparent reason and absence of fear in the presence of danger.

Communication and language

- Gross deficits and deviances in language development.
- No mode of communication such as babbling, facial expression, gestures, mimes etc.
- Absence of imaginative activity such as play acting of adult roles, fantasy characters of animals, lack of interest in imaginative stories.

- Marked abnormality in the production of speech (volume, pitch, stress, rhythm, rate etc.).
- Marked abnormalities in the form or content of speech including stereotyped or repetitive use of speech, use of „you‟ when „I‟ is meant, idiosyncratic use of phrases.
- Marked impairment in the ability to initiate or sustain a conversation with others despite adequate speech.

Activities

- Marked restricted, repertoire of activities and interests.
- Stereotyped body movements e.g. hand flicking or twisting, spinning, head banging etc.
- Persistent preoccupation with parts of objects (e.g. spinning wheels of toy cars) or attachment to unusual objects.
- Marked distress over changes in trivial aspects of environment.
- Markedly restricted range of interests and a preoccupation with one narrow interest.

Other features

- Autistic children are resistant to transition and change.
- Over-responsive or under-responsive to sensory stimuli.
- May have a heightened pain threshold or an altered response to pain.
- Other behavioural problems like hyperkinesis, aggression, temper tantrums, self-injurious behaviour, head banging, biting, scratching and hair pulling are common.
- Idiot Savant Syndrome: In spite of a pervasive or abnormal development of functions, certain functions may remain normal, e.g. calculating ability, prodigious remote memory, musical abilities, etc.
- Absence of hallucinations, delusions, loosening of associations as in schizophrenia.
- Kanner's "Autistic triad". Kanner said autistic aloofness, speech and language disorder and obsessive desire for sameness constitute a triad characteristic of infantile autism.

Course and prognosis

- Autistic disorder has a long course and guarded prognosis.
- About 10 to 20 per cent autistic children begin to improve between four to six years of age and eventually attend an ordinary school and obtain work.
- 10 to 20 per cent can live at home, but need to attend a special school or training center and cannot work.

- 60 per cent improve little and are unable to lead an independent life, mostly needing long-term residential care.
- Those who improve may continue to show language problem, emotional coldness and odd behaviour.

Treatment

- Pharmacotherapy is a valuable treatment for associated symptoms like aggression, temper tantrums, self-injurious behaviour, hyperactivity and stereotypies. Some drugs that have been used are risperidone, serotinin specific reuptake inhibitors, clomipramine and lithium. Antiepileptic medication is used for generalized seizures.

  Behavioural methods: Contingency management may control some of the abnormal behaviour of autistic children. The term contingency management refers to a group of procedures based on the principle that, if any behaviour persists, some of its consequences are reinforcing it. If these consequences can be altered, the behaviour will change. The parents instructed and supervised by a clinical psychologist often carry out this method at home.

Contingency management has the following stages:

- First the behaviour to be changed is defined and another person (usually a nurse, spouse or parent) is trained to record it; for example, a mother might count the number of times a child with learning difficulties shouts loudly.
- Second, the events that immediately follow (and therefore are presumed to reinforce the behaviour) are identified; for example, the parents may pay attention to the child when he shouts but ignore him at other times.
- Third, reinforcements are devised for alternative behaviours, for example, being approved or earning points by refraining from shouting for an agreed time. Staff or relatives are trained to provide the chosen reinforcements immediately after the desired behaviour and to withhold them at other times.
- As treatment progresses, records are kept of the frequency of the problem behaviours and of the desired behaviours.
- Although treatment is mainly concerned with the consequences of behaviour, attention is also given to changing any events that might be provoking the behaviour. For example, in a psychiatric ward, the abnormal behaviour of one child may be provoked on each occasion by the actions of another child.
- **Special schooling:** Most autistic children require special schooling and older adolescents many need vocational training.
- **Counselling and supportive therapy:** The family of an autistic child needs considerable help to cope with the child's behaviour which is often distressing.

Others: Development of a regular routine, positive reinforcements to teach self-care skills, speech therapy or sign language teaching, behaviour techniques to encourage interpersonal interactions.

Nursing management assessment

The following factors need to be considered in assessing an autistic child (Lord and Rutter, 1994):

- Cognitive level
- Language ability
- Communication skills, social skills and play and repetitive are other abnormal behaviour
- Stage of social development in relation to age, mental age and stage of language development
- Associated medical conditions
- Psychosocial factors.

Intervention

- Work with the child on a one-to-one basis.
- Protect the child when self-mutilative behaviour occurs. Devices such as helmet, padded mittens, or arm covers may be used.
- Try to determine if self-mutilative behaviour occurs in response to increasing anxiety, and if so, to what the anxiety may be attributed. Intervene with diversion or replacement activities as anxiety level starts to rise. These activities may provide needed feelings of security and substitute for self-mutilative behaviour.
- Assign limited number of caregivers to the child. Ensure warmth, acceptance and availability are conveyed.
- Provide child with familiar objects such as familiar toys of a blanket. Support child's attempts to interact with others.
- Give positive reinforcement for eye contact with something acceptable to the child (e.g. food, familiar object). Gradually replace with social reinforcement (i.e. touch, hugging).

Anticipate and fulfill the child' needs until communication can be established.

- Slowly encourage him to express his needs verbally. Seek clarification and validation.
- Give positive reinforcement when eye contact is used to convey nonverbal expressions or when the child tries to speak.
- Teach simple self-care skills by using behaviour modification techniques.
- Language training plays a big part in teaching autistic children. At first they have to learn the names of things by linking the name with the actual object. When teaching the word „table" they must see and feel a real table and lots of different tables, otherwise they may think that table refers to only that particular object. Look at the child's face and pronounce simple words. Ask the child to repeat the words. Show picture books and name the objects. Verbs like sitting, walking, running can be acted to show the child what these words mean.

- Autistic children have personal identity disturbance and need to be assisted to recognise separateness during self-care activities, such as dressing and feeding. The child should be helped to name own body parts. This can be facilitated with the use of mirrors, drawings and pictures of himself. Encourage appropriate touching of and being touched by others.
- The role of the parent is crucial for any intervention with the autistic child; the parent generally acts as a co-therapist and plays an integral role in treatment. The behaviour of their autistic child is often very distressing and parental counselling begins with clarification of the diagnosis and an explanation of the characteristics of the disorder. To effectively participate in the treatment programme, the parents must have acknowledged the extent of their child's handicap and be able to work with him at the appropriate developmental level.

A typical Autism

A pervasive developmental disorder that differs from autism in terms of either age of onset or failure to fulfill diagnostic criteria i.e. disturbance in reciprocal social interactions, communication and restrictive stereotyped behaviour is a typical autism. A typical autism is seen in profoundly retarded individuals.

Rett's Syndrome

A condition of unknown cause, reported only in girls. It is characterised by apparently normal or near-normal early development which is followed by partial or complete loss of acquired hand skills and of speech, together with deceleration in head growth, usually with an onset between 7 and 24 months of age.

Asperger's Syndrome

The condition is characterised by severe and sustained abnormalities of social behaviour similar to those of childhood autism with stereotyped and repetitive activities and motor mannerisms such as hand and finger twisting or whole body movements. It differs from autism in that there is no general delay or retardation of cognitive development orlanguage.

4.0 CONCLUSION

This unit looked at classification of childhood psychiatric mental disorder and disorders of psychological development in childhood.

5.0 SUMMARY

The understanding of learners in this new field of psychiatry will enhance their better management of childhood psychiatric disorders.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the disorders of psychological development.
2. Explain two of the disorders of psychological development.

7.0 REFERENCES/FURTHERREADING

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

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SELF ASSESSMENT EXERCISE V

Classify childhood psychiatric disorders

ANSWER:

Mental retardation (F7)

Disorders of psychological development (F8)

- Specific developmental disorders of speech and language.
- Specific developmental disorders of scholastic skills.
- Specific developmental disorders of motor function.
- Pervasive developmental disorders.

Behavioural and emotional disorders with onset occurring in childhood and adolescence (F9)

- Hyperkinetic disorders.
- Conduct disorders.
- Emotional disorders:
  - Separation anxiety disorder of childhood

- Phobic anxiety disorder of childhood
- Social anxiety disorder of childhood
- Sibling rivalry disorder.

• Disorder of social functioning:
  • Elective mutism.

• Tic disorders.

• Other behavioural and emotional disorders in childhood and adolescence:
  - Non-organic enuresis
  - Non-organic encopresis
  - Feeding disorders of infancy and childhood
  - Stereotyped movement disorders
  - Stuttering.

UNIT 3 DISORDERS OF CHILDHOOD PSYCHIATRY II

CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
3.1 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR-MARKED ASSIGNMENT
7.0 REFERENCES/FURTHERREADING

1.0 INTRODUCTION

This unit is a continuation of the last unit on disorders of childhood psychiatry. The focus of this unit is behavioural and emotional disorders with onset usually occurring in childhood and adolescence such as hyperkinetic disorder, conduct disorder, emotional disorders with onset specific to childhood, disorders of social functioning.

2.0 OBJECTIVES

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

- identify various behavioural and emotional disorders with onset in childhood and adolescence
- explain five of the behavioural and emotional disorders.

3.0MAIN CONTENT

3.1 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

Hyperkinetic disorder

Hyperkinetic disorder (Attention-Deficit Hyperactivity Disorder or ADHD in DSMIV) is a persistent pattern of inattention and or hyperactivity more frequent and severe that is typical of children at a similar level of development. The syndrome was first described by Heinrich Hoff in1854.

Epidemiology

A prevalence of 1.7 per cent was found among primary school children (Taylor et al, 1991). ADHD is four times more common in boys than in girls.

Etiology

i. Biological influences
ii. Genetic factors

- There is greater concordance in monozygotic than in dizygotic twins.

- Siblings of hyperactive children have about twice the risk of having the disorder as does the general population.

- Biological parents of children with the disorder have a higher incidence of ADHD than do adoptive parents.

Biochemical theory

A deficit of dopamine and norepinephrine has been attributed in the over activity seen in ADHD. This deficit of neurotransmitters is believed to lower the threshold for stimuli input.

Pre, peri and postnatal factors

- Prenatal toxic exposure, prenatal mechanical insult to the foetal nervous system.

- Prematurity, foetal distress precipitated or prolonged labour, perinatal asphyxia and low Apgar scores.

- Postnatal infections, CNS abnormalities resulting from trauma etc.

Environmental influences

- Environmental lead.

- Food additives, colouring preservatives and sugar have also been suggested as possible causes of hyperactive behaviour but there is no definite evidence.

Psychosocial factors

- Prolonged emotional deprivation.

- Stressful psychic events.

- Disruption of family equilibrium.

Clinical features

- Sensitive to stimuli, easily upset by noise, light, temperature and other environmental changes.

- At times the reverse occurs and the children are flaccid and limp, sleep more and the growth and development is slow in the first month of life.

- More commonly active in crib, sleep little.

- General coordination deficit.

- Short attention span, easily distractible.

- Failure to finish tasks.

- Impulsivity.

- Memory and thinking deficits.

- Specific learning disabilities.

In school

- Often fidgets with hands or feet or squirms in seat.

- Answers only the first two questions; often blurts out answers to questions before they have been completed.

- Unable to wait to be called on in school and may respond before everyone else.

- Has difficulty waiting turn in games or group situations.

- Often loses things necessary for tasks or activities at school.

Home

- Explosive or irritable.

- Emotionally labile and easily set off to laughter or tears.

- Mood is unpredictable.

- Impulsiveness and an inability to delay gratification.

- Often talks excessively.

- Often engages in physical dangerous activities without considering possible consequences (for example, runs into street without looking).

Diagnosis

- Detailed prenatal history and early developmental history.

- Direct observation, teacher's school report (often the most reliable), and parent's report.

Treatment

Pharmacotherapy

- CNS stimulants: Dextroamphetamine, methylphenidate, pemoline.

- Tricyclic antidepressants.

- Antipsychotics.

- Serotonin specific re-uptake inhibitions.

- Clonidine.

Psychological Therapies

- Behaviour modification techniques.

- Cognitive behavior therapy.

- Social skills training.

Nursing Intervention

- Develop a trusting relationship with the child. Convey acceptance of the child separate from the unacceptable behaviour.

- Ensure that patient has a safe environment. Remove objects from immediate area in which patient could injure self due to random hyperactive movements. Identify deliberate behaviours that put the child at risk for injury. Institute consequences for repetition of this behaviour. Provide supervision for potentially dangerous situations.

- Since there is non-compliance with task expectations, provide an environment that is as free of distractions as possible.

- Ensure the child's attention by calling his name and establishing eye contacts, before giving instruction.

- Ask the patient to repeat instructions before beginning at ask.

- Establish goals that allow patient to complete a part of the task, rewarding each step completion with a break for physical activity.

- Provide assistance on a one-to-one basis, beginning with simple concrete instructions.

- Gradually decrease the amount of assistance given to task performance, while assuring the patient that assistance is still available if deemed necessary.

- Offer recognition of successful attempts and positive reinforcement for attempts made. Give immediate positive feedback for acceptable behaviour.

- Provide quiet environment, self-contained classrooms and small group activities. Avoid over stimulating places such as cinema halls, bus stops and other crowded persons.

- Assess parenting skill level, considering intellectual, emotional and physical strengths and limitations. Be sensitive to their needs as there is often exhaustion of parental resources due to prolonged coping with a disruptive child.
- Provide information and materials related to the child's disorder and effective parenting techniques. Give instructional materials in written and verbal form with step-by-step explanations.

- Explain and demonstrate positive parenting techniques to parents or caregivers, such as time-in for good behaviour, or being vigilant in identifying the child's behaviour and responding positively to that behaviour.

- Educate child and family on the use of psycho stimulants and behavioural response anticipated.

- Coordinate overall treatment plan with schools, collateral personnel, the child and the family.

Conduct Disorders

Conduct disorders are characterised by a persistent and significant pattern of behaviour in which the basic rights of others are violated or rules of society are not followed. The diagnosis is only made when the conduct is far in excess of the routine mischief of children and adolescents. The onset occurs much before 18 years of age, usually even before puberty. The disorder is much more (about five to ten times) common in boys.

Etiology

Genetic factors: Studies with monozygotic and dizygotic twins as well as with non-twin siblings have revealed a significantly higher number of conduct disorders among those whose family members are affected with the disorder (Baum, 1989). Alcoholism and personality disorder in the father is reported to be strongly associated with conduct disorders.
Biochemical factors: Various studies have reported a possible correlation between elevated plasma levels of testosterone and aggressive behaviours.

Organic factors: Children with brain damage and epilepsy are more prone to conduct disorders.

Psychosocial Factors

- Parental rejection.

- Inconsistent management with harsh discipline.

- Frequent shifting of parental figures.

- Large family size.
- Absent father.
- Parents with antisocial personality disorder or alcohol dependence.
- Parental permissiveness.
- Marital conflict and divorce in parents.
- Associations with delinquent subgroups.
- Inadequate/inappropriate communication patterns in the family.

Clinical Features

- Frequent lying.
- Stealing or robbery.
- Running away from school or home.
- Deliberate fire-setting.
- Breaking someone else's house articles, car etc.
- Deliberately destroying other's properties.
- Cruelty towards other people and animals.
- Physical violence with rape, assaultive behaviour and use of weapons etc.
- In addition to the typical symptoms of conduct behaviour, secondary complications often develop like, drug abuse and dependence, unwanted pregnancies, syphilis, AIDS, criminal record, suicidal and homicidal behaviour.

Treatment

The treatment is difficult. The most common mode of management is placement in a corrective institution. Behavioural, educational and psychotherapeutic measures are employed for changing the behaviour.
Drug treatment may be indicated in the presence of epilepsy (anticonvulsants), hyperactivity (stimulant medication), impulse control disorder and episodic aggressive behaviour (lithium, carbamazepine) and psychotic symptoms(antipsychotics).

Nursing Intervention

• The nurse should bear in mind that there is always the risk of violence in these children. She should therefore observe the child's behaviour frequently during routine activities and interactions. She should be aware of behaviour that indicates a rise in agitation.

• Redirect violent behaviour with physical outlets for suppression of anger and frustration.

• Ensure that a sufficient number of staff is available to indicate a show of strength if necessary. Administer tranquilising medication as prescribed. Use of mechanical restraints or isolation should be used only if the situation cannot be controlled by less restrictive means.

• Explain to the client the correlation between feelings of inadequacy and the need for acceptance from others, and how these feelings provoke aggression or defensive behaviour such as blaming others for own faulty behaviour. Practice more appropriate responses through role play.

• Set limits on manipulative behaviour and identify the consequences of manipulative behaviour. Administer the consequences matter-of-factly and in a non-threatening manner if such behaviours occur.

• Provide immediate positive feedback for acceptable behaviour.

• Encourage the child to maintain a log book and make daily entries of his behaviour. The entry should consist of a brief statement of an incident when the client was angry or disagreed with another person, what the client thought about the incident afterwards (in his own words), what the client thought about doing, and what he actually did, and the outcome. This provides opportunity for the child to identify his predominant patterns of thinking and behaving in different situations, and recognise new and acceptable ways of responding in situations which provoke such behaviours.

• Review the log with the client before discharge. Provide feedback regarding improved behavioural responses and areas where continued work is needed. Encourage client to continue the log after discharge.

• Social skills training: Some views of aggression emphasise the aggressive child's limited repertoire of cognitive and behavioural skills related to successful peer and adult interaction. This perspective has led to the use of social skills training in the programmes of conducive disorder. The key steps for teaching social skills are:

- presenting the target skill to the child by describing it and discussing when it is relevant;

- demonstrating the skill by modelling;

- asking the child to rehearse the skill and providing feedback;

- role playing example situations that call for use of the skill and

- giving the child an assignment involving practice of the skill in real life situations outside the clinical setting.

• Working with the school: Aggressive children often display problems across settings, including school, or even in a particular classroom. The nurse should emphasise on close collaboration between parents and school personnel likely to come into contact with the child (principal, assistant principal, guidance counselors, school psychologists etc.). Children who see their parents and teachers working together find it easier to control their behaviour in home and in school. Truancy requires separate consideration.

Pressure should be brought upon the child to return to school, and if possible, the support of the family should be enlisted. At the same time an attempt should be made to resolve educational or other problems at school. In all this, it is essential to maintain good communication between the nurse, parents and teachers.

Juvenile Delinquency

According to Dr. Sethna, Juvenile delinquency involves wrongdoing by a child or a young person who is under an age specified by the law of the place concerned. From the legal point of view, a juvenile delinquent is a person who is below 16 years of age (18 years, in case of a girl) who indulges in antisocial activity.
Recently, there was a clarification made by the Supreme Court in the existing juvenile justice act, that a regular court would try a juvenile if he is arrested after crossing the age of 16 though he might have committed the crime when he was under the age of 16 (The Hindu, 15th May2000).

Causes

Social causes

• Defects of the family, like broken families, uncaring attitude of parents, bad conduct of parent, etc.

• Defects of the school, like harsh punishment by the teachers, weakness in some subjects, a level of education that is above the child's capacity.

• Children living in crime-dominated areas.

- Absent or defective recreation.

- War and post-war conditions.

Psychological causes: Personality characteristics, (emotional instability, immaturity), emotional insecurity and mental illness.

Economic causes: Poverty, leading to stealing, prostitution and other antisocial activities to satisfy unfulfilled desires.

Reformatory Measures

- Probation, where the juvenile delinquent is kept under the supervision of a probation officer, whose job is to help him get established in normal life.

- Institutions like reformatory schools, remand homes, certified schools, auxiliary homes. These institutions provide for all-round progress of the delinquent.

- Psychological therapies like play therapy, finger-painting, psychodrama.

- Governmental measures: The Children's Act of 1977 under which remand homes and borstal schools were made available; vocational training and follow-up services. Under the care programme sponsored by the Central Government, five borstal schools, 15 boys clubs and five probation hostels have been established.

Separation Anxiety Disorder

In these disorders there is excessive anxiety concerning separation from those individuals to whom the child is attached such as mother, fathers, caregiver, etc.

Clinical Features

- This is an unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return.

- Persistent reluctance or refusal to go to sleep, without being near or next to a major attachment figure.

- Persistent inappropriate fear of being alone.

- Repeated nightmares.

- Repeated occurrence of physical symptoms e.g. nausea, stomachache, headache etc., on occasions that involve separation from a major attachment figure, such as leaving home to go to school.

- Excessive tantrums, crying and apathy immediately following separation from a major attachment figure.

Treatment

Individual counseling: This is often useful to give the child opportunity to understand the basis for anxiety and also to teach the child some strategies for anxiety management.

Parental counseling: Parental counseling is needed when there is evidence that they are overanxious or over-protective about the child. They should be persuaded to allow the child more autonomy.

Family therapy: It is often needed when the child's disorder appears to be related to the family system. Treatment is designed to promote healthy functioning of the family system.

Pharmacological management: Anxiolytic drugs such as diazepam may be needed occasionally when anxiety is extremely severe, but they should be used for short periods only.

Phobic Anxiety Disorder

Minor phobic symptoms are common in childhood and usually concern animals, insects, darkness, school and death. The prevalence of more severe phobias varies with age. In most cases, all fears decline by early teenage years.

Treatment

Most childhood phobias improve without specific treatment, provided the parents adopt a firm and reassuring approach. For phobias that do not improve, behavioural treatment combined with reassurance and supports are most helpful. Systematic desensitisation (gradual introduction of the phobic object or situation while the subject is in a state of relaxation), is an established treatment. Other methods are implosive therapy or flooding which involves persuading the child to remain in the feared situation at maximum intensity from the start, (the reverse of desensitisation).

Social Anxiety Disorder

Children with this disorder show a persistent or recurrent fear and avoidance of strangers which interferes with social functioning. Treatment includes simple behavioural methods, combined with reassurance and support.

Sibling Rivalry Disorder

Sibling rivalry/jealousy may be shown by marked competition with siblings for the attention and affection of parents, associated with unusual pattern of negative feelings. Onset is during the months following the birth of the younger sibling. In extreme cases there is over -hostility, physical trauma towards and undermining of the sibling, regression with loss of previously acquired skills (such as bowel and bladder control) and a tendency to babyish behaviour. There is an increase in oppositional behaviour with the parents, temper tantrums and dysphonia exhibited in the form of anxiety, misery or social withdrawal.

Management

- Parents should be helped to divide their attention appropriately between the two children.
- Help the older child feel valued. At the same time, limits should be set as appropriate.
- Preventive interventions such as preparing the child mentally for the arrival of the sibling during pregnancy itself and involving him in the care of the sibling.

Elective Mutism

This condition is characterised by a marked, emotionally determined selectively in speaking such that the child demonstrates his language competence in some situations, but fails to speak in other situations. Most typically the child speaks at home or with close friends and is mute at school or with strangers.

Management

Management includes a combination of behavioural and family therapy techniques to promote communication and the use of speech. Individual psychotherapy may also help.

Tic Disorders

Tic is an abnormal involuntary movement, which occurs suddenly, repetitively, rapidly and is purposeless in nature. It is of two types:

1. Motor tic, characterised by repetitive motor movements

2. Vocal tips, characterised by repetitive vocalisations.

Tic disorders can be either transient or chronic. A special type of chronic tic disorder is Gilles de la Tourette's syndrome or Tourette's disorder. This is characterised by multiple motor and vocal tics, with duration of more than one year. Onset is usually before 11

years of age and almost always before 21 years of age. The disorder is more common (about three times) in males and has a prevalence rate of about 0.5per1000.

Types of the disorder

Motor Tics

Motor tics can be simple or complex.

Simple Motor Tics

These may include eye blinking, grimacing and shrugging of shoulders, tongue protrusion.

Complex Motor Tics

These are facial gestures, stamping, jumping, hitting self, squatting, twirling, echokinesis (repetition of observed acts), and copropraxia (obscene acts). Motor tics are often the earliest to appear; beginning in the head region and progressing downwards. These are followed by vocal tics.

Vocal Tics

Vocal tics also can be simple or complex.

Simple Vocal Tics: Simple vocal tics include coughing, barking, throat clearing, sniffing and clicking.

Complex Vocal Tics

These include echolalia (repetition of heard phrases), palilalia (repetition of heard words) coprolalia (use of obscene words), and mental coprolalia (thinking of obscene words).

Etiology of Tourette's syndrome: The etiology of Tourette's syndrome is not known but the presence of learning difficulties, neurological soft signs, hyperactivity, abnormal EEG record, abnormal evoked potentials and abnormal C.T. brain findings in some patients‟ points towards a biological basis. There is some evidence to suggest that Tourette's syndrome may be inherited as autosomal dominant disorder with variable penetrance.

Treatment: Pharmacotherapy is the preferred mode of treatment. The drug of choice is haloperidol. In resistant cases or in case of severe side effects, pimozide of clonidine can be used. Behaviour therapy may be used sometimes, as an adjunct.

Non-organic enureses

It is a disorder characterised by involuntary voiding of urine by day and/or night which is abnormal in relation to the individuals‟ mental age and which is not a consequence of a lack of bladder control due to any neurological disorder, epileptic attacks or any structural abnormality of urinary tract. Enuresis would not ordinarily be diagnosed in a child under the age of five years or with a mental age less than four years.

In most cases, enuresis is primary (the child has never attained bladder control). Sometimes it may be secondary (enuresis starting after the child achieved continence for a certain period of time).

Management

- Exclude any physical basis for enuresis by history, examination and if necessary, investigation of the renal tract.

- Explain to the parents and child about the maturational basis of the problem and the likelihood of spontaneous improvement.

- The child should be encouraged to keep a diary of the pattern of night time dryness/wetness, which can be done with a star chart. This consists of a record of dry nights with a star placed on the sheet for each dry night. The star chart system has three functions:

- it provides an accurate record of the problem;

- it tests motivation and cooperation of the child and the family; and

- it acts as a positive reinforcement for the desired behaviour.

- Fluid restriction after 6 o‟ clock in the evening.

- Interruption of child's sleep and emptying the bladder in the toilet.
- **Bell and pad technique:** It is based on the classical conditioning behaviour. A bell is attached to the napkin or panties and when the child passes urine, the alarm goes off; the child then has to wake up, change his napkin, bed sheets, etc. Reinforcement is given for dry nights.

- **Medications:** Tricyclic antidepressants like imipramine or amitriptyline, 25-50mg at night. The mechanism of action is unknown, but results have demonstrated its effectiveness.

- The parents should be instructed not to blame the child in anyway. On no account should the child be embarrassed or humiliated, which will only serve to aggravate the problem.

Non-organic encopresis

It is the repeated voluntary or involuntary passage of feces, usually of normal or near normal consistency, in places not appropriate for that purpose in the individual's socio-cultural setting.

Management

- Family tensions regarding the symptoms must be reduced and a non-punitive atmosphere must be created. Parental guidance and family therapy often is needed.

- Behavioural techniques e.g. star charts, in which the child places a star on a chart for dry or continent nights.

- Individual psychotherapy to gain the cooperation and trust of the child.

Feeding Disorder of Infancy and Childhood

It generally involves refusal of food and extreme faddiness in the presence of an adequate food supply and reasonably competent caregiver and the absence of organic disease. There may or may not be associated rumination (repeated regurgitation without nausea or gastrointestinal illness).

Pica

Pica of infancy and childhood is characterised by eating non-nutritive substances (soil, paint chipping, paper etc.). Treatment consists of common-sense precautions to keep the child away from abnormal items of diet. Pica usually diminishes as the child grows older.

Stereotyped Movement Disorders

These disorders are characterised by voluntary, repetitive, stereotyped, nonfunctional, often rhythmic movements that do not form part of any recognised psychiatric or neurological condition. The movements include body rocking, head rocking, hair plucking, hair twisting, finger flicking, mannerisms and hand flapping.

Management

- Individual and family interventions.

- Behavioural strategies.

Stuttering (stammering)

It refers to frequent hesitation or pauses in speech characterised by frequent repetition or prolongation of sounds or syllables or words,

disrupting rhythmic flow of speech. The usual treatment is speech therapy.

4.0 CONCLUSION

There are many behavioural and emotional disorders with onset usually occurring in childhood and adolescence in which proper knowledge of the mental health service providers will assist the individual patients, parents, family and the environment at large in either preventing or managing the cases.

5.0 SUMMARY

We do hope the learners have learnt greatly in this unit to help the clients/patients, parents, families and the society.

6.0 TUTOR-MARKEDASSIGNMENT

1. List five behavioural and emotional disorders with onset usually occurring in childhood and adolescence.
2. Describe the management in detail of anyone.

7.0 REFERENCES/FURTHERREADING

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

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SELF ASSESSMENT EXERCISE VI

- identify various behavioural and emotional disorders with onset in childhood and adolescence

ANSWER

Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

a. Hyperkinetic disorder

Hyperkinetic disorder (Attention-Deficit Hyperactivity Disorder or ADHD in DSMIV) is a persistent pattern of inattention and or hyperactivity more frequent and severe that is typical of children at a similar level of development. The syndrome was first described by Heinrich Hoff in1854.

b. Conduct Disorders

Conduct disorders are characterised by a persistent and significant pattern of behaviour in which the basic rights of others are violated or rules of society are not followed. The diagnosis is only made when the conduct is far in excess of the routine mischief of children and adolescents. The onset occurs much before 18 years of age, usually even before puberty. The disorder is much more (about five to ten times) common in boys.

c. Juvenile Delinquency

According to Dr. Sethna, Juvenile delinquency involves wrongdoing by a child or a young person who is under an age specified by the law of the place concerned. From the legal point of view, a juvenile delinquent is a person who is below 16 years of age (18 years, in case of a girl) who indulges in antisocial activity.

Recently, there was a clarification made by the Supreme Court in the existing juvenile justice act, that a regular court would try a juvenile if he is arrested after crossing the age of 16 though he might have committed the crime when he was under the age of 16 (The Hindu, 15th May2000).

d. Separation Anxiety Disorder

In these disorders there is excessive anxiety concerning separation from those individuals to whom the child is attached such as mother, fathers, caregiver, etc.

e. Phobic Anxiety Disorder

Minor phobic symptoms are common in childhood and usually concern animals, insects, darkness, school and death. The prevalence of more severe phobias varies with age. In most cases, all fears decline by early teenage years.

f. Social Anxiety Disorder

Children with this disorder show a persistent or recurrent fear and avoidance of strangers which interferes with social functioning. Treatment includes simple behavioural methods, combined with reassurance and support.

g. Sibling Rivalry Disorder

Sibling rivalry/jealousy may be shown by marked competition with siblings for the attention and affection of parents, associated with unusual pattern of negative feelings. Onset is during the months following the birth of the younger sibling. In extreme cases there is over -hostility, physical trauma towards and undermining of the sibling, regression with loss of previously acquired skills (such as bowel and bladder control) and a tendency to babyish behaviour. There is an increase in oppositional behaviour with the parents, temper tantrums and dysphonia exhibited in the form of anxiety, misery or social withdrawal.

h. Elective Mutism

This condition is characterised by a marked, emotionally determined selectively in speaking such that the child demonstrates his language competence in some situations, but fails to speak in other situations. Most typically the child speaks at home or with close friends and is mute at school or with strangers.

i. Tic Disorders

Tic is an abnormal involuntary movement, which occurs suddenly, repetitively, rapidly and is purposeless in nature. It is of two types:

j. Non-organic enureses

It is a disorder characterised by involuntary voiding of urine by day and/or night which is abnormal in relation to the individuals‟ mental age and which is not a consequence of a lack of bladder control due to any neurological disorder, epileptic attacks or any structural abnormality of urinary tract. Enuresis would not ordinarily be diagnosed in a child under the age of five years or with a mental age less than four years.

In most cases, enuresis is primary (the child has never attained bladder control). Sometimes it may be secondary (enuresis starting after the child achieved continence for a certain period of time).

k. Feeding Disorder of Infancy and Childhood

It generally involves refusal of food and extreme faddiness in the presence of an adequate food supply and reasonably competent caregiver and the absence of organic disease. There may or may not be associated rumination (repeated regurgitation without nausea or gastrointestinal illness).

l. Pica

Pica of infancy and childhood is characterised by eating non-nutritive substances (soil, paint chipping, paper etc.). Treatment consists of common-sense precautions to keep the child away from abnormal items of diet. Pica usually diminishes as the child grows older.

m. Stereotyped Movement Disorders

These disorders are characterised by voluntary, repetitive, stereotyped, nonfunctional, often rhythmic movements that do not form part of any recognised psychiatric or neurological condition. The movements include body rocking, head rocking, hair plucking, hair twisting, finger flicking, mannerisms and hand flapping.

n. Stuttering (stammering)

It refers to frequent hesitation or pauses in speech characterised by frequent repetition or prolongation of sounds or syllables or words, disrupting rhythmic flow of speech. The usual treatment is speech therapy.

UNIT 1: FUNCTIONAL PSYCHIATRIC DISORDER

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7.0 REFERENCES/FURTHER READINGS

1.0 Introduction

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

2.0 Objectives

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

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

3.0 Main Content

3.1 Definition

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in the presence of clear consciousness, which usually leads to social withdrawal. The word "Schizophrenia" was coined in 1908 by the Swiss psychiatrist Eugen Bleuler. It is derived from the Greek words *skhizo* (split) and *phren* (mind). In ICD10, schizophrenia is classified under the code F2.

3.1.2 Epidemiology

Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures and in all parts of the world. About 15 percent of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50 percent of all mental hospital beds. About three to four per 1000 in every community suffer from schizophrenia. About one percent of the general population stands the risk of developing this disease in their lifetime. Schizophrenia is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 35 years for women. About two-thirds of cases are in the age group of 15 to 30 years. The disease is more common in lower socio-economic groups.

3.1.3 Aetiology

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

3.1.4 Genetic Factors

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

- Children with one schizophrenic parent: 12%
- Children with both schizophrenic parents: 40%
- Siblings of schizophrenic patient: 8%
- Second-degree relatives: 5-6%
- Dizygotic twins of schizophrenic patients: 12%
- Monozygotic twins of schizophrenic patients: 47%

3.1.5 Biochemical Factors

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

Other biochemical hypotheses: Various other biochemicals have been implicated in the predisposition to schizophrenia. These include abnormalities in the neurotransmitters nor epinephrine, serotonin, acetylcholine and gamma-aminobutyric acid (GABA), and neuro-regulators such as prostaglandins and endorphins.

3.1.6 Psychological Factors

Family relationship act as major influence in the development of the illness: Mother-child relationship: Early theorists characterized the mothers of schizophrenics as cold, overprotective and domineering, thus retarding the ego development of the child. Dysfunctional family system: Hostility between parents can lead to a schizophrenic daughter (marital skew and schism).

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

3.1.7 Social Factors

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

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

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

- Hearing one's thoughts spoken aloud (audible thoughts or thought echo).
- Hallucinatory voices in the form of statement and reply (the patient hears voices discussing him in the third person).
- Hallucinatory voices in the form of a running commentary (voices commenting on one's action).
- Thought withdrawal (thoughts cease and subject experiences them as removed by an external force).
- Thought insertion (subject experiences thoughts imposed by some external force on his passive mind).
- Thought broadcasting (subject experiences that his thoughts are escaping the confines of his self and are being experienced by others around).
- Delusional perception (normal perception has a private and illogical meaning).
- Somatic passivity (bodily sensations especially sensory symptoms are experienced as imposed on body by some external force).
- Made volition or acts (one's own acts are experienced as being under the control of some external force, the subject being like a robot).
- Made impulses (the subject experiences impulses as being imposed by some external force).
- Made feelings or affect (the subject experiences feelings as being imposed by some external force).

3.1.9 Clinical Features

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

3.1.9.1 Thought and Speech Disorders

- Autistic thinking (preoccupations totally removing a person from reality).
- Loosening of associations (a pattern of spontaneous speech in which the things said in juxtaposition lack a meaningful relationship with each other).

- Thought blocking (a sudden interruption in the thought process).
- Neologism (a word newly coined, or an everyday word used in a special way, not readily understood by others).
- Poverty of speech (decreased speech production).
- Poverty of ideation (speech amount is adequate but content conveys little information).

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

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

- Verbigeration (senseless repetition of some words or phrases over and over again).
- Delusions of various kinds i.e. delusions of persecution (being persecuted against); delusions of grandeur (belief that one is especially very powerful, rich, born with a special mission in life); delusions of reference (being referred to by others); delusions of control (being controlled by an external force); somatic delusions.
- Other thought disorders are over inclusion (tending to include irrelevant items in speech), impaired abstraction, concreteness and ambivalence.

3.1.9.2 Disorders of Perception

- Auditory hallucinations (described under SFRS).
- Visual hallucinations may sometimes occur along with auditory hallucinations; tactile, gustatory and olfactory types are far less common.

3.1.9.3 Disorders of Affect

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

3.1.9.4 Disorders of Motor Behaviour

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

3.1.9.5 Other Features

- Decreased functioning in work, social relations and self-care, as compared to earlier life.
- Loss of ego boundaries.
- Loss of insight.
- Poor judgment.
- Suicide can occur due to the presence of associated depression, command hallucination, impulsive behaviour, or return of insight that causes the patient to comprehend the devastating nature of the illness and take his life.

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

3.10 Clinical Types

Schizophrenia can be classified into the following subtypes:

1. Paranoid
2. Hebephrenic (disorganized)
3. Catatonic
4. Residual

5. Undifferentiated
6. Simple
7. Post- schizophrenic depression

3.10.1 Paranoid Schizophrenia

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

- Delusions of persecution: In persecutory delusions, individuals believe that they are being malevolently treated in some way. Frequent themes include being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed or obstructed in the pursuit of long-term goals.
- Delusions of jealousy: The content of jealous delusions centres around the theme that the person's sexual partner is unfaithful. The idea is held on inadequate grounds and is unaffected by rational judgment.
- Delusions of grandiosity: Individuals with grandiose delusions have irrational ideas regarding their own worth, talent, knowledge or power. They may believe that they have a special relationship with famous persons, or grandiose delusions of a religious nature may lead to assumption of the identity of a great religious leader.
- Hallucinatory voices that threaten or command the patient, or auditory hallucinations without verbal form, such as whistling, humming and laughing.
- Other features include disturbance of affect (though affective blunting is less than in other forms of schizophrenia), volition, speech and motor behaviour.

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

3.10.2 Hebephrenic (disorganized) Schizophrenia

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

3.10.3 Catatonic Schizophrenia

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

Clinical features of excited catatonia:

- Increase in psychomotor activity (ranging from restlessness, agitation, excitement, aggressiveness to at times violent behaviour).
- Increase in speech production.
- Loosening of associations and frank incoherence.

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

Clinical features of retarded catatonia (catatonic stupor):

- Mutism: Absence of speech.
- Rigidity: Maintenance of rigid posture against efforts to be moved.
- Negativism: A motiveless resistance to all commands and attempts to be moved, or doing just the opposite.
- Posturing: Voluntary assumption of an inappropriate and often bizarre posture for long periods of time.
- Stupor: Does not react to his surroundings and appears to be unaware of them.
- Echolalia: Repetition or mimicking of phrases or words heard.
- Echopraxia: Repetition or mimicking of actions observed.
- Waxy flexibility: Parts of body can be placed in positions that will be maintained for long periods of time, even if very uncomfortable (flexible like wax).
- Ambitendency: A conflict to do or not to do, e.g. on asking to put out tongue, it is slightly protruded but taken back again.
- Automatic obedience: Obeys every command though he has first been told not to do so.

3.10.4 Residual Schizophrenia

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

3.10.5 Undifferentiated Schizophrenia

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

3.10.6 Simple Schizophrenia

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

3.10.7 Post-schizophrenic Depression

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

3.11 Course and Prognosis

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

good outcome. More than 50 percent of patients have a poor outcome, with repeated hospitalizations.

Prognostic Factors in Schizophrenia

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

3.12 Treatment

3.12.1 Pharmacotherapy

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

Chlorpromazine: 300-1500 mg/day PO; 50-100 mg/day IM

Fluphenazine decanoate: 25-50 mg IM every 1-3 weeks Haloperidol:

5-100 mg/day PO; 5-20 mg/day IM Trifluoperazine: 15-60 mg/day

PO; 1-5 mg/day IM Clozapine: 25-450 mg/day PO

Risperidone: 2-10mg/day PO

3.12.2 Electroconvulsive Therapy (ECT)

Indications for ECT in schizophrenia include:

* Catatonic stupor

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

3.12.3 Psychological Therapies

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

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

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

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

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

3.12.4 Psychosocial Rehabilitation

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

3.13 Nursing Management

Nursing Assessment

Assessment of the schizophrenic patient may be a complex process, based on information gathered from a number of sources. Schizophrenic patients in an acute episode of the illness are seldom able to make a significant contribution to their history. Data may be obtained from family members if possible, old records if available, or from other individuals who are in a position to report on the progression of the patient's behaviour.

Nursing Diagnosis I

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

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

Intervention:

Interventions	Rationale
(a) Convey acceptance of the patient's need for the false belief, but that you do not share the belief.	The client must understand that you do not view the idea as real.
(b) Do not argue or deny the belief	Arguing or denying serves no useful purpose as delusional ideas are not eliminated by this approach; further, this may adversely affect the development of a trusting relationship.

(c) Reinforce and focus on reality. Discourage long discussions about the irrational thinking. Instead talk about real events and real people.	Discussions that focus on the false ideas are purposeless and useless and may even aggravate the condition.
(d)If the client is highly suspicious, the following interventions may help: use same staff as far as possible; be honest and keep all promises avoid physical contact in the form of touching the patient etc; avoid laughing, whispering or talking quietly where the client can see but cannot hear what is being said; avoid competitive activities; use assertive, matter-of-fact yet friendly approach	 To promote trust To prevent the client from feeling threatened -do- -do-

Nursing Diagnosis II

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

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

Intervention:

Interventions	Rationale
(a) Observe the client for signs of hallucinations (listening pose, laughing or talking to self, stopping in mid-sentence).	Early intervention may prevent aggressive response to command hallucinations.
(b) Avoid touching the client without warning.	The client may perceive touch as threatening may respond in an aggressive manner.
(c) An attitude of acceptance will encourage the patient to share the consent of the hallucination with you.	This is important to prevent possible injury to the patient or others from command hallucinations.

(d) Do not reinforce the hallucinations. Use "the voices" instead of words like "they" that imply validation. Say "Even though I realize the voices are real to you, I don't hear any voices speaking".	The client should know that you do not share the false perception.
(e) Help the client understand the connection between anxiety and hallucinations.	If the client can learn to interrupt rising anxiety, hallucinations may be prevented.
(f) Try to distract the client away from the hallucinations and involve him in interpersonal activities and actual situations.	This is to bring the client back to reality.

Nursing Diagnosis III

Social isolation related to inability to trust, panic anxiety, delusional thinking, evidenced by withdrawal, sad, dull affect, preoccupation with own thoughts, expression of feelings of rejection of aloneness imposed by others.

Objective: Patient will voluntarily spend time with other patients and staff members in group activities on the unit.

Intervention:

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

Nursing Diagnosis IV

Potential for violence, self-directed or directed at others, related to extreme suspiciousness, panic anxiety, catatonic excitement, rage reactions, command hallucinations, evidenced by physical violence, destruction of objects in the environment, self-destructive behaviour or active aggressive suicidal acts. Objectives: Patient will not harm self or others.

Intervention:

Intervention	Rationale
Maintain low level of stimuli in client's environment (low lighting, low noise, few people, simple decoration, etc.).	Anxiety level rises in a stimulating environment and may trigger off aggression
Observe client's behaviour. Do this while carrying out routine activities to avoid creating suspiciousness in the individual.	Close observation is necessary so frequently that intervention can occur if required, to ensure client's and other's safety.
Remove all dangerous objects from the client's environment.	To prevent the client from using them to harm self or others in an agitated, confused state.
Redirect violent behaviour with physical outlets for the anxiety.	Physical exercise is a safe and effective way of relieving pent-up tension.
Staff should maintain a calm attitude towards the client.	Anxiety is contagious and can be transmitted from staff to client.
Have sufficient staff available to indicate a show of strength to the client if it becomes necessary.	This shows the client evidence of control over the situation and provides some physical security for the staff.
Administer tranquilizers as prescribed. Use of mechanical restraints may become necessary in some cases.	If the client is not calmed by "talking down" or the use of medications, restraints may have to be used as a last resort.

Nursing Diagnosis V

Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by loosening of associations, echolalia, verbalizations that reflect concrete thinking and poor eye contact. Objective: Patient will be able to communicate appropriately and comprehensible by the time of discharge. Intervention:

Interventions	Rationale
(a) Attempt to decode incomprehensible communication pattern. Seek validation and clarification by stating "Is it what you mean…?" or "I don't understand what you mean by that. Would you please clarify it for me?"	These techniques reveal how the patient is being perceived by others, while the responsibility for not understanding is accepted by the nurse.

(b) Facilitate trust and understanding by maintaining staff assignments as consistently as possible. The techniques of ***verbalizing the implied*** is used with the client who is mute (either unable or unwilling to speak). For example, "That must have been a very difficult time for you when your mother left. You must have felt all alone".	This approach conveys empathy and encourages the client to disclose painful issues.
(c) Anticipate and fulfill client's needs until functional communication pattern returns.	Self-care ability may be impaired in some patients who may need assistance initially.

Nursing Diagnosis VI

Self-care deficit related to withdrawal, panic anxiety, perceptual or cognitive impairment, evidenced by difficulty in carrying out tasks associated with hygiene, dressing, grooming, eating and toileting. Objective: Patient will demonstrate ability to meet self-care needs independently.

Intervention:

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

Nursing Diagnosis VII

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

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

Intervention:

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

Evaluation

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

- Has the patient established trust with at least one staff member?
- Is delusional thinking still prevalent?
- Are hallucinations still evident?
- Is the patient able to interact with others appropriately?
- Is the patient able to carry out all activities of daily living independently?

Nursing Management for a patient who exhibits withdrawn behaviour

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

health problems, including schizophrenia, mood disorders and suicidal behaviour.

Characteristics of Withdrawn Behaviour Pattern

- Withdrawn behaviour pattern may present the picture of a lonely individual who does not respond to the environment. He may walk up and down talking to himself, or may stand or sit in the corner assuming unusual and most uncomfortable positions.
- He has difficulty in expressing his feelings, so he may present the picture of a totally apathetic person, or he may express them in inappropriate ways.
- Ambivalence is another characteristic that might be seen in a withdrawn patient. For example, he may love and hate a person at the same time.
- Disordered thought process is another feature in this patient. The outward expression of this disorganization can be a meaningless jumble of words/sentences, or making up of new words. The patient can also experience sudden thought block. As he creates his own world, the world becomes filled with his own projected ideas and thoughts.
- Regression is another process predominant in a withdrawn patient. When it becomes severe, physical needs like sleep, rest, nutrition and hygiene may be interfered with.

Interventions

- In taking care of a withdrawn patient, the nurse might be faced with many problems. Communication and interpersonal relationships are the biggest difficulties because the withdrawn patient tends to use symbolized language, or may prefer to rely on non-verbal behaviour completely. Establishing initial contact using calm, non-threatening and consistent approaches is important. It necessitates a lot of hard work and patience from the nurse as the patient needs a long period of testing out before he finally trusts her.
- Dealing with hallucinations and delusions may be a problem as this happens in accordance with his own self-created world. Anybody who is trying to destroy that comfortable world may be seen by the patient as a threat to him and to his security. Disintegration in thinking is what makes the withdrawn patient the worst of the mentally ill. As this process can go on for a long time before it is noticed by others, it is often very late when it is identified. This makes it more difficult for the nurse in her efforts to bring the patient back to reality. A lot of tact and expert skill is important, and opportunities should be created for the client to recognize the nurse as a safe contact with present reality and to begin to respond.
- Regression in the patient causes a difficult practical problem, as the patient has to be considered and taken care of as a child. At the same time he has to be treated as an adult, fostering his adult characteristics.

Providing sensory stimulation, meeting the client's physiologic and hygiene needs, and promoting the client's physical activity and interactions with others are important interventions.

- Certain general principles in working with these patients are: avoid change of staff, reduce the number of staff who works with them and be available when the patient really needs the nurse. He may perceive the unavailability of the nurse as another disappointment in his relationship with people in general.
- A one-to-one relationship with the patient is considered most beneficial and least anxiety-producing to the patient. It is necessary to encourage reality contact whenever

possible and to discourage him from living in the unreal world. This may be achieved by providing opportunities for interaction with the real environment.

- Give the client positive feedback for any response to your attempted interaction or to the external environment. Gradually increase the amount of time the client spends with others and the number of people with whom the client interacts.
- Active friendliness: As the patient is withdrawn and does not approach anybody, the approach has to be made from the nurse's side and many attempts will have to be made to initiate any conversation or communication.
- Kind firmness: This is another attitude that is to be considered essential. The nurse assumes firmness in expecting the patient to behave in certain ways but should expect the behaviour in a kind manner without being authoritative and demanding, showing kindness and understanding while listening to the patient, and helping him handle any difficult situations.

4.0 **Conclusion**

You have been given extensive clinical types of schizophrenia that will guide you in making adequate observation in clinical areas when you go for clinical attachment.

5.0 **Summary**

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

6.0 Tutor Marked Assignment

(1) List and describe the various clinical types of schizophrenia.

(2) Explain the clinical features of each of the types mentioned above.

Answer to Exercise 1

- Picture of a lonely individual.
- Difficulty in expressing his feelings
- Love and hate a person at the same time.
- Disordered thought process
- Regression

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SELF ASSESSMENT EXERCISE VII

Describe Schizophrenia and its epidemiological state

ANSWER

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

leads to social withdrawal. The word “Schizophrenia” was coined in 1908 by the Swiss psychiatrist Eugen Bleuler. It is derived from the Greek words *skhizo* (split) and *phren* (mind). In ICD10, schizophrenia is classified under the code F2.

Epidemiology: Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures and in all parts of the world. About 15 percent of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50 percent of all mental hospital beds. About three to four per 1000 in every community suffer from schizophrenia. About one percent of the general population stands the risk of developing this disease in their lifetime. Schizophrenia is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 35 years for women. About two-thirds of cases are in the age group of 15 to 30 years. The disease is more common in lower socio-economic groups.

UNIT 2: MOOD DISORDERS

MAIN CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
3.1 Mood disorders
3.2 Manic episode
3.3 Depressive episode
3.4 Other mood disorders
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR MARKED ASSIGNMENT
7.0 REFERENCES

1.0 **Introduction**

This unit will take you through the mood disorders in major mental illness. These are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, which is not due to any other physical or mental disorder. The prevalence rate of mood disorders is 1.5 percent and it is uniform throughout the world.

2.0 **Objectives**

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

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

3.0 Main content

Mood disorders

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

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

Etiology

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

Biological Theories

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

Biochemical theories: A deficiency of nor epinephrine and serotonin has been found in depressed patients and they are elevated in mania. Dopamine, GABA and acetylcholine are also presumably involved.

Psychosocial Theories

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

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

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

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

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

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

3.1.1 **Manic episode**

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

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

Classification of Mania (ICD10)

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

Clinical Features

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

Elevated, Expansive or Irritable Mood

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

- Euphoria (Stage I): Increased sense of psychological well-being and happiness not in keeping with ongoing events.
- Elation (Stage II): Moderate elevation of mood with increased psychomotor activity.

- Exaltation (Stage III): Intense elevation of mood with delusions of grandeur.
- Ecstasy (Stage IV): Severe elevation of mood, intense sense of rapture or blissfulness seen in delirious or stuporous mania.

Expansive mood is unceasing and unselective enthusiasm for interacting with people and surrounding environment.
Sometimes irritable mood may be predominant, especially when the person is stopped from doing what he wants.
There may be rapid, short-lasting shifts from euphoria to depression or anger.

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

- Flight of ideas: Thoughts racing in mind, rapid shifts from one topic to another.
- Pressure of speech: Speech is forceful, strong and difficult to interrupt. Uses playful language with punning, rhyming, joking and teasing and speaks loudly.
- Delusions of grandeur.
- Delusions of persecution.
- Distractibility.

Other Features

- Increased sociabilities.
- Impulsive behaviour.
- Disinhibition.
- Hypersexual and promiscuous behaviour.
- Poor judgment.
- High-risk activities (buying sprees, reckless driving, foolish business investments, distributing money or articles to unknown persons).
- Dressed up in gaudy and flamboyant clothes although in severe mania there may be poor self-care.
- Decreased need for sleep (<3 hrs).
- Decreased food intake due to over-activity.
- Decreased attention and concentration.
- Poor judgment.
- Absent insight.

Treatment
Pharmacotherapy

- Lithium: 900-2100 mg/day.
- Carbamazepine: 600-1800 mg/day.
- Sodium valproate: 600-2600 mg/day.

- Other drugs: Clonazepam, calcium channel blockers, etc.

Electroconvulsive Therapy (ECT)

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

Psychosocial Treatment

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

Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

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

Objective: Patient will not injure self. Intervention:

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

Nursing Diagnosis II

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

Objective: Patient will not harm self or others.

Intervention:

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

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

- Never see a potentially violent person alone.
- Keep a comfortable distance away from the patient (arm length).
- Be prepared to move, violent patient can strike out suddenly.
- Maintain a clear exit route for both the staff and patient.
- Be sure that the patient has no weapons in his possession before approaching him.

- If patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away.
- Keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon.
- Distract the patient momentarily to remove the weapon (throwing water in the patient's face, yelling etc.).
- Give prescribed antipsychotic medications.

Nursing Diagnosis III

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

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

Interventions	Rationale
(a) Provide high-protein, high caloric, nutritious finger foods and drinks that can be consumed „on the run".	Patient has difficulty sitting still long enough to eat a meal.
(b) Find out patient's likes and dislikes and provide favourite foods.	To encourage the patient to eat.
(c) Provide 6 – 8 glasses of fluids per day. Have juice and snacks on unit at all times.	Intake of nutrients is required on regular basis to compensate for increased caloric requirements due to hyperactivity.
(d) Maintain accurate record of intake, output and calorie count. Weigh the patient regularly.	These are useful data to assess patient's nutritional status.
(e) Supplement diet with vitamins and minerals.	To improve nutritional status.
(f) Walk or sit with patient while he eats.	To offer support and to encourage patient to eat.

Nursing Diagnosis IV

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

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

Intervention:

Interventions	Rationale

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

Nursing Diagnosis V

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

Objective: Patient will have realistic expectations about self.

Interventions:

Interventions	Rationale
(a) Ask how client would like to be addressed. Avoid approaches that imply different perception of the client's importance.	Grandiosity is thought actually to reflect low self-esteem.
(b) Explain rationale for requests by staff unit routine etc.; strictly adhere to courteous approaches, matter-of- fact style and friendly attitudes.	Nursing approaches should reinforce patient's dignity and worth; understanding reasons enhances co- operation with regimen.

(c) Encourage verbalization and identification of feelings related to issues of chronicity, lack of control over self, etc.	Problem solving begins with agreeing on the problem.
(d) Offer matter-of-fact feedback regarding unrealistic plans. Help him to set realistic goals for himself.	Unrealistic goals will increase failures and lower self-esteem even more.
(e) Encourage client to view life after discharge and identity aspects over which control is possible. Through role play, practice how he will demonstrate that control.	Role rehearsal is helpful in returning patient to the level of independent functioning. When the individual is functioning well, sense of self- esteem is enhanced.

Nursing Diagnosis VI

Altered family processes related to euphoric mood and grandiose ideas, manipulative behaviour, refusal to accept responsibility for own actions. Objective: The family members will demonstrate coping ability in dealing with the patient.

Intervention:

Intervention	Rationale
(a) Determine individual situation and feelings of individual family members like guilt, anger, powerlessness, despair and alienation.	Living with a family member having bipolar illness fosters a multitude of feelings and problems that can affect interpersonal relationships and may result in dysfunctional responses and family disintegration.
(b) Assess patterns of communication. For example: Are feelings expressed freely? Who makes decisions? What is the interaction between family members?	Provides clues to the degree of problem being experienced by individual family members and coping skills used to handle the crisis.
(c) Determine patterns of behaviour displayed by patient in his relationships with others, e.g. manipulation of self-esteem of others, limit testing etc.	These behaviours are typically used by the manic individual to manipulate others. The result is alienation, guilt, ambivalence and high rates of divorce can occur.

(d) Assess the role of patient in the family, like provider etc, and how the illness affects the roles of other members.	When the role of an ill person is not filled family disintegration can occur.
(e) Provide information about behaviour patterns and expected course of the illness.	Assists family to understand the various aspects of bipolar illness. This may relieve guilt and promote family discussions of the problems and solutions.

Evaluation

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

Depressive episode

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

Depression occurs twice as frequently in women as in men.

Classification (ICD10)

- Mild depression
- Moderate depression
- Severe depression
- Severe depression with psychotic symptoms

Clinical Features

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

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

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

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

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

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

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

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

- Significant decrease in appetite or weight.
- Early morning awakening, at least 2 or more hours before the usual time of waking up.
- Diurnal variation, with depression being worst in the morning.
- Pervasive lack of interest and lack of reactivity to pleasurable stimuli.
- Psychomotor agitation or retardation.

Other Features

- Difficulties in thinking and concentration.
- Subjective poor memory.
- Menstrual or sexual disturbances.
- Vague physical symptoms such as fatigue, aching discomfort, constipation etc.

Treatment

Pharmacotherapy

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

Electroconvulsive therapy (ECT)

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

Psychosocial Treatment

- Cognitive therapy: It aims at correcting the depressive negative cognitions like hopelessness, worthlessness, helplessness and pessimistic ideas and replacing them with new cognitive and behavioural responses.
- Supportive psychotherapy: Various techniques are employed to support the patient. They are reassurance, ventilation, occupational therapy, relaxation and other activity therapies.
- Group therapy: Group therapy is useful for mild cases of depression. In group therapy negative feelings such as anxiety anger, guilt, despair are recognized and emotional growth is improved through expression of their feelings.
- Family therapy: Family therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors, which may help in faster and more complete recovery.
- Behaviour therapy: It includes social skills training, problem solving techniques, assertiveness training, self-control therapy, activity scheduling and decision making techniques.

Course and Prognosis of Mood Disorders

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

- Abrupt or acute onset
- Severe depression

- Typical clinical features
- Well-adjusted premorbid personality
- Good response to treatment.

Poor Prognostic Factors

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

Other mood disorders

Bipolar Mood Disorder

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

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

Bipolar I: Episodes of severe mania and severe depression Bipolar

II: Episodes of hypomania and severe depression Recurrent

Depressive Disorder

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

Persistent Mood Disorder

(Cyclothymia and Dysthymia)

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

Dysthymia (neurotic/reactive depression) is a chronic, mild depressive state persisting for months or years. It is more common in females with an

average age of onset in late third decade. An episode of major depression may sometimes become super-imposed on an underlying neurotic depression. This is known as “double depression”.

Endogenous	Reactive
(a) Caused by factors within the individual	Caused by stressful events.
(b) Premorbid personality: cyclothymic or dysthymic	Premorbid personality: anxious or obsessive
(c) Early morning awakening (late insomnia)	Difficulty in falling asleep (early insomnia)
(d) Patient feels more sad in the morning	Patient feels more sad in the evening.

(e) Feels better when alone.	Feels better when in a group
(f) Psychotic features like psychomotor retardation, suicidal tendencies, delusions etc are common	Usually psychomotor agitation and no other psychotic features.
(g) Relapses are common	Relapses are uncommon
(h) ECT and antidepressants are used for management	Psychotherapy and antidepressants are used for management.
(i) Insight is absent	Insight is present

Nursing Management of Major Depressive Episode

Nursing Assessment

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

- Presence of marked helplessness
- Male sex
- More than 40 years of age
- Unmarried, widowed or divorced
- Written or verbal communication of suicidal intent or plan
- Early stages of depression
- Recovery from depression (at the peak of depression the patient is usually either too depressed or too retarded to commit suicide). □Period of three months from recovery

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

High risk for self-directed violence related to depressed mood, feelings of worthlessness and anger directed inward on the self.

Objective: Patient will not harm self.

Intervention:

Interventions	Rationale
(a) Ask the patient directly "Have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan?"	The risk of suicide is greatly increased if the patient has developed a plan and if means exist for the patient to execute the plan.

(b) Create a safe environment for the patient. Remove all potentially harmful objects from patient's vicinity (sharp objects, straps, belts, glass items, alcohol etc.); supervise closely during meals and medication administration.	Patient's safety is nursing priority
(c) Formulate a short-term verbal or written contract that the patient will not harm self. Secure a promise that the patient will seek out staff when feeling suicidal.	A degree of the responsibility for his safety is given to the patient. Increased feelings of self-worth may be experienced when patient feels accepted unconditionally regardless of behaviour.
(d) It may be desirable to place the client near the nursing station. Do not leave the patient alone. Observe for passive suicide – the patient may starve or fall asleep in the bath-tub or sink.	Patient's safety is nursing priority
(e) Close observation is especially required when the patient is recovering from the disease.	At the peak of depression the patient is usually too retarded to carry out his suicidal plans.
(f) Do not allow the patient to put the	Patient's safety is nursing priority
bolt on his side of the door bathroom or toilet.	
(g) If the patient suddenly becomes unusually happy or gives any other clues of suicide, special observation may be necessary.	-do-
(h) Encourage the patient to express his feelings, including anger.	Depression and suicidal behaviour may be viewed as anger turned inward on the self. If the anger can be verbalized in a non-threatening environment, the patient may be able to eventually resolve these feelings.

Group Activity
Discuss among yourselves the different approaches to management of a Schizophrenic and Mood disorder client.

Nursing Diagnosis II

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

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

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

Nursing Diagnosis III

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

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

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

Nursing Diagnosis IV

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

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

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

Nursing Diagnosis V

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

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

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

Nursing Diagnosis VI

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

Objective: Patient will improve sleep pattern. Intervention:

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

Nursing Diagnosis VIII

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

Objective: Patient's nutritional status will improve.

Intervention:

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

(e) Record the client's patterns of bowel elimination.	To assess for constipation.
(f) Encourage more fluid intake, roughage diet and green leafy vegetables.	For relief of constipation if present

Nursing Diagnosis VIII

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

Objective: Patient will maintain adequate personal hygiene. Intervention:

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

Evaluation

Evaluation is facilitated by using the following types of questions: Has self-harm to the individual been avoided?

- Have suicidal ideations subsided?
- Does patient set realistic goals for self?
- Is he able to verbalize positive aspects about self, past accomplishments and future prospects?

4.0 **Conclusion**

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

5.0 **Summary**

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

6.0 Tutor Marked Assignment

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

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

7.0 **References / Further Readings**

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

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SELF ASSESSMENT EXERCISE VIII

Simply classify mood disorders

ANSWER

Mood disorders according to ICD10 (F3) are classified as follows:

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

UNIT 3: PSYCHONEUROSES

MAIN CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
    3.1 Differences between psychosis and neurosis
3.2 Classification
3.3 Phobic anxiety disorder
3.4 Generalized anxiety disorder
3.5 Panic disorder
3.6 Obsessive-compulsive disorder
3.7 Reaction to stress and adjustment disorder
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3.9 Somatoform disorder
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR MARKED ASSIGNMENT
7.0 REFERENCES

1.0 **Introduction**

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

2.0 **Objectives**

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

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

3.0 Main content

3.1 **Differences between psychosis and neurosis**

Etiology	Psychotic disorder	Neurotic disorder
Genetic factors	More important	Less important
Stressful life events	Less important	More important
Clinical features		
Disturbances of thinking	Common	Rare
and perception		
Disturbances in cognitive function	Common	Rare

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

3.2 Classification Phobic anxiety disorder

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

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

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

- It is disappropriate to the circumstances that precipitate it.
- It cannot be dealt with by reasoning or controlled through will power.
- The individual avoids the feared object or situation.

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

3.3 Types of Phobia

- Simple phobia
- Social phobia
- Agoraphobia

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

- Acrophobia – fear of heights

- Hematophobia - fear of the sight of blood
- Claustrophobia - fear of closed spaces
- Gamophobia - fear of marriage
- Insectophobia - fear of insects
- AIDS phobia - fear of AIDS

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

Agoraphobia: It is characterized by an irrational fear of being in places away from the familiar setting of home, in crowds, or in situations that the patient cannot leave easily. As the agoraphobia increases in severity, there is a gradual restriction in normal day-today activities. The activity may become so severely restricted that the person becomes self-imprisoned at home.

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

3.4 Etiology

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

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

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

3.5 **Course**

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

3.6 Treatment

Pharmacotherapy

- Benzodiazepines (e.g. alprazolam, clonazepam, lorazepam, diazepam)
- Anti-depressants (e.g. imipramine, sertraline, phenelzine)

Behaviour therapy

- Flooding
- Systematic desensitization
- Exposure and response prevention
- Relaxation techniques.

Cognitive therapy

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

3.7 Nursing Management

Nursing Assessment

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

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

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

Intervention:

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

Nursing Diagnosis II

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

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

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

3.8 Generalized anxiety disorder

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

3.8.1 Clinical Features

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

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

Physical:

- Gastrointestinal – dry mouth, difficulty in swallowing, epigastric discomfort, frequent or loose motions.
- Respiratory – constriction in the chest, difficulty inhaling, over breathing.
- Cardiovascular – palpitations, discomfort in chest.
- Genitourinary – frequency or urgent micturition, failure of erection, menstrual discomfort, amenorrhea
- Neuromuscular system – tremor, prickling sensations, tinnitus, dizziness, headache, aching muscles.
- Sleep disturbances – insomnia, night terror.

- Other symptoms: depression, obsessions, depersonalization, derealization

3.8.2 Course

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

3.9 Panic disorder

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

3.9.1 Clinical Features

- Shortness of breath and smothering sensations
- Choking, chest discomfort or pain
- Palpitations
- Sweating, dizziness, unsteady feelings or faintness
- Nausea or abdominal discomfort
- Depersonalization or derealization
- Numbness or tingling sensations
- Flushes or chills
- Trembling or shaking
- Fear of dying
- Fear of going crazy or doing something uncontrolled.

3.9.2 Course

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

3.9.3 Etiology of Anxiety Disorders (both GAD and panic disorder)

- Genetic theory: Anxiety disorder is most frequent among relatives of patients with this condition. About 15 to 20 percent of the first-degree relatives of patients with anxiety disorder exhibit anxiety disorders themselves. The concordance rate in monozygotic twins of patients with panic disorder is 80 percent.
- Biochemical factors: Alteration in GABA levels may lead to production of clinical anxiety.
- Psychodynamic theory: According to this theory, anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanisms of ego come into action. In anxiety repression fails to function adequately and the secondary defense mechanisms are not activated. Hence anxiety comes to the forefront.

- Behavioural theory: Anxiety is viewed as an unconditional inherent response of the organism to a painful stimulus.
- Cognitive theory: According to this theory anxiety is related to cognitive distortions and negative automatic thoughts.

3.9.4 Treatment

Pharmacotherapy

- Benzodiazepines (e.g. alprazolam, clonazepam)
- Antidepressants for panic disorder
- Betablockers to control severe palpitations that have not responded to anxiolytics (e.g. propranolol)

Behavioural therapies

- Bio-feedback
- Hyperventilation control

Other psychological therapies

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

3.9.5 Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

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

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

Intervention:

Intervention	Rationale
(a) Stay with the patient and offer reassurance of safety and security.	Presence of trusted individual provides feeling of security and assurance of personal safety.

(b) Maintain a calm, non-threatening matter-of-fact approach.	Anxiety is contagious and may be transferred from staff to patient or vice-versa.
(c) Use simple words and brief messages, spoken calmly and clearly to explain hospital experiences.	In an intensely anxious situation, patient is unable to comprehend anything but the most elementary communication.
(d) Keep immediate surroundings low in stimuli (dim lighting, few people).	A stimulating environment may increase anxiety level.
(e) Administer tranquilizing medication as prescribed by physician. Assess for effectiveness and for side-effects.	Anti-anxiety medication provides relief from the immobilizing effects of anxiety.
(f) When level of anxiety has been reduced, explore possible reasons for occurrences.	Recognition of precipitating factors is the first step in teaching patient to interrupt escalating anxiety.
(g) Teach signs and symptoms of escalating anxiety and ways to interrupt its progression (relaxation techniques, deep-breathing exercises and medication, or physical exercise like brisk walls and jogging.	The first three of these activities result in physiologic response opposite of the anxiety response i.e. a sense of calm, slowed heart rate etc. The latter activities discharge energy in a healthy manner.

Nursing Diagnosis II

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

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

Intervention:

Intervention	Rationale
(a) Allow patient to take as much responsibility as possible for self- care activities, provide positive feedback for decisions made.	Providing choices will increase patient's feeling of control.

(b) Assist patient to set realistic goals.	Unrealistic goals set the patient up for failure and reinforce feelings of powerlessness.
(c) Help identify life situations that are within patient's control.	Patient's emotional condition interferes with the ability to solve problems.
(d) Help patient identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability.	Assistance is required to perceive the benefits and consequences of available alternatives accurately, to deal with unresolved issues and accept what cannot be changed.

Evaluation

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

Is the client experiencing a reduced level of anxiety?

- Does the client recognize symptoms as anxiety-related?
- Is the client able to use newly learned behaviours to manage anxiety?

3.10 Obsessive-compulsive disorder Definition

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

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

- They are ideas, impulses or images, which intrude into conscious awareness repeatedly.
- They are recognized as the individual's own thoughts or impulses.
- They are unpleasant and recognized as irrational.
- Patient tries to resist them but is unable to.
- Failure to resist leads to marked distress.
- Rituals (compulsions) are performed with a sense of subjective compulsion (urge to act).
- They are aimed at either preventing or neutralizing the distress or fear arising out of obsessions.

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

Classification (ICD10)

- OCD with predominantly obsessive thoughts or ruminations.
- OCD with predominantly compulsive acts.
- OCD with mixed obsessional thoughts and acts.

Etiology Genetic Factors

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

Biochemical Influences

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

Psychoanalytic Theory

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

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

Behaviour Theory

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

Clinical Picture

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

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

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

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

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

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

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

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

Course and Prognosis

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

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

Treatment

Pharmacotherapy

- Antidepressants (e.g. fluvoxamine, sertraline, etc.)
- Anxiolytics (e.g. benzodiazepines)

Behaviour Therapy

- Exposure and response prevention
- Thought stoppage
- Desensitization
- Aversive conditioning

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

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

- Sit in a comfortable chair, bring to mind the unwanted thought concentrating on only one thought per procedure.
- As soon as the thought forms give the command “Stop!” Follow this with calm and deliberate relaxation of muscles and diversion of thought to something pleasant.
- Repeat the procedure to bring the unwanted thought under control.

Other Therapies

- Supportive psychotherapy.
- ECT – for patient’s refractory to other forms of treatment.

Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

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

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

Intervention:

Intervention	Rationale
(a) Work with patient to determine types of situations that increase anxiety and result in ritualistic behaviours.	Recognition of precipitating factors is the first step in teaching the patient to interrupt escalating anxiety.
(b) Initially meet the patient's dependency needs. Encourage independence and give positive reinforcement for independent behaviours.	Sudden and complete elimination of all avenues for dependency would create intense anxiety on the part of the patient. Positive reinforcement enhances self-esteem and encourages repetition of desired behaviours.
(c) In the beginning of treatment, allow plenty of time for rituals. Do not be judgmental or verbalize disapproval of the behaviour.	Denying patient this activity may precipitate panic anxiety.
(d) Support patient's efforts to explore the meaning and purpose of the behaviour.	Patient may be unaware of the relationship between emotional problems and compulsive behaviours. Recognition is important before change can occur.
(e) Provide structured schedule of activities for patient, including adequate time for completion of rituals.	Structure provides a feeling of security for the anxious patient.

(f) Gradually begin to limit amount of time allotted for ritualistic behaviour as patient becomes more involved in unit activities.	Anxiety is minimized when patient is able to replace ritualistic behaviour.
(g) Give positive reinforcement for non-ritualistic behaviours.	Positive reinforcement encourages repetition of desired behaviour.
(h) Help patient learn ways of interrupting obsessive thoughts and ritualistic behaviour with techniques	These activities help in interruption of obsessive thoughts.
such as thought stopping, relaxation and exercise.	

Nursing Diagnosis II

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

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

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

Evaluation

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

- Does the client continue to display obsessive-compulsive symptoms?

- Is the client able to use newly learned behaviours to manage anxiety?
- Can the client adequately perform self-care activities?

Reaction to stress and adjustment disorder

This category includes: Acute stress reaction

- Post-traumatic stress disorder (PTSD)
- Adjustment disorders

Acute Stress Reaction

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

Post-traumatic Stress Disorder (PTSD)

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

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

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

Adjustment Disorders

It is characterized by predominant disturbance of emotions and conduct. This disorder usually occurs within one month of a significant life change. Treatment of Stress and Adjustment Disorders Drug treatment

- Antidepressants
- Benzodiazepine

Psychological therapies

- Supportive psychotherapy
- Crisis intervention
- Stress management training.

Dissociative (Conversion) disorder

Conversion disorder is characterized by the presence of one or more symptoms suggesting the presence of a neurological disorder that cannot be explained by any known neurological or medical disorder. Instead, psychological factors like stress and conflicts are associated with onset or exacerbation of the symptoms. Patients are unaware of the psychological basis and are thus not able to control their symptoms.

Some features of the disorder include:

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

- These symptoms of conversion are often advantageous to the patient. For example, a woman who develops psychogenic paralysis of the arm may escape from taking care of an elderly relative. Such an advantage is called secondary gain.
- The patient does not produce the symptoms intentionally.
- The patient shows less distress or shows lack of concern about the symptoms, called as belle indifference.
- Physical examination and investigations do not reveal any medical or neurological abnormalities.

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

Dissociative Amnesia

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

Dissociative Fugue

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

Dissociative Stupor

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

Ganser's Syndrome

Ganser's syndrome is a rare condition with four features: giving „approximate answers" to questions designed to test intellectual functions, psychogenic physical symptoms, hallucinations and apparent clouding of consciousness. The term „approximate answers" denotes answers (to simple questions) that are plainly wrong, but are clearly related to the correct

answers in a way that suggest that the latter is known. For example, when asked to add three and three a patient might answer seven and when asked four and five, might answer ten; each answer is one greater than the correct answer. Hallucinations are usually visual and may be elaborate.

Multiple Personality Disorder (Dissociative Identity Disorder)

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

sudden, and the behaviour usually contrasts strikingly with the patient's normal state.

Trance and Possession Disorders

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

Dissociative Motor Disorders

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

Dissociative Convulsions (hysterical fits or pseudo-seizures)

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

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

Dissociative Sensory Loss and Anesthesia

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

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

Etiology of Conversion Disorders

Psychodynamic Theory

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

Behaviour Theory

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

Treatment

- Free association
- Hypnosis
- Abreaction therapy
- Supportive psychotherapy
- Behaviour therapy (aversion therapy, operant conditioning etc.)
- Drug therapy: Drugs have a very limited role. A few patients have anxiety and may need short-term treatment with benzodiazepines. **Nursing Intervention**
- Monitor physician's ongoing assessments, laboratory reports and other data to rule out organic pathology.
- Identify primary and secondary gains.
- Do not focus on the disability; encourage patient to perform self-care activities as independently as possible. Intervene only when patient requires assistance.
- Do not allow the patient to use the disability as a manipulative tool to avoid participation in the therapeutic activities.
- Withdraw attention if the patient continues to focus on physical limitations.
- Encourage patient to verbalize fears and anxieties.
- Positive reinforcement for identification or demonstration of alternative adaptive coping strategies.
- Identify specific conflicts that remain unresolved and assist patient to identify possible solutions.
- Assist the patient to set realistic goals for the future.
- Help the patient to identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability.

Somatoform disorders

These disorders are characterized by repeated presentation with physical symptoms which do not have any physical basis, and a persistent request for investigations and treatment despite repeated assurances by the treating doctors.

These disorders are divided into following categories:

- Somatization disorder
- Hypochondriasis
- Somatoform autonomic dysfunction

- Persistent somatoform pain disorder

Somatization Disorder

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

Hypochondriasis

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

Somatoform Autonomic Dysfunction

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

Persistent Somatoform Pain Disorder

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

Treatment

Drug therapy

- Antidepressants
- benzodiazepines

Psychological treatment

- Supportive psychotherapy
- Relaxation therapy

4.0 **Conclusion**

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

5.0 **Summary**

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

6.0 Tutor Marked Assignment

(1) Differentiate between psychosis and neurosis.

(2) How can neuroses be prevented in our society today?

Answer to Exercise

- recognized as the individual's own thoughts or impulses.
- unpleasant and recognized as irrational.

- Patient tries to resist them but is unable to.
- Leads to marked distress.
- Performed with a sense of subjective compulsion
- Aimed at either preventing or neutralizing the distress or fear arising out of obsessions.

7.0 **References / Further Readings**

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SELF ASSESSMENT EXERCISE IX

Differentiate between psychoses and neuroses

ANSWER

Differences between psychoses and neuroses

Etiology	Psychotic disorder	Neurotic disorder
Genetic factors	More important	Less important
Stressful life events	Less important	More important
Clinical features		
Disturbances of thinking	Common	Rare
and perception		
Disturbances in cognitive function	Common	Rare
Behaviour	Markedly affected	Not affected
Judgment	Impaired	Intact
Insight	Lost	Present
Reality testing	Lost	Present
Treatment		
Drugs	Major tranquilizers commonly used	Minor tranquilizers and anti-depressants are commonly used

ECT	Very useful	Not useful
Psychotherapy	Not much useful	Very useful
Prognosis	Difficult to treat; relapses are common; complete recovery may not be possible	Relatively easy to treat; relapses are uncommon; complete recovery is possible.

UNIT 4: ORGANIC MENTAL DISORDER

MAIN CONTENTS

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
    3.1 Classification of organic mental disorder
        3.1.1 Dementia (Chronic Organ Brain Syndrome)
        3.1.2 Delirium (Acute Organic Brain Syndrome)
        3.1.3 Organic amnestic syndrome
    3.2 Mental disorders to due brain damage, dysfunction and physical disease
    3.3 Personality and behavioural disorders due to brain disease, damage and dysfunction
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR MARKED ASSIGNMENT
7.0 REFERENCES

1.0 Introduction

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

2.0 Objectives

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

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

3.0 Main content

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

3.1 Classification of organic mental disorder

- Dementia
- Delirium

- Organic amnestic syndrome
- Mental disorders due to brain damage, dysfunction and physical disease
- Personality and behavioural disorders due to brain disease, damage and dysfunction

3.1.1 Dementia (Chronic Organ Brain Syndrome)

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

Incidence

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

Etiology: Untreatable and irreversible causes:

3.1.2 Degenerating disorders of CNS

Alzheimer's disease (this is the most common of all dementing illnesses)

Pick's disease

Huntington's disease

Parkinson's disease

Treatable and reversible causes:

- Vascular – multi-infarct dementia
- Intracranial space occupying lesions
- Metabolic disorders – hepatic failure, renal failure
- Endocrine disorders – myxedema, Addison's disease
- Infections – AIDS, meningitis, encephalitis
- Intoxication – alcohol, heavy metals (lead, arsenic), chronic barbiturate poisoning
- Anoxia – anemia, post-anesthesia, chronic respiratory failure
- Vitamin deficiency, especially deficiency of thiamine and nicotine
- Miscellaneous – heatstroke, epilepsy, electric injury.

Stages of dementia

Stage I: Early stage (2 to 4 years)

- Forgetfulness
- Declining interest in environment
- Hesitancy in initiating actions
- Poor performance at work

Stage II: Middle stage (2 to 12 years)

- Progressive memory loss
- Hesitates in response to questions
- Has difficulty in following simple instructions
- Irritable, anxious
- Wandering
- Neglects personal hygiene
- Social isolation

Stage III: Final stage (up to a year)

- Marked loss of weight because of inadequate intake of food
- Unable to communicate
- Does not recognize family
- Incontinence of urine and feces
- Loses the ability to stand and walk
- Death is usually caused by aspiration pneumonia
- Clinical Features (for Alzheimer's Type)
- Personality changes: lack of interest in day-to-day activities, easy mental fatigability, self-centered, withdrawn, decreased self-care
- Memory impairment: recent memory is prominently affected
- Cognitive impairment: disorientation, poor judgment, difficulty in abstraction, decreased attention span.
- Affective impairment: labile mood, irritableness, depression
- Behavioural impairment: stereotyped behaviour, alteration in sexual drives and activities, neurotic/psychotic behaviour
- Neurological impairment: aphasia, apraxia, agnosia, seizures, headache
- Catastrophic reaction: agitation, attempt to compensate for defects by using strategies to avoid demonstrating failures in intellectual performances, such as changing the subject, cracking jokes or otherwise diverting the interviewer.
- Sundowner syndrome: It is characterized by drowsiness, confusion, ataxia; accidental falls may occur at night when external stimuli such as light and interpersonal orienting cues are diminished

Course and Prognosis

Insidious onset but slow progressive deterioration occurs.

Treatment

Until now, no specific medicine is available to treat Alzheimer's disease. A drug called "Tacrine" is being used in western countries.

Tacrine (Tetra hydro amino acridine) is a long-acting inhibitor of acetylcholine and also delays the progression of the illness.

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

- benzodiazepines for insomnia and anxiety
- antidepressants for depression
- antipsychotics to alleviate hallucinations and delusions
- anticonvulsants to control seizures

Nursing Intervention

1. Provide a safe environment:

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

2. Establish good interpersonal relationships:

- verbal communication should be clear and unhurried
- questions that require “yes‟ or “no‟ answers are best

3. Facilitate adequate grooming hygiene and other activities of daily living

- compliment the person when he/she looks good
- remember to check finger and toe nails regularly, cut them if the person cannot do it by him/herself
- encourage and help in cleaning teeth and bathing
- people with dementia may have problems with the lock on the bathroom door; if this happens it is advisable to remove the lock
- remind the person to go to the toilet at regular intervals, just leave the toilet door open, and leave a light at night times to find the way.

4. Maintain adequate food and fluid intake:

- allow plenty of time for meals
- a well balanced diet with plenty of fibre such as fruits, vegetables, whole wheat should be used to prevent constipation
- tell the person which meal it is and what there is to eat; food served should be neither too hot nor too cold.

5. Facilitate adequate rest and sleep:

- provide calm and quiet environment for sleep
- keep him clean and dry
- provide regular exercises to improve sleep

6. Facilitate orientation:

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

7. Decrease socially inappropriate behaviour and facilitate the development of acceptable social skills:

- reinforce socially acceptable skills
- over-correction should be avoided
- give necessary information repeatedly
- focus on the things the person does well rather than on mistakes or failures
- ignore unacceptable behaviour.

8.Increase interest in surroundings:

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

9. Involve the family and community in treatment and rehabilitation programme:

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

3.1.3 Delirium (Acute Organic Brain Syndrome)

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

Incidence

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

Etiology

- Vascular: hypertensive encephalopathy, cerebral arteriosclerosis, intracranial hemorrhage
- Infections: encephalitis, meningitis
- Neoplastic: space occupying lesions
- Intoxication: chronic intoxication or withdrawal effect of sedative- hypnotic drugs
- Traumatic: subdural and epidural hematoma, confusion, laceration, post-operative, heatstroke
- Vitamin deficiency e.g. thiamine
- Endocrine and metabolic: diabetic coma and shock, uremia, myxedema, hyperthyroidism, hepatic failure
- Metals: heavy metals (lead, manganese, mercury), carbon monoxide and toxins
- Anoxia: anemia, pulmonary or cardiac failure.

Clinical Features

- Impairment of consciousness: clouding of consciousness ranging from drowsiness to stupor and coma.
- Impairment of attention: difficulty in shifting, focusing and sustaining attention.
- Perceptual disturbances: illusions and hallucinations, most often visual.
- Disturbance of cognition: impairment of abstract thinking and comprehension, impairment of immediate and recent memory, increased reaction time.
- Psychomotor disturbance: hypo and hyperactivity, aimless groping or picking at the bed clothes (flocculation), enhanced startle reaction.
- Disturbance of the sleep-wake cycle: insomnia or in severe cases total sleep loss or reversal of sleep-wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams and nightmares, which may continue as hallucinations after awakening.

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

Course and Prognosis

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

Treatment

- Identification of cause and its immediate correction, e.g. 50 mg of 50 percent dextrose IV for hypoglycemia, O_2 for hypoxia, 100 mg of B1 IV for thiamine deficiency, IV fluids for fluids and electrolyte imbalance.
- Symptomatic measures: benzodiazepines (10 mg diazepam or 2 mg lorazepam IV) or antipsychotics (5 mg haloperidol or 50 mg chlorpromazine IM) may be given.

Nursing Intervention

1. Providing safe environment:

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

2. Alleviating patient's fear and anxiety:

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

3. Meeting the physical needs of the patient:

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

4. Facilitate orientation:

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

3.1.4 Organic Amnestic Syndrome

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

Etiology

- Thiamine deficiency, the most common cause being chronic alcoholism. It is called "Wernicke-Korsakoff syndrome". Wernicke's encephalopathy is the acute phase of delirium preceding the amnestic syndrome, while Korsakoff's syndrome is the chronic phase of amnestic syndrome.
- Head trauma
- Bilateral temporal lobectomy
- Hypoxia
- Brain tumors
- Herpes simplex encephalitis
- Stroke

Clinical Features

- Recent memory impairment
- Anterograde and retrograde amnesia
- There is no impairment of immediate memory

Management

- Treatment for underlying cause

3.2 Mental Disorders to Brain Damage, Dysfunction and Physical Disease

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

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

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

Drugs: Steriods, antihypertensives, antimalarials, alcohol and psychoactive substances.
The following mental disorders come under this category:

- Organic hallucinations
- Organic catatonic disorder
- Organic delusional disorder
- Organic mood disorder
- Organic anxiety disorder

3.3 Personality and Behavioural Disorders Due to Brain Disease, Damage and Dysfunction

These disorders are characterized by significant alteration of the premorbid personality due to underlying organic cause. There is no disturbance of consciousness and global

intellectual function. The personality change may be characterized by emotional lability, poor impulse control, apathy, hostility or accentuation of earlier personality traits.

Etiology

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

Management

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

4.0 **Conclusion**

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

5.0 **Summary**

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

6.0 Tutor Marked Assignment

- What is delirium?
- Identify 3 mental and psychiatric disorders that due to brain disease

7.0 References / Further Readings

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SELF ASSESSMENT EXERCISE X

a. Describe organic mental disorders
b. Dementia is a major mental illness. Discuss.

ANSWER

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

b. Dementia (Chronic Organ Brain Syndrome)

Dementia is an acquired global impairment of intellect, memory and personality but without impairment of consciousness. Dementia occurs more commonly in the elderly than in the middle-aged. It increases with age from 0.1 percent in those below 60 years of age to 15 to 20 percent in those who are 80 years of age.

Etiology: Untreatable and irreversible causes. These include**:**

- Vascular – multi-infarct dementia
- Intracranial space occupying lesions
- Metabolic disorders – hepatic failure, renal failure
- Endocrine disorders – myxedema, Addison's disease
- Infections – AIDS, meningitis, encephalitis
- Intoxication – alcohol, heavy metals (lead, arsenic), chronic barbiturate poisoning
- Anoxia – anemia, post-anesthesia, chronic respiratory failure
- Vitamin deficiency, especially deficiency of thiamine and nicotine
- Miscellaneous – heatstroke, epilepsy, electric injury.

The treatment includes:

Until now, no specific medicine is available to treat Alzheimer's disease. A drug called "Tacrine" is being used in western countries.

Tacrine (Tetra hydro amino acridine) is a long-acting inhibitor of acetylcholine and also delays the progression of the illness.

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

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- antidepressants for depression
- antipsychotics to alleviate hallucinations and delusions
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Nursing Intervention

- Provide a safe environment:

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

- Establish good interpersonal relationships:

verbal communication should be clear and unhurried
questions that require "yes" or "no" answers are best

- Facilitate adequate grooming hygiene and other activities of daily living

compliment the person when he/she looks good
remember to check finger and toe nails regularly, cut them if the person cannot do it by him/herself

encourage and help in cleaning teeth and bathing
people with dementia may have problems with the lock on the bathroom door; if this happens it is advisable to remove the lock
remind the person to go to the toilet at regular intervals, just leave the toilet door open, and leave a light at night times to find the way.

- Maintain adequate food and fluid intake:

allow plenty of time for meals
a well-balanced diet with plenty of fibre such as fruits, vegetables, whole wheat should be used to prevent constipation
tell the person which meal it is and what there is to eat; food served should be neither too hot nor too cold.

- Facilitate adequate rest and sleep:

provide calm and quiet environment for sleep
keep him clean and dry
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- Facilitate orientation:

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

- Decrease socially inappropriate behaviour and facilitate the development of acceptable social skills:

reinforce socially acceptable skills
over-correction should be avoided
give necessary information repeatedly
focus on the things the person does well rather than on mistakes or failures
ignore unacceptable behaviour.

- Increase interest in surroundings:

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

- Involve the family and community in treatment and rehabilitation programme:

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

UNIT 5 EPILEPSY

MAIN CONTENT

1.0 INTRODUCTION
2.0 OBJECTIVES
3.0 MAIN CONTENT
    3.1 Introduction
    3.2 Causes of epilepsy
    3.3 Clinical types of epilepsy
    3.4 Diagnosis of epilepsy
    3.5 Management of epilepsy
    3.6 Status epilepticus
    3.7 Febrile convulsions
    3.8 Withdrawal of use of antiepileptic drugs
4.0 CONCLUSION
5.0 SUMMARY
6.0 TUTOR MARKED ASSIGNMENT
7.0 REFERENCES

1.0 **Introduction**

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

2.0 **Objectives**

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

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

3.0 Main Content

3.1 Introduction

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

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

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

3.2 Causes of epilepsy Epilepsy has several causes. The following causes are identified:

(a) Constitutional (or Idiopathic Epilepsy)

(b) Symptomatic Epilepsy.

a. Constitutional (or Idiopathic Epilepsy)

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

b. **Symptomatic Epilepsy**

There are many causes

(i) Congenital abnormalities and perinatal injuries may result in seizures presenting in infancy or childhood.

(ii) Metabolic disorders – e.g. hypocalcaemia, hypoglycemia, pyridoxine deficiency and ketonuria – all cause epilepsy (seizures) in newborns and infants.

(iii) Trauma – e.g. birth injuries to the skull (e.g. forceps delivery), road traffic accident affecting the skull, especially.

(iv) Tumors and other space-occupying lesions.

(v) Vascular diseases – they cause seizures especially in the elderly.

(vi) Infectious diseases – must be considered in all age groups as potentially reversible causes of seizures. Seizures may occur in the context of an acute infective or inflammatory illness, such as bacterial meningitis or herpes encephalitis. Also in conditions like neurosyphilis, or cerebral cysticercosis, brain abscess and chronic kidney disease.

3.3 Clinical types of epilepsy

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

A. those that are generalized, and

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

A. Generalized Seizures (Epilepsy)

(1) Petit mal seizures (or absence seizures)

(2) Grand mal (or major epilepsy)

(3) Tonic, clonic or atonic seizures

(4) Atypical absences

(5) Myoclonic seizures.

B. Partial Seizures

(1) Simple partial seizures

(2) Complex partial seizures

A. Generalised Seizures (Epilepsy)

(1) Petit mal (or absence seizures)

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

(2) Grand mal seizures (or major epilepsy)

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

Aura (or warning): This precedes loss of consciousness and lasts only for 2 seconds. The patient experiences something which "warns" him that the convulsion is to follow. It is not present in all cases; it may take many forms but it is usually constant in each individual patient who, therefore, easily recognizes its nature.

The patient has an indescribable "feeling" in the stomach which rises to the throat. It may even be an unpleasant taste in the mouth, an unpleasant smell, or a flash of light. Tonic Phase: This starts with loss of consciousness and patient falls to the ground and may injure himself. The muscles become rigid with the hands

and teeth clenched. Breathing becomes obstructed by the tonic contraction of the respiratory muscles. The last few inspirations being stridulous give rise to the so-called "epileptic cry". The face becomes cyanosed and the veins become engorged. This stage lasts for about 30 seconds.

3. Clonic Phase

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

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

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

4. Tonic, clonic or atonic seizures

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

5. Atypical absences

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

6. Myoclonic seizures

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

(6) **Psychomotor Seizures**

This category now includes practically all types of attacks which do not conform to the classic descriptions of grandmal focal, Jacksonian seizure or petit mal. Automatisma, patterned movements, apparently purposeful movements, incoherent speech, turnings of the head and eyes, smacking of the slips twisting and writhing movements of the extremities, clouding of consciousness and amnesia commonly occur. It has been postulated that "equivalent states" exist in which the patient exhibits a behaviour disturbance rather than the classic convulsion. Temporal lobe foci (spikes, sharp waves or combinations) are frequently associated with this type of epilepsy.

B.Partial Seizures (that is focal, local epilepsies) The initial clinical and electroencephalographic manifestations of partial seizures indicate that only a restricted part of one cerebral hemisphere has been activated. The ictal manifestations depend upon the area of the brain involved. Partial seizures are subdivided into simple seizures in which consciousness is preserved and complex seizures, in which it is impaired. Partial seizures of either type sometimes become secondarily generalized, leading to a tonic, clonic or tonic-clonic attack. Examples of partial seizures include – Jacksonian, temporal lobe and psychomotor seizures.

i. Simple Partial Seizures.

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

ii. Complex Partial Seizures.

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

3.4 Diagnosis of epilepsy

- History (of illness): With reference to signs and symptoms e.g. nonspecific changes such as headache, mood alterations, lethargy and myoclonic jerking alert some patients to an

impending seizure hours before it occurs. These parodromal symptoms are distinct from the aura which may precede a generalized seizure by a few seconds or minutes and which is itself a part of the attack, arising locally from a restricted region of the brain.

Electroencephalography (E.E.G.): The findings may support the clinical diagnosis of epilepsy – by demonstration paroxysmal abnormalities containing spikes or sharp waves; may provide a guide to prognosis and may help classification of the disorder, is important for determining the most appropriate anticonvulsant drug with which to start treatment. (Special attention to temporal lobe leads (in EEG) confirms psychomotor epilepsy's diagnosis).

Laboratory tests – e.g. full blood count, blood glucose determination, liver and renal function tests and serologic tests for syphilis.

X-ray – especially of the skull.
Pneumoencephalographic – introduction of "air or oxygen" to the subdural space surrounding the brain and also into the ventricles of the brain. X-ray photographs are then taken and these show the outline ventricles.

3.5 Management of epilepsy

a. Management of Seizures
b. Other Nursing Care – including those with other psychiatric problems (in the hospital)
c. Medical treatment

(a) Management of Seizures

Management during a fit is dependent on accurate observation, adequate support or assistance of the patient, during fit and specific and accurate report of the fit.
When the epileptics suffer from fits, the nurse should loosen the clothing above the neck and chest to permit free respiration. Take away dangerous objects on which the patient may knock his head or body and sustain injury. In order to prevent the patient from biting his tongue, they should place in between patient's lower and upper set of teeth, a wooden spatula or some protecting article such as spoon handle, around which a handkerchief is wrapped. It is as well to let the patient lie down where he has fallen provided there are no objects against which he may strike the head or extremities during fits.
A pillow may be placed beneath his head, the nurse should not try to restrain the movements. It is well to turn the patient's head to one side to help clear the mouth of saliva. If the patient has just eaten before the fits, care should be taken to remove any food from his mouth. He should be kept under observation until he sleeps quietly or he has become clear mentally. After fits have ceased, an ice-bag (or hard pillow) may be placed on the head. After waking, the patient may require dry clothing because of excessive perspiration on his cloth during the fit. As soon as possible after the fit, the nurse must find time to write down her observations. While the fit is actually in progress she should give a verbal running commentary to herself of what is happening. This helps the later writing of the report. As soon as she observes a patient who has a fit, the nurse should note the time, because she should report accurately on the total length of the fit and the length of each stage. Time may seem very long when she is helplessly watching a patient and the period during which the patient is not breathing may seem endless, when in fact

it may last only thirty seconds. The nurse should prepare a summary of the condition of the ward as she finds it and remember what the patient had been doing just prior to the fit. Fits may occur more frequently when a patient is upset or it may have some relation to the intake of food and it is a help if the existence of recurrent antecedent activity can be established. Some patients, for example are most likely to have fits when there has been some quarrel or unpleasant scene in the ward. Others regularly have fits during hospital concerts or in the wards when someone plays the piano. Loss of consciousness or disturbance of consciousness should be reported and the nurse should practice making the necessary observations swiftly and in correct order. She should call the patient's name, noting any utterances which may give evidence of his having heard or observed the nurses. She should report posture or the succession of postures, the movement of the head and eyes, the direction of movement. The direction of fall should be noted. The exact length of time of each stage of the attack is important. Muscle tone should be observed, whether the tonic, or rigid, stage is unilateral or bilateral, whether it starts simultaneously throughout the whole body, or on which side or which part of the body it appears first. Twitching may start at one particular point and spread from there, and the order in which various parts of the body are affected should be noted. The eyes should be observed. The reaction of pupils to light corneal reflexes and eye movements must be mentioned. As soon as the attack has ceased, temperature, pulse and respiration with blood pressure are recorded, colour is noted. Biting of the tongue and incontinence are reported, knee jerks and Babinski reflexes are tested (Babinski's sign is an upward movement of the big toe when the sole of the feet is stroked). After the attack, it is necessary to note the depth of the sleep which follows, how easy it is to arouse the patient and the duration of sleep if the patient is left undisturbed. Any complaints made, by the patient are recorded, e.g. headache or vomiting, so it is any evidence of confusion in speech or action. It is very important to establish the length of time during which the patient remains confused because during it he requires supervision and is not responsible for his actions.

(b) Other Nursing Care of Epileptic Patient in the Hospital

Although epilepsy is a physical illness and not a mental illness; and most of them are able to live a normal life, some patients are in mental hospitals because they suffer from such mental disorder as schizophrenia or depression as well as epilepsy. The nursing care of these is determined by the nature of the mental disorder, although the occurrence of fits creates additional problems. Fits are very terrifying to witness. Both the epilepsy and the mental illness require appropriate treatment. Many epileptic patients have mental disorders which are in some way caused by their epilepsy or related directly to it. Some epileptic patients, at the time of fits, or even at other times, find it increasingly difficult to control any emotional reactions which may perhaps unwillingly be aroused by people in the environment. The patient may be irritable, experience hate or anger and, not being able to keep himself under control, may become violent, abusive and dangerous. Moreover, if he feels that he is losing control he may become extremely frightened. Tension mounts until he becomes intolerable, and an uncontrollable outburst of violence occurs. Nobody enjoys violence least of all the patients, who afterwards feels guilty and ashamed. He hates himself and hates others for causing him to loose control over himself. Such a patient requires someone who understands him and so can prevent an outburst before it reaches a peak. In mental hospital this is quite possible. When the nurse knows

the patient really well, she can usually detect when he is becoming more irritable and tense and can persuade him to relax. The most important of various methods is for the nurse to remain calm, not to show anger or hostility and not to become frightened. This is only possible if she knows the patient well, realizes that he is ill, and treats his aggression as a symptom of his illness. Outside mental hospitals it is not always possible for calmness to reign in the face of a patient's aggressive behaviour. The patient and his environment react on each other until real danger exists which in hospital can be prevented.

(c) Other specific nursing cares include:

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

(ii) During a fit, the most important duty of the nurse is to prevent injury. Epileptic patients in the hospital are kept under fairly constant observation day and night. Record patient's fits and observations made in ward report and "epileptic (seizure) chart" – if opened for patient. Certain obvious dangers are avoided. Fires are guarded so that burns, the most common injuries outside hospital, rarely occur. Feeding: Meals are supervised in case a fit occurs, and the patient is encouraged to cut up his food into small pieces because he might choke if a fit occurred while large pieces of food were in his mouth. Food given must be a balanced diet.

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

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

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

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

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

(d) Medical Treatment

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

Anti-Convulsants are drugs of choice in the treatment of Epilepsy.

Some of these include:

(i) Epanutin (Phenytoin sodium) Dose: 300-400mg daily

(ii) Phenobarbitone

(iii) Primidone (Mysoline) Dose: 500-1,500mg daily

(iv) Phenytoin (Dilantin) Dose: (adult) 300mg daily

(v) Carbamazepine (Tegretol) Dose: 15-25mg/kg in children 1g or 2mg (tolerated)

Other Anticonvulsants are: Donazepam 4-8mg (in 3-4 divided doses only), Ethosuximide 1000-2000mg daily, Valproate 100-1600mg daily. Note: Never withdraw anticonvulsant drugs suddenly. Although the objective of therapy is complete suppression of symptoms, in many cases this is not possible. Most epileptic must continue to receive anticonvulsant therapy throughout life. However, if seizures are entirely controlled for 3-5 years the dosage may be slowly reduced (over a period of 1-2 years) and finally withdrawn to ascertain if seizures will recur.

(e) Advice on Discharge (Epileptic Patients)

(1) Occupation – Epileptic finds life just as difficult. Many jobs are out of question for him. It would be most unwise for an epileptic to drive a bus or a car, or to choose any occupation which requires climbing ladders or handling dangerous machinery.

(2) Epileptic Attack Card – If given in the hospital, an epileptic patient should carry Epileptic Attack Card whenever he is going out. This card often introduces the patient to the public. Usually kept in his pocket, it helps the public to have an idea about patient's problem.

(3) Drugs and Hospital Appointments – Often patients are given hospital appointments for Hospital's follow-up medical check-up. Patient should try to keep appointment. He should also use drugs given to him so as to stabilize his improvement.

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

3.6 **Status Epilepticus**

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

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

There are many forms of status epilepticus. The most common, generalized tonic-clonic status epilepticus, is a life-threatening emergency, requiring immediate cardiovascular, respiratory and metabolic management as well as pharmacologic therapy. The latter virtually always requires intraveneous administration of antitpileptic medications. Poor to the length of time between onset of status epilepticus and the start of effective treatment.

Management (of patient with status epilepticus)

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

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

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

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

(2) Amobarbital sodium (sodium amytal), 0.5-1g. I.V. may be given. Phenobarbital sodium, 0.4-0.8g, injected slowly I.V. may be used.

Paraldehyde, 1-2ml. diluted in a triple volume of saline and given slowly

I.V. is an effective alternative. If the convulsion continues, repeat the intravenous dose "very slowly and cautiously", or give 8-12ml. I.M. Diphenylhydantoin sodium (Dilantin Sodium) may be injected intravenously at a rate not to exceed 50mg/minutes: a total dosage of 150-250mg may be required. The mainstay of continuing therapy for status epilepticus is intravenous phenytoin, which is effective and non-sedative. It should be given as a loading dose of 13-18mg/kg. in adults; the usual error is to give too little of the drug. Administration should be at a maximum rate of 50mg/ min. It is safest to give the drug directly by intravenous push but it can also be diluted in saline; it precipitates rapidly in the presence of glucose. Especially in elderly people, careful monitoring of cardiac rhythm and blood pressure is necessary. At least part of the cardiotoxicity is from the diluent, propylene glycol, in which the phenytoin is dissolved. **Note:** In previously treated epileptic patients, the administration of a large loading dose of phenytoin may cause some dose-related toxicity such as ataxia. This is usually a relatively minor problem during the acute status episode and is easily alleviated by the later adjustment of plasma levels.

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

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

3.7 Febrile convulsions

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

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

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

6. The immature brain may respond to high fever and an infectious agent with a convulsion.

Management (of patient with Febrile Convulsions)

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

Prognosis

a. The Prognosis of febrile convulsions varies. Many children subsequently develop Psychomotor seizures.

b. Nonfebrile convulsions also occur in a majority of patients with a history of febrile convulsions.

c. Most children with a history of febrile convulsions have had only 1-2 such febrile seizures.

3.8 Withdrawal of use of antiepileptic drugs

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

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

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

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

4.0 **Conclusion**

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

5.0 **Summary**

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

6.0 **Tutor Marked Assignment**

Explain the aetiology, manifestation, complication and management of Epilepsy

7.0 References / Further Readings

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SELF ASSESSMENT EXECISE XI

a. Describe epilepsy
b. Enumerate the likely causes of epilepsy

ANSWER

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

b. Likely causes of epilepsy epilepsy has several causes. The following causes are identified:

(i) Constitutional (or Idiopathic Epilepsy)
(ii) Symptomatic Epilepsy.

i. Constitutional (or Idiopathic Epilepsy)

Seizures usually begin between 5 and 20 years of age but may start later in life.

No specific cause can be identified and there are no other neurologic abnormalities.

ii. Symptomatic Epilepsy

There are many other causes

(vii) Congenital abnormalities and perinatal injuries may result in seizures presenting in infancy or childhood.

(viii) Metabolic disorders – e.g. hypocalcaemia, hypoglycemia, pyridoxine deficiency and ketonuria – all cause epilepsy (seizures) in newborns and infants.

(ix) Trauma – e.g. birth injuries to the skull (e.g. forceps delivery), road traffic accident affecting the skull, especially.

(x) Tumors and other space-occupying lesions.
(xi) Vascular diseases – they cause seizures especially in the elderly.

Infectious diseases – must be considered in all age groups as potentially reversible causes of seizures. Seizures may occur in the context of an acute infective or inflammatory illness, such as bacterial meningitis or herpes encephalitis. Also in conditions like neurosyphilis, or cerebral cysticercosis, brain abscess and chronic kidney disease