NATIONAL OPEN UNIVERSITY OF NIGERIA

COURSE CODE: NSC503

COURSE TITLE: MENTAL HEALTH AND PSYCHIATRIC NURSING III

COURSE CODE: NSC503 (4 CREDIT UNIT)

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COURSE GUIDE

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1.0 Introduction

This course focuses on building on knowledge of psychosocial development from childhood to adulthood and the understanding of human behavior in health and illness and the knowledge acquired from NSC 314 (Mental Health Nursing and Psychiatric Nursing I) and NSC 412 (mental health and psychiatric nursing II) It is designed to equip the students to completely employ nursing process and evidence base nursing practice in the development of nursing care of Psychiatric clients. The course will expose the students to specific mental health issues related to substance abuse, therapeutic modalities in dynamics of human behaviours in the application of interventions and the concept and practice of community mental health nursing.

2.0 What you will learn in this course

The overall aim of NSC 503: Mental Health and Psychiatric Nursing III is to enable you build on what you have learnt in Mental Health and Psychiatric Nursing I and II as this course advanced on the previous one. Some of the topics covered in this unit includes Substance Abuse, Alcoholism, Epilepsy, Therapeutic Modalities in Psychiatry, Crisis Intervention, Community Mental Health Nursing, Legal Aspects of Mental Health Nursing, History Taking of Psychiatric Patients, Electro-Convulsive Therapy, Occupational and Recreational Therapies, Rehabilitation and Psychiatric Pharmacology.

3.0 Course aims

The aim of this course can be achieved by adequate response to the following :

- .
- Outline the substances commonly abused.
- Explain the concept of alcoholism.
- Discuss various therapeutic modalities in psychiatry.
- Explain the concept of crisis intervention.
- Describe community mental health nursing.
- Discuss the legal aspects of mental health.
- Explain how history taking of psychiatric patients is carried out.
- Describe Electro-convulsive therapy.
- Discuss occupational and recreational therapy with the concept of rehabilitation.
- Outline the various drugs used in psychiatry.

4.0 Course objectives

Each unit also has specific objectives which you need to read carefully and you can always refer to them in the course of your reading to aid your self-evaluation.

On successful completion of the course, you should be able to:

- Out-line the characteristics of substance abuses.
- Define alcoholism
- Discuss various therapeutic modalities in psychiatry.

- Discuss legal aspects of mental health nursing.
- Discuss crisis intervention.
- Correctly take history of psychiatric patients.
- Apply electroconvulsive therapy.
- Describe occupational and recreational therapies.
- Outline drugs used in psychiatry.

5.0 Working through this course

In order to successfully complete this course you are required to read the study units, read reference books and other materials provided by the university.

6.0 Course materials

Major components of the course are:

- Course Guide
- Study Units
- References/ Further Readings

7.0 Assessment

There are two aspects of the assessment of the course. Firstly, the tutor marked assessment and secondly, there will be a written examination (final). In dealing with the assignments, you are expected to apply information, knowledge and strategies gathered during the course. The tutor marked assignments are expected to be submitted to your study centre in accordance with the directives of the university.

8.0 Tutor marked assignment

Each unit has tutor marked assignment questions at the end of the units.

9.0 References/Further Readings

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Unit 1: Substance Abuse

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1.0 Introduction

Please recall that in the last unit, we examined organic mental disorders and the effect of drugs on mental health, in this unit the learners will be exposed to substance abuse (drug abuse and drug addiction).

2.0 Objectives

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

- Define drug abuse and addiction
- Differentiate between drug abuse and addiction
- List five drugs commonly abused
- Enumerate some causes of drug abuse
- State the principles of diagnosis
- Describe the guide to the management of substance abuse crisis
- Methods of combating drug abuse and drug addiction

- list four socio-economic and psychological problems of drug abuse and addiction

Main content

Introduction

Drug abuse as defined by WHO has to be a persistent or sporadic excessive use of a drug and that use of drug is inconsistent with or unrelated to acceptable medical practice. With this definition, it shows that any drug can be abused. Drug abuse itself is not an illness but it may and usually leads to an illness. Although marijuana is the drug most extensively resorted to, the sedatives, stimulants and hallucinogens are widely abused and addiction to the "hard" narcotics has increased considerably. The variety of drug effects and the constant introduction of new drugs and agents and rediscovery of old ones have led to some confusion in the terminology of inappropriate or inadvisable drug use.

DEFINITIONS OF TERMS; These are common terms used in substance abuse

Misuse implies overzealous or indiscreet administration of drugs by physicians. To misuse a drug might be to take it for the wrong indication, in the wrong dosage, or for too long a period, to mention only a few obvious examples.

Abuse implies the use of drugs for other legitimate medical purposes. That is, abuse might be construed as any use of a drug for nonmedical purposes, almost always for altering consciousness.

Drug dependence: Dependence is a biologic phenomenon. Psychic Dependence is manifested by compulsive drug-seeking behaviour in which the individual uses the drug repetitively for personal satisfaction. Heavy cigarette smoking is an example. Physical Dependence is present when the withdrawal of the drug produces symptoms that are frequently the opposite of those sought by the user. It has been suggested that the body adjusts to a new level of homoeostasis during the period of drug use and reacts in opposite fashion when the new equilibrium is disturbed.

Addiction is usually taken to mean a state of physical and psychic dependence, but the word is too precise to be useful.

Addiction as defined by 'WHO' is a "behavioral pattern of drug use characterized by overwhelming involvement with the use of a drug, compulsive drug-seeking behaviour, and a high tendency to relapse after withdrawal". The W.H.O. stresses that "addiction should be viewed on a continuum relative to the degree where drug use affects the total life quality of the drug use and to the range of circumstances in which it controls his behaviour".

Effects of drug abuse

Some drugs when abused produce dependence with the following characteristics:

(i) Compulsion to take the drug on a continuous or sporadic basis in order to experience its psychic effects (psychological dependence).
(ii) Presence of physical symptoms when the drug is suddenly withdrawn (withdrawal symptom).
(iii) Tolerance.
(iv) Detrimental effect on the individual and the society.

Substances commonly abused

(a) Common analgesics – e.g. aspirin
(b) Stimulants e.g. kolanuts, coffee
(c) Alcohol
(d) Sedatives e.g. barbiturates
(e) Amphetamine
(f) Cannabis (Indian hemp).

Causes of drug abuse

1. Habit formation
2. Peer group
3. Self-medication
4. Over-prescription of drugs by some doctors
5. Environment
6. Illnesses particularly emotional disorders.
7. Stress in homes and places of work

Principles of diagnosis

Substance abuse

Abuse is characterized by a pattern of pathologic use lasting for at least a month and causing impairment in social and occupational functioning.

Pattern of Pathologic Use: Although the pattern varies depending upon the substance used, it may be characterized by

(i) intoxication throughout the day",
(ii) inability to cut down or stop use,
(iii) repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day
(iv) continuation of substance use despite a serious physical disorder that the individual knows is exacerbated by use of the substance,
(v) need for daily use of the substance for adequate functioning and episodes of a complication of the substance intoxication

(vi) Impairment in Social or Occupational-functioning: Behaviour may include erratic, impulsive, or aggressive actions and failure to meet important obligations to friends and family. Disturbed social interaction is a consequence of intoxicated behaviour and personality changes that may be produced by the psychoactive drug. There may also be legal difficulties associated with behaviour during the intoxicated state (e.g. car accidents) or criminal behaviour to obtain money to purchase the substance. It is important to distinguish criminal activity (e.g. theft) to perpetuate drug intoxication from recreational drug use in conflict with local customs and laws.

(vii) Impairment in occupational functioning may include missing work or school and inability to function effectively because of intoxication.

Substance Dependence

Substance dependence is a more severe form of substance abuse and it is characterized by the following;

(i) Tolerance: Tolerance means markedly increased amounts of the substance are required to achieve the desired effect, or there is markedly diminished effect with regular use of the same dose.

(ii) Withdrawal: "In withdrawal, a substance specific syndrome follows cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiologic state of intoxication". Characteristics of the withdrawal syndrome vary with the substance used. Frequently observed symptoms are anxiety, restlessness, irritability, insomnia and impaired attention.

Multiple Drug Abuse

When the history includes use of more than one substance, multiple diagnosis of substance use disorders should be made, except under the following conditions:

1. when the specific substances cannot be identified;
2. when the substances used are from different (non-alcoholic) categories or
3. when the substances abused cannot be classified – it is thus designated as "unspecified, mixed, or other substances abuse" respectively. Multiple drug abuse is common among drug abusers, and the resulting

spectrum of symptoms often makes diagnosis and treatment difficult.

Drug tolerance is associated with some (but not all) patterns of drug abuse. This diagnosis is complicated when multiple drugs are used, some of which (e.g. sedative-hypnotics) may manifest cross-tolerance. An abuser of a sedative-hypnotic such as a short-acting barbiturate or benzodiazepine may combine use of drugs and alcohol, producing mixed addiction. Individuals who abuse various drugs in the same group may develop substantial tolerance but are not immune to the life-threatening consequences of the drugs – e.g. they are often seen in emergency room after overdose or associated dysfunction such as having a blackout while driving. These serious consequences of substance abuse may be the first symptom of addictive disease seen by the physician.

Underlying Psychopathologic Disorders

Individuals with primary substance use disorders should be evaluated for underlying psychopathologic conditions such as an affective disorder or thought disorder (or both problems such as medical diseases or complications). Following detoxification from drug dependence, individuals whose only problem is the primary addictive disease are better managed in an abstinence-oriented treatment approach. Individuals who have both an addictive disease and an underlying psychopathologic disorder may require psychotropic medication following detoxification and are less well suited to abstinence-oriented treatment.

Guide to management of substance abuse crisis

A. Assessment

This should include the following:

(1) Substance Used:

- Type of substance (or availability of sample for identification or testing if the patient does not know the type).
- Route of administration (inhaled, ingested, injected etc.)

(2) Pattern and circumstances of substance use

- self-medication because of physical, mental or emotional problem
- concomitant use of prescription or over-the-counter medications
- Alternating or concomitant use of other drugs in the same drug group.
- Identifiable events, such as loss or celebration, precipitating the substance abuse crisis.
- If the drug is used habitually, pattern of development and method of maintenance of habit.

(3) Extent of potential support system

- Family or friends available to help the patient follow through on

treatment
- Community groups or agencies specifically addressing the patient's abuse pattern.
(4) History of previous treatment
- Type and duration of treatment
- Results
(5) Other
- Effects of drug use on the patient's life (e.g. financial problems, changes in physical appearance).
- Physical infirmity that could exacerbate the problem
- Willingness to change abuse habits.

B. Initial Management of the Crisis

Before treatment is begun, it is important to assure the patient of confidentiality and explain the rationale for treatment and what to expect. The patient's behaviour is observed carefully; vital signs are monitored, and the patient is given only symptomatic treatment before the substance is identified. No medication should be given if there is any question about identification of the drug.

The goal of the 3 approaches listed is to achieve an alteration in the patient's status or a favorable resolution of the crisis. Judgment must be used in selecting the most appropriate approach in the circumstances.

(i) Assistance: The involvement of another individual or authority in the substance abuse crisis often helps patients endure the crisis and workout a personal solution. This gives them an opportunity for growth through mastery of the crisis. Psychiatric emergency clinicians often directly involve others or ask patients to recommend someone with whom they are comfortable to reassure and guide them during the crisis.

(ii) Complete Management: Some cases require complete management of the crisis by the clinician, as in the active treatment of drug over-does.

(iii) Patient Education: In some instances, clinicians provide additional information or resources so that patient can resolve their own substance abuse crisis.

C. Follow-up Strategies

After crisis intervention for the drug overdose, medical management of the complications and appropriate detoxification procedures, the physician should evaluate the patient to determine if there are any associated physical problems, persistent organic mental disorder or major underlying psychopathological conditions. In most cases, the substance use disorder must be viewed as the primary disease process. Fewer than 10% of patients who have addictive disease have a major underlying psychopathologic

condition.

However, if an underlying problem exists it is difficult to follow a drug-free-abstinence-oriented approach to treatment, since the patient will often require psychotropic medication for management of the psychopathologic disorder. Antidepressants may be prescribed for a major depressive episode, or an antipsychotic drug may be given for an underlying thought disorder. For some patients with primary addictive disease, a drug maintenance programmes (e.g. with methadone) may be implemented, but abstinence-based recovery-oriented strategies should be tried first.

Most follow-up strategies are psychosocial in nature and include family therapy and individual psychotherapy. Successful strategies include participation in non-medical self-help groups, such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous. These programmes focus on abstinence and emphasize the principles of recovery, with the group process supporting and maintaining recovery. On occasion, the addict will require residential therapy, typically in a highly structured behaviour modification self-help community.

Follow-up care must be tailored to the individual's addictive disease process and must be flexible enough to change as the patient's needs change. The physician should recognize that addiction is a chronic, relapsing disease with potentially fatal and consequences but that recovery is possible.

Methods of combating drug abuse and drug addiction

1. Legal Penalties: The government should make provision for penalties that await offenders. Those who sell out dangerous drugs should be adequately punished. There should be legal codes controlling buying and selling of drugs. The Ports and Customs should be adequately controlled. Adequate laws should be enacted.
2. Law Enforcement Agents: The Police together with the Pharmacists should inspect shops, chemist shops and see to adequate storage and dispensing of drugs. Offenders should be planned.
3. Health Education: The public should be educated regarding the use of certain drugs especially without valid Doctor's prescription. The public could be educated via Radio, Television, Public lectures and mounting of Posters.
4. Provision of Effective and Efficient Health Care Delivery: There is no doubt that if effective and efficient Health Care delivery is provided by the Government, it will go a long way to reduce or discourage self-medication and minimize risk of drug abuse and drug dependence.

Socio-economic and psychological problems of drug abuse and drug addiction

(i) Deviant Behaviours: Some people abuse drug in order to carry out some deviant activities to the detriment of the health of the other members of the society. For example, most of the vices are committed under the influence of drug. Some people break into some houses after taking some drugs.

(ii) Mental Illness: Some of the mentally sick in our society today have abused drugs – sometimes in their life. Drug abuse and drug dependence may result in any form of mental illness; and the more mentally sick we have in the society, the more dangerous the society will be for the rest of the populace.

(iii) Broken Homes: Experiences have shown that drug abuse and drug dependence could result in broken homes.

(iv) Low Productivity: When many people who could have been engaged in meaningful production are mentally sick, there will be a generally low productivity output.

(v) Late Diagnosis of Disease: Some people treat themselves at home, ignorantly and later come to the hospital when the disease would have gone in an advanced stage. Some of them end up staying in the hospital for a very long time while others die.

(vi) Death: Intake of an overdose of some drugs could easily lead to death.

4.0 **Conclusion**

The effects of drug abuse and drug addiction are preventable in any society. In Nigeria, the Federal Government set up agencies in this direction like NAFDAC so as to curb the incidence of substance abuse and its menace but the success depends on every member of the society. Drugs have also played a role in political history. For example, the opium wars of the nineteenth century between China and Britain and the drug movement of the 1970s in the United States changed the course of history. Even today, we are struggling with political and social events that relate to drugs and other illicit substances.

5.0 **Summary**

In this unit, the learner has gone through lecture on substance abuse (what, how, who, where, when of substance abuse and its effects). The devastating effects of substance abuse are alarming in our society, the prevention requires the concerted efforts of all and sundry as the world of substance use and abuse is always changing. As health care providers become more familiar with current chemical fads, new and more potent drugs are

introduced.

7.0 **References / Further Readings**

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Unit2: Alcoholism

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1.0 Introduction

Alcohol is brewed in all cultures from time immemorial and is known to have high abuse potential in all cultures so it should be considered with rapt attention. This unit will expose you to the subject matter of alcoholism, its meaning, types, causes, effects, stages, complication and treatment of alcoholism.

2.0 Objectives

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

- describe what alcoholism is
- state the types of alcoholism
- list the cause of alcoholism
- explain the effects of alcoholism
- enumerate the stages of alcoholism
- describe the complications and treatment of alcoholism

Main content

Introduction

Alcoholism is a syndrome consisting of 2 phases:
Problem drinking and alcohol addiction. Problem drinking is the repetitive use of alcohol often to alleviate tension or solve other emotional problems. Alcohol addiction similar to that which occurs following the repeated use of barbiturates or similar drugs.

Definition: The term '**Alcoholism'** is a very general one and is used to describe a state in which excessive indulgence in alcohol has become harmful to the individual's physical or mental health, to his inter-personal relations, or to his social or economic functioning. An 'alcoholic' is a person whose drinking pattern is having these consequences or beginning to show the signs of their development. In contrast to the self-indulgent the heavy drinker who drinks because he likes it, while the alcoholic is dependent on alcohol and drinks because he must. Alcoholism is a major problem world-wide.

Diagnostic Criteria for disorders associated with alcohol abuse and dependence is stated below.

Alcohol abuse: is characterized by 3 criteria.

(1) A pattern of pathologic alcohol use, such as the need for daily drinks or the presence of binges or blackouts.
(2) Impairment in social or occupational functioning due to alcohol use, such as loss of a job or legal difficulties; and
(3) Duration of disturbance of at least one month.

Alcohol dependence: is characterized by 2 criteria.

(1) Either a pattern of pathologic alcohol use or impairment in social or occupational functioning due to alcohol; and
(2) Either tolerance or withdrawal

Tolerance: is defined as a need for increased amount of alcohol to achieve a desired effect or as a markedly diminished effect with regular use of the same amount of alcohol.

Withdrawal: is defined as the development of alcohol withdrawal (certain characteristic sign and symptoms, such as tremor, tachycardia, and restlessness) after cessation of or reduction in drinking.

Types of alcoholism

Alcoholism is not a uniform disorder, and a number of different types may be recognized.

Various methods of classification are known, but the following represent the main groups.

(a) **Habitual Excessive Drinkers:** These people drink for pleasure or social reasons and become habituated to it. They grow tolerance and no physical or mental complications except that in some people, there may be outbursts of disturbed behaviour loss of employment, financial difficulties and disruption of family relationship.

(b) **Habitual Symptomatic Excessive Drinkers:** There is a psychological dependence o alcohol which is needed to relieve physical or

emotional discomfort. The drinking is thus a symptom of a disturbance in another field.

(c) **Periodic Excessive Drinkers:** Some alcoholics are subject to periodic bouts of heavy drinking (sometimes called "**dipsomania**") but in the intervals can often abstain or drink only moderately. Severe recurrent anxiety or depression is sometimes the basis of such drinking.

(d) **Alcohol Addiction:** In the fully established addict, the bodily metabolism has become adapted to the presence of alcohol. Physical dependency has developed and sudden interruption of alcohol consumption may lead to severe physical withdrawal symptoms. At first there may be weakness, sweating, anorexia, nausea, irritability and restlessness; later tremors, severe apprehension, hallucinations and convulsions may occur.

Causes of alcoholism

There is no single cause of alcoholism. Biomedical, psychologic and social factors all play a role in its development and stressful events; sometimes serve as catalysts of drinking behaviour.

The following factors contribute:

(i) National differences in drinking habits cost of alcohol, licensing laws and wine production.

(ii) Social factors – probably make it more common in men than women.

(iii) It sometimes run in family but definitely not inherited.

(iv) The predisposing unstable personality may have some genetic basis; the influence of the parental example is probably an important factor.

(v) Some shy and oversensitive individuals drink to be able to mix more freely.

(vi) Some use as a sedative to reduce tension. It is also used to reduce various mental conflicts or to escape from difficult life situations.

Effects of alcoholism

Increased alcohol use can lead to both physical and psychologic dependence, which result in a number of important biomedical, psychological, and social sequelae such as cirrhosis, depression, marital problems and occupational problems. These sequelae themselves are stressful and lead to more drinking, further dependence and additional sequelae - and the cycle continues.

Other effects of alcoholism are classified into two:

Physical: Diminishing appetite with nausea and vomiting, especially in the morning is commonly present and is due to "chronic gastritis". This is to some extent responsible for the vitamin B deficiency.

Mental: The alcoholic eventually may become selfish, inconsiderate, deceitful and unrealiable in his behaviour. His mood may vary between self-

pity, remorse and outbursts of violence. He's often suspicious of the wife and accuses her of infidelity.

Stages of alcoholism

1. Pre-alcoholic: It is characterized by a gradual change in socially motivated drinking to a means of relieving personal tension.
2. Prodomal phase: Begins when the need for alcohol is no more social, rather it is psychological. It is characterized by sudden onset of black-outs. They have guilty feelings and avoid reference to alcohol in social gatherings.
3. The Crucial Phase: There is loss of behavioural control, drinking become conspicuous. He tries to stop, but cannot stop. He is critical of others; he does not like correction and becomes aggressive. He may loose his job, friends and there is a decrease in sexual drive and malnutrition sets in.
4. The Chronic Phase: There is marked ethical deterioration, impairment of thinking and can drink with anyone regardless of status. He has lost complete control and he gets hopelessly and helplessly drunk. He starts to loose tolerance for alcohol because of Liver damage. He now accepts defeat and is ready for treatment.

Complications

(1) **Alcoholic Hallucinosis:** This syndrome occurs either during heavy drinking or on withdrawal and is characterized by a paranoid psychosis without the tremulousness, confusion and clouded sensorium seen in withdrawal syndromes. The patient appears normal except for the auditory hallucinations, which are frequently persecutory and may cause the patient to behave aggressively.

(2) **Delirium Tremens:** It is an acute organic psychosis that is usually manifest within 24-72 hours after the last drink (but may occur up to 7-10 days later). It is characterized by mental confusion tremor, sensory hyperactivity, visual hallucinations (often of snakes, bugs etc), automatic hyperactivity, diaphoresis, dehydration, electrolyte disturbances (hypokalemia, hypomagnesemia), seizures and cardiovascular abnormalities.

Delirium tremens is therefore a toxic state that occurs in response to withdrawal or diminution of alcoholic intake. It is particularly common in patients who are withdrawn from alcohol when admitted to the hospital for treatment of phenmonia or fractures. Patient can be treated with sedation, such as chlorpromazine, 100 mg 4 times daily orally; and paraldehyde

12-16mls orally, in cold fruit juice or cracked ice. The duration of delirium tremens is 2-7 days.

If patient is dehydrated, dehydrate with oral fluids or give dextrose and saline solution intravenously; add Vit. Bco. intramuscularly. Because of the frequency of convulsions, diphenylhydantoin (Dilantin), 100mg 3 times a day orally, should be considered.

It has been suggested that the mental symptoms in alcoholic illnesses are not due to poisoning by the alcohol but to vitamin B deficiency as a result of faulty absorption from the stomach due to the alcoholic, gastritis usually present.

Note: If alcohol is taken over long periods in large quantities permanent structural damage may be done to the central nervous system resulting in some permanent intellectual reduction and probably other mental symptoms. Large quantities take over short periods, on the other hand, produce symptoms of acute intoxication or poisoning which tend to clear-up fairly rapidly and completely.

(3) **Withdrawal Syndrome:** When an alcoholic suddenly stops drinking (especially the addicts) withdrawal syndrome results, acute withdrawal syndrome results/occurs when the patient has been hospitalized for some unrelated problem and presents as a diagnostic problem.

(4) **Korsakoff Psychosis:** It's an organic brain damage that is irreversible. It consists of marked loss of memory for recent events, disorientation, confabulations.

(5) **Wernicke's Encephalopathy:** There is disorientation, associated with paralysis of ocular muscles, nystagmus, ataxia. It is due to acute deficiency of vitamin B1.

Other complications are:

Liver Cirrhosis

Gastritis

Peripheral Neuritis

Cardiomyopathy

Chronic Brain Syndromes; Cerebellar degeneration; and Peripheral neuropathies.

Treatment

Treatment should be directed first at the stage of dependence on drinking and finally should attempt to explore and modify predisposing causes.

(i) Acute Stage: Unless the patient is in a very poor stage of health, alcohol is usually withdrawn abruptly.

In heavy drinkers – prevent risk of fits and delirium tremens with anticonvulsant drug and tranquilizers.
Presence of weight loss, salt depletion and malnutrition necessitates liberal administration of fluids, salts, vitamins (often given parenterally in very large doses) and glucose with small doses of insulin.
Tension and restlessness are controlled by tranquilizers of the Phenothiazine group e.g. Largactil (given by injection). Large doses of Chlormethiazole 1-2g in divided doses is given for delirium in heavy drinkers.

(ii) Long Term Treatment

(a) Apomorphine

This therapy attempts to induce a conditioned aversion to alcohol by associating drinking with repeated nausea and vomiting. This treatment is carried out in hospital and only if patient's condition is alright.
Patient is given in the morning 1/10gr. apomorphine injection (or **Emetine**) at the same time 4 oz of 50% alcohol by mouth. Apomorphine is a powerful emetic and induces nausea and vomiting.
Apomorphine injection and alcohol by mouth are repeated 2 hourly until the evening of the third day. During this time, the patient is given injections of vitamin B but is allowed no food and no fluids except alcohol.
On the evening of the 3rd day he has a normal meal and thereafter is given a full diet and if necessary a course of modified insulin. He is given no more alcohol and injections of apomorphine are tapered off by giving him 1/40gr 4 hourly for 24 hours and 1/80gr 6 hourly for 24 hours. The treatment requires skilled nursing and vital signs are monitored regularly and charted.
(b) **Antabuse** (Disulfiram)
This is a drug which interferes with the breakdown of alcohol in the body so that the toxic substance acetaldehyde accumulates in the blood and causes unpleasant side effects. The effects of alcohol on a patient taking Antabuse is usually dramatic.
Within a few minutes, his face becomes very flushed, his pulse rate rises and he usually complains of headache, palpitation and breathlessness. The patient having had this experience develops a negative attitude to alcohol intake.
(c) Psychotherapy: Patient benefits from individual and group psychotherapy. Either method aims at discouraging patient in drinking (i.e. Apomorphine and Antabuse).

(d) Alcoholics Anonymous (A.A.)

The alcoholics, who generally feel misunderstood, rejected and ostracized by society finds in this fellowship a body of people who have undergone experiences very similar to his own. He feels understood, accepted and achieves a feeling of belonging. He assists other alcoholics and in so doing helps himself, gradually regarding his self-respect and self-confidence. Alcoholic Anonymous (A.A.) is therefore a directive and inspirational form of group therapy for Alcoholics.

(e) Other cares:

Nurses roles include: Psychological care, physical care, diet general observations of rehabilitation of patient.

4.0 **Conclusion**

The practice of using substances to make one feel better is as old as humans themselves. Even animals have been seen eating certain plants that change their behaviours. Alcohol has played a role in many cultures throughout recorded time. Many people think of alcohol as a stimulant because they feel relaxation, alertness and pleasure when they drink. Actually these feelings are caused by the depressant effects of alcohol on the central nervous system. Once swallowed, alcohol is rapidly diffused to all the body's organs.

5.0 **Summary**

With continued use of alcohol, tolerance develops and individuals become dependent on alcohol. If drinking does not stop, death from multiple organ failure (especially the liver) results, usually after a series of assorted chronic health problems.

6.0 **Tutor Marked Assignment**

What are the effects of alcoholism on the development of the nation?

7.0 **References / Further Readings**

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Unit 3: Crisis Intervention

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1.0 **Introduction**

Mental health clients may be labeled with one or more psychiatric diagnosis, but all have one thing in common i.e. unsuccessful coping behaviours. The very nature of mental illness is characterized by actions that are not in keeping with society's definitions of appropriate behaviours. Mental health caregivers provide clients with education about and opportunities to engage in more effective behaviours. When experiencing stress, people use their resources to decrease the discomfort. These efforts called coping mechanisms used as the tools that help us work through the ups and downs of daily living. A crisis is an upset in the homeostasis of an individual. A crisis has several characteristics that separate it from other stressful situations. For example, a crisis occurs when an individual's usual coping mechanisms are ineffective so the crisis demands new solutions with new coping strategies. Crisis is self-hinting because human beings can not endure high levels of continued stress, crisis are usually resolved within a short time and because a crisis usually affects more than one person, for everyone within the person's support system is affected by the crisis.

2.0 **Objectives**

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

- define what crisis is
- define grief crisis is
- list the characteristics of individuals prone to crisis

- enumerate the types of crisis

- describe the resolution of crisis
- describe the stages of grief
- explain how grief is resolved

Main content

Crisis

Crisis can be viewed as an integral component of everyday life situations. A crisis may influence people's lives in different ways. As a consequence of a crisis experience, the individual may go down to a lower or less healthy level of functioning than what was before the crisis, or he may resume the same level of functioning by repressing the crisis and the related emotions. On the other hand, he may function at a healthier level than prior to the crisis, because the challenge of a crisis can bring out new strengths, skills and coping mechanisms.

Intervention at a crisis is extremely important to prevent mental illness, because long-standing problems make the person totally incapable of handling the situation. If proper guidance is provided at the correct time, the victim will come out of it better equipped to handle future problems in life.

Definition

Crisis is a state of disequilibrium resulting from the interaction of an event with the individual's or family's coping mechanisms, which are inadequate to meet the demands of the situation, combined with the individual's or family's perception of the meaning of the event (Taylor 1982)

Crisis Proneness

Hendricks (1985) suggests that certain individuals are more prone to crisis than others. The following are characteristics often found in individuals who are regarded as being more susceptible to crisis:

- Dissatisfaction with employment or lack of employment.
- History of unresolved crisis.
- History of substance abuse.
- Poor self-esteem, unworthiness.
- Superficial relationships with others.
- Difficulty in coping with everyday situations.
- Under utilization of resources and support systems.
- Aloofness and lack of caring.

It is important to note that individual personality traits must also be considered in conjunction with these characteristics. Crisis is defined by the individual; what is a crisis for one is merely an occurrence for another. This

factor is a critical component that must be evaluated in relation to crisis prone characteristics as well as personality traits.

Types of Crisis

Maturational Crisis

Maturational crisis can be defined as the predicable processes of growth and development that evolve over a period of time, the ultimate goal of these processes is maturity.

The transition points where individuals move into successive stage often generate disequilibrium. Individuals are required to make cognitive and behavioural changes and to integrate those physical changes that accompany development.

The extent to which individuals experience success in the mastery of these tasks depends on previous successes, availability of support systems, influence of role models and acceptability of the new role by others.

The transitional periods or events that are most commonly identified as having increased crisis potential are adolescence, marriage, parenthood, midlife and retirement.

Situational Crisis

A situational crisis is one that is precipitated by an unanticipated stressful event that creates disequilibrium by threatening one's sense of biological, social or psychological integrity.

Examples of events that can precipitate situational crises are premature birth, status and role changes, death of a loved one, physical or mental illness, divorce, change in geographic location and poor performance in school.

Social Crisis

Social crisis is accidental, uncommon and unanticipated and results in multiple losses and radical environmental changes. Social crisis include natural disasters like flood, earthquakes, violence, nuclear accidents, mass killings, contamination of large areas by toxic wastes, wars etc. This type of crisis is unlike maturational and situational crisis because it does not occur in the lives of all people.

Because of the severity of the effects of social crisis coping strategies may not be effective. Individuals confronted with social crisis usually do not have previous experience from which to draw expertise. Support systems may be unavailable because they may also be involved in similar situations. Mental health professionals are called upon to act quickly and provide services to large numbers of people and in some cases, the whole community.

Phases of Crisis

Caplan (1964) has described four phases of crisis as described below:

Phase I

Perceived threat acts as a precipitant that generates increased anxiety. Normal coping strategies are activated, and if unsuccessful, the individual moves into Phase II.

Phase II

The ineffectiveness of the Phase I coping mechanisms leads to further disorganization. The individual experiences a sense of vulnerability. The individual may attempt to cope with the situation in a random fashion. If the anxiety continues and there is reduction, the individual enters Phase III.

Phase III

Redefinition of the crisis is attempted and the individual is most amenable to assistance in this phase. New problem solving measures may also affect a solution. Return to pre-crisis level of functioning may occur. If problem solving is unsuccessful, further disorganization occurs and the individual is said to have entered Phase IV.

Phase IV

Severe to panic levels of anxiety with profound, cognitive, emotional and physiological changes may occur. Referral to further treatment resources is necessary.

Signs and Symptoms of Crisis

- The major feeling in a crisis situation is anxiety. The individual experiences a heavy burden of free-floating anxiety.
- The anxiety may be manifested through depression, anger and guilt. The victim will attempt to get rid of the anxiety using various coping mechanisms, healthy or unhealthy.
- The individual may become incapable of even taking care of his daily needs and may neglect his responsibilities.
- The individual may become irrational and blame others for what has happened to him.

Resolution of Crisis

Healthy resolution of a crisis depends upon the following three factors:

1. Realistic appraisal of the precipitating event, i.e. recognition of the relationship between the event and feelings of anxiety id necessary for effective problem-solving to occur.
2. Availability of support systems.

3. Availability of coping measures over a life-time: A person develops a repertoire of successful coping strategies that enable him to identify and resolve stressful situations.

There are three ways by which the individual may resolve the crisis:

Pseudo-resolution

In this, the individual uses repression and pushes out of consciousness the incident and the intense emotions associated with it, so there will not be any change in the level of functioning of the individual. But in future, if and when a crisis occurs, the repressed feelings may come to surface and influence the feelings aroused by the new crisis. In such a situation, the particular crisis may be more difficult to resolve because the feelings associated with the earlier crisis are neither expressed nor handled at that time.

Unsuccessful Resolution

In this, the victim uses pathological adaptation at any phase of crisis, resulting in a lower level of functioning. The victim, rather than accepting the loss and reorganizing his life, keeps ruminating over the loss. An example is prolonged grief reaction, which results in depression.

Successful Resolution

In this, the victim may go through the various phases of crisis, but reaches Phase III where various coping measures are utilized to resolve the crisis situation. The individual develops better skills and problem solving ability, which can be and will be used in various situations in future.

Crisis Intervention

Crisis intervention is a technique used to help an individual or family to understand and cope with the intense feelings that are typical of a crisis. Nurses function as part of the interdisciplinary team in the use of crisis intervention as a therapeutic modality. Nurses may employ crisis techniques in their work with high-risk groups such as clients with chronic diseases, new parents and bereaved persons.

Nurses may also use crisis intervention in dealing with intra-group staff issues and client management issues.

Aims of Crisis Intervention Technique

- To improve a correct cognitive perception of the situation.
- To assist the individual in managing the intense and overwhelming feelings associated with the crisis.

Intervention

A. Steps to provide a correct cognitive perception

Assessment of the situation

- This may be achieved by direct questioning with the purpose of identification of the problem and the people involved.
- It is necessary to identify the support systems available and to know the depth in which the individual's feelings are affected.
- Assessment should also be done to identify the strengths and limitation of the victim.

Defining the event

- The victim at times may not be able to identify the precipitating even because of possible denial, or due to reluctance to talk about it.
- It may be necessary for the therapist to review the details of the incidents in the past 2 to 4 weeks in order to identify the event that precipitated the crisis. Such a review will also help to bring the precipitating even to the awareness of the victim.

Develop a plan of action

- The victim and the people closely associated with him should have actual involvement in developing the plan of action.
- The therapist must be aware that the victim may not be in a condition mentally to comprehend complicated information due to the overwhelming anxiety experienced by him. The instructions given by the therapist must be simple and clear, and too much information should not be given at a time. The instructions may have to be written down, as the victim may not be able to retain all the information.

B. Steps to assist the victim in managing the intense feelings

Helping the individual to be aware of the feelings

- The victim needs help in identifying his own feelings, which is the first step in handling them.
- The therapist should use appropriate communication technique so that the victim will feel comfortable to express his feelings without the fear of being judged or criticized.
- The therapist also should be efficient in observing the non-verbal and verbal behaviour of the victim, so that he will be able to make a careful assessment of his feelings.

Helping the individual to attain mastery over the feelings

- The individual should be given adequate support and guidance through the therapeutic process in order to handle the feelings associated with the crisis but special care should be taken not to give any false reassurance.

- He should not in any way be encouraged to blame others, as this will only let him escape from taking any responsibility.
- Care must be taken that the individual may not develop too much dependency on the therapist, which is unhealthy.
- After the victim and the support groups make the plan of action under the guidance of the therapist, this should be discussed with the victim and the concerned others, so that they will have a clear understanding of the methods of implementation of the plan.
- To improve coping with the situation necessary environmental manipulation must be done in physical or interpersonal areas.
- It is advisable to have another appointment for the victim to visit the therapist within a week, in order to assess how the plan is working out, and if needed, to revise and modify the plan.

Grief

Grief is a subjective state of emotional, physical and social responses to the loss of a valued entity. The loss may be real, in which case, it can be substantiated by others (e.g. death of a loved one) or perceived by the individual alone, in which case, it can not be perceived or shared by others (e.g. loss of feeling of femininity following mastectomy).

Stages of Grief

Kubler-Ross (1969) having done extensive research with terminally ill patients identified five stages of feelings and behaviours that individuals experience in response to a real, perceived or anticipated loss:

Stage I-Denial: This is a stage of shock and disbelief. The response may be one of "No, it can't be true!" Denial is a protective mechanism that allows the individual to cope within an immediate time-frame while organizing more effective defense strategies.

Stage II-Anger: "Why me?" and "It is not fair!" are comments often expressed during the anger stage. Anger may be directed at self or displaced on loved ones, caregivers and even God. There may be a preoccupation with an idealized image of the lost entity.

Stage III-Bargaining: "If God will help me through this, I promise I will go to church every Sunday and volunteer my time to help others". During this stage, which is generally not visible or evident to others, a bargain is made with God in an attempt to reverse or postpone the loss.

Stage IV-Depression: During this stage, the full impact of the loss is experienced. This is a time of quiet desperation and disengagement from all associations with the lost entity.

Stage V-Acceptance: The final stage brings a feeling of peace regarding the loss that has occurred. Focus is on the reality of the loss and its meaning for the individuals affected by it.

All individuals do not experience each of these stages in response to a loss, nor do they necessarily experience them in this order. some individuals grieving behaviour may fluctuate and even overlap between stages.

Resolution of Grief

Resolution of the process of mourning is thought to have occurred when an individual can look back on the relationship with the lost entity and accept both the pleasure and the disappointments (both the positive and negative aspects) of the association. Pre-occupation with the lost entity is replaced with energy and desire to pursue new situations and relationships.

The length of the grief process may be prolonged by a number of factors:

- If the relationship with the lost entity had been marked with ambivalence, reaction to the loss may be burdened with guilt, which lengthens the grief reaction.
- In anticipatory grief where a loss is anticipated, individuals often begin the work of grieving before the actual loss occurs. Most people experience the grieving behaviour once the actual loss occurs, but having this time to prepare for the loss can facilitate the process of mourning, actually decreasing the length and intensity of the response.
- The number of recent losses experienced by an individual also affects the length of the grieving process and whether he is able to complete one grieving process before another loss occurs.

Maladaptive Grief Responses

Maladaptive grief responses to loss occur when an individual is not able to satisfactorily progress through the stages of grieving to achieve resolution. Several types of grief responses have been identified as pathological [Lindemann (1944), Parkes (1972)].

These are prolonged, delayed/inhibited and distorted responses.

Prolonged Response

It is characterized by an intense preoccupation with memories of the lost entity for many years after the loss has occurred.

Delayed or Inhibited Response

The individual becomes fixed in the denial stage of the grieving process. The emotional pain associated with loss is not experienced, but there may be evidence of anxiety disorders or sleeping disorders. The individual may remain in denial for many years until the grief response is triggered by a remainder of the loss or even by another unrelated loss.

Distorted Response

The individual who experiences a distorted response is fixed in the anger stage of grieving. The normal behaviour associated with grieving, such as helplessness, hopelessness, sadness, anger and guilt are exaggerated out of proportion to the situation. The individual turns the anger inward on the self and is unable to function in normal activities of daily living. Pathological depression is a distorted grief response.

Exercise 1: What can prolong the grief process?

Treatment

Normal grief does not require any treatment while complicated grief requires medication depending on the prevailing behaviour responses.

Nursing Intervention

- Provide an open accepting environment.
- Encourage ventilation of feelings and listen actively.
- Provide various diversional activities.
- Provide teaching about common symptoms of grief.
- Reinforce of goal-directed activities.
- Bring together similar aggrieved persons, to encourage communication, share experiences of the loss and to offer companionship, social and emotional support.

4.0 **Conclusion**

Griefs and crises can be successfully managed with adequate adaptation, social support from significant individuals in the society as unresolved griefs and crises may result in major health and psychological problems. Emotional support and referral to various community resources should be offered promptly.

5.0 **Summary**

You have gone through this unit on griefs and crisis management, the knowledge is to assist you as learners for better adaptation and for you to assist you clients.

Tutor Marked Assignments

Describe how you will assist a teenager that drops out of school as a result of loss of her parents in air crash that recently happened

Answer to Exercise 1

- ambivalence, reaction to the loss may be burdened with guilt, which lengthens the grief reaction.
- In anticipatory grief grieving starts before the actual loss occurs.
- The number of recent losses experienced by an individual.

7.0 References / Further Readings

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Module 2: Therapeutic Modalities in Psychiatry

Unit 1: Somatic therapies

Table of Contents

1.0 Introduction

Patients suffering from physical illnesses are given specific treatment because the causes are specific and the signs and symptoms are specific. In a psychiatric setting, the treatment may not be so specific and most patients are given more than one treatment. Some patients do not want treatment and may not cooperate with the doctors and nurses. Some do not realize that they are ill and may actively resist all forms of treatment.

2.0 Objectives

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

- list the examples of psychopharmacology
- describe electroconvulsive therapy
- state the indications and contra-indications of ECT

- discuss the management of a patient undergoing ECT.

Main content

Introduction

The nurse has an extremely important role to play in the treatment of the mentally ill. She is the one who has closer contact with the patient than any other members of the hospital team. She also has a greater opportunity to get to know him and report on his improvement.

The various treatment modalities in psychiatry are broadly divided as:

- Somatic (physical) therapies
- Psychological therapies

Other therapies are:

- Milieu therapy
- Therapeutic community
- Activity therapy

Somatic (Physical) Therapies

Psychopharmacology

The understanding of the biological regulation of thought, behaviour and mood is the basis of all somatic therapies used in modern psychiatry. Psychopharmacology agents are now the first-line treatment for almost every psychiatric ailment. With the growing availability of a wide range of drugs to treat mental illness, the nurse practicing in modern psychiatric settings needs to have a sound knowledge of the pharmacokinetics involved, the benefits and potential risks of pharmacotherapy, as well as her own roles and responsibilities.

The various drugs used in psychiatry are called psychotropic (or psychoactive) drugs. They are so called because of their significant effect on higher mental functions. There are about seven classes of psychotropic drugs. Before going into a detailed description of each, a few guidelines are given below regarding the administration of drugs in psychiatry in general. The specific responsibilities are mentioned separately under each case.

General Guidelines Regarding Drug Administration in Psychiatry

- The nurse should not administer any drug unless there is a written order. Do not hesitate to consult the doctor when in doubt about any medication.
- All medications given must be charted on the patient's case record sheet.
- In giving medication:
    - always address the patient by name and make certain of his identification.

    - do not leave the patient until the drug is swallowed
    - do not permit the patient to go to the bathroom to take the medication
    - do not allow one patient to carry medicine to another.
- If it is necessary to leave the patient to get water, do not leave the tray within the reach of the patient.
- Do not force oral medication because of the danger of aspiration. This is especially important in stuporous patients.
- Check drugs daily for any change in colour, odour and number
- Bottles should be tightly closed and labeled. Labels should be written legibly and in bold lettering. Poison drugs are to be legibly labeled and to be kept in separate cupboard.
- Make sure that an adequate supply of drugs is on hand, but do not overstock.
- Make sure no patient has access to the drug cupboard.
- Drug cupboards should always be kept locked when not in use. Never allow a patient or worker to clean the drug cupboard. The drug cupboard keys should not be given to patients.

Classification of Psychotic Drugs

- Antipsychotics
- Antidepressants
- Mood stabilizing drugs
- Anxiolytics and hypnosedatives
- Antiepileptic drugs
- Antiparkinsonian drugs
- Miscellaneous drugs which include stimulants, drugs used in eating disorders, drugs used in deaddiction, drugs used in child psychiatry, vitamins, calcium channel blockers etc.

Antipsychotics

Antipsychotic are those psychotropic drugs, which are used for the treatment of psychotic symptoms. These are also known as narcoleptics (as they produce neurological side-effects), major tranquilizers, D2-receptor blockers and anti-schizophrenic drugs.

Indications

Organic psychiatric disorders

- Delirium
- Dementia
- Delirium tremens
- Drug-induced psychosis and other organic mental disorders

Functional disorders

- Schizophrenia
- Schizoaffective disorder
- Paranoid disorders

Mood disorders

- Mania
- Major depression with psychotic symptoms

Childhood disorders

- Attention-deficit hyperactivity disorder
- Autism

- Enuresis
- Conduct disorder

Neurotic and other psychiatric disorders

- Anorexia nervosa
- Intractable obsessive-compulsive disorder
- Severe, intractable and disabling anxiety

Medical disorders

- Huntington's chorea
- Intractable hiccough
- Nausea and vomiting
- Tic disorder
- Eclampsia
- Heat stroke
- Severe pain in malignancy
- Tetanus

Pharmacokinetics

Antipsychotic when administered orally are absorbed variably from the gastrointestinal tract, with uneven blood vessels. They are highly bound to plasma as well as tissue proteins. Brain concentration is higher than plasma concentration. They are metabolized in the liver, and excreted mainly through the kidneys. The elimination half-life varies from 10 to 24 hours.

Most of the antipsychotics tend to have a therapeutic window. If the blood level is below this window, the drug is ineffective. If the blood level is higher than the upper limit of the window, there is toxicity or the drug is again ineffective.

Mechanism of Action

Antipsychotics drugs block D2 receptors in the mesobimbic and mesofrontal systems (concerned with emotional reactions). Sedation is caused by alpha-adrenergic blockade. Anti dopaminergic actions on basal ganglia are responsible for causing EPS (extrapyramidal symptoms).

Atypical antipsychotic have antiserotonergic (5-hydroxytryptamine or 5-HT) antiadrenergic and antihistaminergic actions. These are therefore called serotonin-dopamine antagonists.

Adverse Effects of Antipsychotic Drugs

I. Extrapyramidal symptoms (EPS)

1. Neuroleptic-induced Parkinsonism: Symptoms include rigidity, tremors, bradykinesia, stooped posture, drooling, akinesia, and ataxia etc. the disorder can be treated with anticholinergic agents.

2. Acute dystopia: Diatonic movements results from a slow sustained muscular spasm that lead to an involuntary movement. Dystonia can involve the neck, jaw, tongue and the entire body (opisthotonos). There is also involvement of eyes leading to upward lateral movement of the eye known as oculogyric crisis. Dystonias can be prevented by anticholinergics, antihistaminergics, dopamine agonists, beta-adrenergic antagonists, benzodiazepines etc.
3. Akathisia: Akathisia is a subjective feeling of muscular discomfort that can cause patients to be agitated, restless and feel generally dysphonic. Akathisia can be treated with propranolo, benzodiazepines and clonidine.
4. Tardive dyskinesia: It is a delayed adverse effect of antipsychotics. It consists of abnormal, irregular choreoathetoid movements of the muscles of the head, limbs and trunk. It is characterized by chewing, sucking, grimacing and peri-oral movements.
5. Neuroleptic malignant syndrome: This is a rare but serious disorder occurring in a small minority of patients taking neuroleptics, especially high-potency compounds.
   The onset is often, but not invariably, in the first 10 days of treatment. The clinical picture includes the rapid onset (usually over 24-72 hours) of severe motor, mental and autonomic disorders. The prominent motor symptom is generalized muscular hypertonicity. Stiffness of the muscles in the throat and chest may cause dysphasia and dyspnea. The mental symptoms include akinetic mutism, stupor or impaired consciousness. Hyperpyrexia develops with evidence of autonomic disturbances in the form of unstable blood pressure, tachycardia, excessive sweating, salivation and urinary incontinence. In the blood, creatinine phosphokinase (CPK) levels may be raised to very high levels, and the white cell count may be increased. Secondary features may include pneumonia, thromboembolism, cardiovascular collapse and renal failure.
   The syndrome lasts for one or two weeks after stopping the drug.

II. Autonomic side-effects: Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence and impaired ejaculation.
III. Seizures
IV. Sedation
V. Other effects

- Agranulocytosis (especially for clozapine)
- Sialorrhoea or increased salivation (especially for clozapine)

- Weight gain
- Jaundice
- Dermatological effects (contact dermatitis, photosensitive reaction)

Nurse's Responsibility for a Patient Receiving Antipsychotics

- Instruct the patient to take sips of water frequently to relieve dryness of mouth. Frequent mouth washes, use of chewing gum, applying glycerine on the lips are also helpful.
- A high-fiber diet, increased fluid intake and laxatives if needed, help to reduce constipation.
- Advise the patient to get up from the bed or chair very slowly. Patient should sit on the edge of the bed for one full minute dangling his feet, before standing up. Check BP before and after medication is given. This is an important measure to prevent falls and other complications resulting from orthostatic hypotension.
- Differentiate between akathisia and agitation and inform the physician. A change of drug may be necessary if side-effects are severe. Administer antiparkinsonian drugs as prescribed.
- Observe the patient regularly for abnormal movements.
- Take all seizure precautions.
- Patient should be warned about driving a car or operating machinery when first treated with antipsychotics. Giving the entire dose at bedtime usually eliminates any problem from sedation.
- Advise the patient to use sunscreen measures (use of full sleeves, dark glasses etc) for photosensitive reactions.
- Teach the importance of drug compliance, side-effects of drugs and reporting if too severe, regular follow-ups. Give reassurance and reduce unfounded fears and anxieties.
- A patient receiving clozapine is at risk for developing agranulocytosis. Monitor TC, DC essentially in the first few weeks of treatment. Stop the drug if the WBC count drops to less than $3000/mm^3$ of blood. The patient should also be told to report if sore throat or fever develops, which might indicate infection.
- Seizure precautions should also be taken as clozapine reduces seizure threshold. The dose should be regulated carefully and the patient may also be put on anticonvulsants such as eptoin.

Antidepressants

Antidepressants are those drugs, which are used for the treatment of depressive illness. These are also called mood elevators or thymoleptics.

Indications

Depression

- Depressive episode
- Dysthymia
- Reactive depression
- Secondary depression
- Abnormal grief reaction

Childhood psychiatric disorders

- Enuresis
- Separation anxiety disorder
- Somnambulism
- School phobia
- Night terrors

Other psychiatric disorders

- Panic attacks
- Generalized anxiety disorder
- Agoraphobia, social phobia
- OCD with or without depression
- Eating disorder
- Borderline personality disorder
- Post-traumatic stress disorder

Depersonalization syndrome

- Medical disorders
- Chronic pain
- Migraine
- Peptic ulcer disease

Pharmacokinetics

Antidepressants are highly lipophilic and protein-bound. The half-life is long and usually more than 24 hours. It is predominantly metabolized in the liver.

Mechanism of Action

The exact mechanism is unknown. The predominant action is by increasing catecholamine levels in the brain.

TCAs are also called monoamine reuptake inhibitors (MARIs). The main mode of action is by blocking the reuptake of norepinephrine (NE) and/or serotonin (5-HT) at the nerve terminals, thus increasing the NE and 5-HT levels at the receptor site.

MAOIs instead act on MAO (monoamine oxidase), which is responsible for the degradation of catecholamines after re-uptake. The final effect is the same, a functional increase in the NE and 5-HT levels at the receptor site. The increase in brain amine levels is probably responsible for the antidepressants action. It takes about 5 to 10 days for MAOIs and 2 to 3 weeks for TCAs to bring down depressive symptoms.

SSRIs act by inhibiting the re-uptake of serotonin and increasing its levels at the receptor site.

Side Effects

1. Autonomic side effects: Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence, impaired ejaculation, delirium, and aggravation of glaucoma.
2. CNS effects: Sedation, tremor and other extra-pyramidal symptoms, withdrawal syndrome, seizures, jitteriness syndrome, precipitation of mania.
3. Cardiac side effects: Tachycardia, ECG changes, arrhythmias, direct myocardial depression, quinidine-like action (decreased conduction time).
4. Allergic side-effect: Agranulocytosis, cholestatic jaundice, skin rashes, systemic vasculities.
5. Metabolic and endocrine side-effects: Weight gain.
6. Special effects of MAOI drugs: Hypertensive crisis, severe hepatic necrosis, hyperpyrexia.

Nurse's Responsibility for a Patient Receiving Antidepressants

Most of the nurse's responsibilities for a patient on antidepressants are the same as for a patient receiving antipsychotics. In addition:

- Patients on MAOIs should be warned against the danger of ingesting tyramine-rich foods which can result in hypertensive crisis. Some of these foods are beef liver, chicken liver, fermented sausages, dried fish, overriped fruits, chocolate and beverages like wine, beer and coffee.
- Report promptly if occipital headache, nausea, vomiting, chest pain or other unusual symptoms occur; these can herald the onset of hypertensive crisis.
- Instruct the patient not to take any medication without prescription.
- Caution the patient to change his position slowly to minimize orthostatic hypotension.
- Strict monitoring of vitals, especially blood pressure is essential.

Lithium and other mood stabilizing drugs

Mood stabilizers are used for the treatment of bipolar affective disorders. Some commonly used mood stabilizers are:

- Lithium
- Carbamazepine
- Sodium valproate

Lithium

Lithium is an element with atomic number 3 and atomic weight 7. it was discovered by FJ Cade in 1949 and is a most effective and commonly used drug in the treatment of mania.

Indications

- Acute mania
- Prophylaxis for bipolar and unipolar mood disorder.
- Schizoaffective disorder
- Cyclothymia
- Impulsivity and aggression
- Other disorders
    - premenstrual dysphoric disorder
    - bulimia nervosa
    - borderline personality disorder
    - episodes of binge drinking
    - trichotillomania
    - cluster headaches

Pharmacokinetics

Lithium is readily absorbed with peak plasma levels occurring 2-4 hours after a single oral dose of lithium carbonate. Lithium is distributed rapidly in liver and kidney and more slowly in muscle, brain and bone. Steady state levels are achieved in about 7 days. Elimination is predominantly via kidneys. Lithium is reabsorbed in the proximal tubules and is influenced by sodium balance. Depletion of sodium can precipitate lithium toxicity.

Mechanism of Action

The probable mechanisms of action can be:

- It accelerates presynaptic re-uptake and destruction of catecholamines like norepinephrine
- It inhibits the release of catecholamines at the synapse.
- It decreases postsynaptic serotonin receptor sensitivity.

Also these actions result in decreased catecholamine activity, thus ameliorating mania.

Exercise 1: List the roles of a nurse to a depressive patient

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Dosage

Lithium is available in the market in the form of the following preparations:

- Lithium carbonate: 300mg tablets (e.g. Licab); 400mg sustained release tablets (e.g. Lithosun-SR)
- Lithium citrate: 300mg/5ml liquid.

The usual range of dose per day in acute mania is 900-2100mg given in 2-3 divided doses. The treatment is started after serial lithium estimation is done after a loading dose of 600mg or 900mg of lithium to determine the pharmacokinetics.

Blood Lithium Levels

- Therapeutic levels = 0.8 – 1.2 mEq/L (for treatment of acute mania)
- Prophylactic levels = 0.6 – 1.2 mEq/L (for prevention of relapse in bipolar disorder)
- Toxic lithium levels > 2.0 mEq/L

Side Effects

1. Neurological: Tremors, motor hyperactivity, muscular weakness, cogwheel rigidity, seizures, neurotoxicity (delirium, abnormal involuntary movements, seizures, coma).
2. Renal: Polydipsia, polyuria, tubular enlargement, nephrotic syndrome.
3. Cardiovascular: T-wave depression
4. Gastrointestinal: Nausea, vomiting, diarrhoea, abdominal pain and metallic taste.
5. Endocrine: Abnormal thyroid function, goiter and weight gain.
6. Dermatological: Acne form eruptions, popular eruptions and exacerbation of psoriasis.
7. Side-effects during pregnancy and lactation: Teratogenic possibility, increased incidence of Ebstein's anomaly (distortion and downward displacement of tricuspid valve in right ventricle) when taken in first trimester. Secreted in milk and can cause toxicity in infant.

8. Signs and symptoms of lithium toxicity (serum lithim level > 2.0 mEq/L):
   - ataxia
   - course tremor (hand)
   - nausea and vomiting
   - impaired memory
   - impaired concentration
   - nephrotoxicity
   - muscle weakness
   - convulsions
   - muscle twitching
   - dysarthria
   - lethargy
   - confusion
   - coma
   - hyperreflexia
   - nystagmus

Management of Lithium Toxicity

- Discontinue the drug immediately
- For significant short-term ingestions, residual gastric content should be removed by induction of emesis, gastric lavage and adsorption with activated charcoal.
- If possible instruct the patient to ingest fluids
- Assess serum lithium levels, serum electrolytes, renal functions, ECG as soon as possible.
- Maintenance of fluid and electrolyte balance
- In a patient with serious manifestations of lithium toxicity, hemodialysis should be initiated.

Contraindications of Lithium Use

- Cardiac, renal, thyroid or neurological dysfunctions
- Presence of blood dyscrasias
- During first trimester of pregnancy and lactation
- Severe dehydration
- Hypothyroidism
- History of seizures

Nurse's Responsibility for a Patient Receiving Lithium

The pre-lithium work up: A complete physical history, ECG, blood studies (TC, DC, FBS, BUN, creatinine, electrolysis) urine examination (routine and

microscopic) must be carried out. It is important to assess renal function as renal side effects are common and the drug can be dangerous in an individual with compromised kidney function. Thyroid functions should also be assessed as the drug is known to depress the thyroid gland.

To achieve therapeutic effect and prevent lithium toxicity, the following precautions should be taken:

- Lithium must be taken on a regular basis, preferably at the same time daily (for example, a client taking lithium on TID schedule, who forgets a dose should wait until the next scheduled time to take lithium and not take twice the amount at one time because lithium toxicity can occur).
- When lithium therapy is initiated, mild side effects such as fine hand tremors, increased thirst and urination, nausea, anorexia etc may develop. Most of them are transient and do not represent lithium toxicity.
- Serious side-effects of lithium that necessitate its discontinuance include vomiting, extreme hand tremors, sedation, muscle weakness and vertigo. The psychiatrist should be notified immediately if any of these effects occur.
- Since polyuria can lead to dehydration with the risk of lithium intoxication, patients should be advised to drink enough water to compensate for the fluid loss.
- Various situations can require an adjustment in the amount of lithium administered to a client, such as the addition of a new medicine to the client's drug regimen, a new diet or an illness with fever or excessive sweating. In this connection, people involved in heavy outdoor labour are prone to excessive sodium loss through sweating. They must be advised to consume large quantities of water with salt, to prevent lithium toxicity due to decreased sodium levels. If severe vomiting or gastroenteritis develops, the patient should be told to report immediately to the doctor. These are the conditions that have a high potential for causing lithium toxicity by lowering serum sodium levels.
- Frequent serum lithium level evaluation is important. Blood for determination of lithium levels should be drawn in the morning approximately 12-14 hours after the last dose was taken.
- The patient should be told about the importance of regular follow-up. In every six months, blood sample should be taken for estimation of

electrolytes, urea, creatinine, a full blood count and thyroid function test.

Carbamazepine

It is available in the market under different trade names like Tegretol, Mazetol, Zeptol and Zen Retard.

Indications

- Seizures-complex partial seizures, GTCS, seizures due to alcohol withdrawal
- Psychiatric disorders: rapid cycling bipolar disorder, acute depression, impulse control disorder, aggression, psychosis with epilepsy, schizoaffective disorders, borderline personality disorder, cocaine withdrawal syndrome.
- Paroxysmal pain syndrome – trigeminal neuralgia and phantom limb pain.

Dosage

The average daily dose is 600-800mg orally, in divided doses. The therapeutic blood levels are 6-12µg/ml. Toxic blood levels are reached at more than 15µg/ml.

Mechanism of Action

Its mood stabilizing mechanism is not clearly established. Its anticonvulsant action may however be by decreasing synaptic transmission in the CNS.

Side Effects

Drowsiness, confusion, headache, ataxia, hypertension, arrhythmias, skin rashes, Steven-Johnson syndrome, nausea, vomiting, diarrhoea, dry mouth, abdominal pain, jaundice, hepatitis, oliguria, leucopenia, thrombocytopenia, bone marrow depression leading to aplastic anemia.

Nurse's Responsibilities

- Since the drug may cause dizziness and drowsiness advise him to avoid driving and other activities requiring alertness.
- Advise patient not to consume alcohol when he is on the drug.
- Emphasize the importance of regular follow-up visits and periodic examination of blood count and monitoring of cardiac, renal, hepatic and bone marrow functions.

Sodium Valproate (Encorate chrono, valparin, Epilex, Epival)

Indications

- Acute mania, prophylactic treatment of bipolar I disorder, rapid cycling bipolar disorder.
- Schizoaffective disorder.
- Seizures

- Other disorders like bulimia nervosa, obsessive-compulsive disorder, agitation and PTSD

Mechanism of Action

The drug acts of gamma-amino butyric acid (GABA) an inhibitory amino acid neurotransmitter. GABA receptor activation serves to reduce neuronal excitability.

Dosage

The usual dose is 15mg/kg/day with a maximum of 60mg/kg/day orally.

Side effects

Nausea, vomiting, diarrhoea, sedation, ataxia, dysarthria, tremor, weight gain, loss of hair, thrombocytopenia, platelet dysfunction.

Nurse's Responsibilities

- Explain to the patient to take the drug immediately after food to reduce GT irritation
- Advise to come for regular follow-up and periodic examination of blood count, hepatic function and thyroid function. Therapeutic serum level of valproic acid is 50-100 micrograms/ml.

Anxiolytics (Anti-anxiety drugs) and Hypnosedatives

These are also called minor tranquillizers. Most of them belong to the benzodiazepine group of drugs.

Classification

1. Barbiturates: Example, Phenobarbital, pentobarbital, secobarbital and thiopentone.
2. Non-barbiturates non-benzodiazepine anti-anxiety agents: Example, Meprobamate glutethimide, ethanol, diphenhydramine and methaqualon.
3. Benzodiazepines: Presently benzodiazepines are the drugs of first choice in the treatment of anxiety and for the treatment of insomnia.
   - Very short-acting: Example, Triazolam, Midazolam.
   - Short-acting: Example, Oxazepam (Serepax), Lorazepam (Ativan, Trapex, Larpose), Alprazolam (Restyl, Trika, Alzolam, Quiet, Anxit).
   - Long-acting: Example, Chlordiazepoxide (Librium), Diazepam (Valium, Calmpose), Clonazepam (Lonazep), Flurazepam (Nindral), Nitrazepam (Dormin).

Indications for Benzodiazepines

- Anxiety disorders
- Insomnia
- Depression
- Panic disorder and social phobia

- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Bipolar I disorder
- Other psychiatric indications include alcohol withdrawal, substance-induced and psychotic agitation

Dosage (mg/day)
Alprazolam: 0.5-6 PO
Oxazepam: 15-120 PO
Lorazepam: 2-6 PO/IV/IM
Diazepam: 2-10 PO/IM/slow IV
Clonazepam: 0.5-20 PO/IM
Chlordiazepoxide: 15-100 PO; 50-100 slow IV
Nitrazepam: 5-20 PO

Mechanism of Action

Benzodiazepines bind to specific sites on the GABA receptors and increase GABA level. Since GABA is an inhibitory neurotransmitter, it has a calming effect on the central nervous system, thus reducing anxiety.

Side Effects

Nausea, vomiting, weakness, vertigo, blurring of vision, body aches, epigastric pain, diarrhoea, impotence, sedation, increased reaction time, ataxia, dry mouth, retrograde amnesia, impairment of driving skills, dependence and withdrawal symptoms (the drug should be withdrawn slowly, as a result).

Nurse's Responsibility in the Administration of Benzodiazepines

- Administer with food to minimize gastric irritation.
- Advise the patient to take medication exactly as directed. Abrupt withdrawal may cause insomnia, irritability and sometimes even seizures.
- Explain about adverse effects and advise him to avoid activities that require alertness.
- Caution the patient to avoid alcohol or any other CNS depressants along with benzodiazepines; also instruct him not to take any over-the-counter (OTC) medications.
- If IM administration is preferred give deep IM.
- For IV administration do not mix with any other drug. Give slow IV as respiratory or cardiac arrest can occur; monitor vital signs during IV administration. Prevent extravasations since it can cause phlebitis and venous thrombosis.

Antiparkinsoninan agents

In clinical practice anticholinergic drugs, amantadine and the antihistamines have their primary use as treatments for medication-induced movement disorders, particularly neuroleptic-induced parkinsonism, acute dystonia and medication-induced tremor.

Anticholinergics

- Trihexyphenidyl
- Benztropine
- Biperiden

Dopaminergic Agents

- Bromocriptine
- Carbidopa/Levodopa

Monoamine Oxidase Type B Inhibitors

- Selegiline

Trihexyphenidyl (Artane, Trihexane, Trihexy, Pacitane)

Indications

- Drug-induced parkinsonism
- Adjunct in the management of parkinsonism

Mechanism of Action

It acts by increasing the release of dopamine from presynaptic vesicles, blocking the re-uptake of dopamine into presynaptic nerve terminals or by exerting an agonist effect on postsynaptic dopamine receptors.

Trihexyphenidyl reaches peak plasma concentrations in 2-3 hours after oral administration and has a duration of action of up to 12 hours.

Dosage

1-2mg per day orally initially. Maximum dose up to 15 mg/day in divided doses.

Side Effects

Dizziness, nervousness, drowsiness, weakness, headache, confusion, blurred vision, mydriasis, tachycardia, orthostatic hypotension, dry mouth, nausea, constipation, vomiting, urinary retention and decreased sweating.

Nurse's Responsibilities

- Assess parkinsonian and extrapyramidal symptoms. Medication should be tapered gradually.
- Caution patient to make position changes slowly to minimize orthostatic hypotension.
- Instruct the patient about frequent rinsing of mouth and good oral hygiene.

- Caution patient that this medication decreases perspiration, and over-heating may occur during hot weather.

Antabase drugs

Disulfiram is an important drug in this class and is used to ensure abstinence in the treatment of alcohol dependence. Its main effect is to produce a rapid and violently unpleasant reaction in a person who ingests even a small amount of alcohol while taking disulfiram.

Clonidine

Indications

- Control of withdrawal symptoms from opioids
- Tourette's disorder
- Control of aggressive or hyperactive behaviour in children
- Autism

Mechanism of Action

- Alpha 2- adrenergic receptor agonist.
- The agonist effects of clonidine on presynaptic alpha 2- adrenergic receptors result in a decrease in the amount of neurotransmitter released from the presynaptic nerve terminals. This decrease serves generally to reset the sympathetic tone at a lower level and to decrease arousal.

Dosage

Usual starting dosage is 0.1mg orally twice a day; the dosage can be raised by 0.3mg a day to an appropriate level.

Side Effects

Dry mouth, dryness of eyes, fatigue, irritability, sedation, dizziness, nausea, vomiting, hypotension and constipation.

Nurse's Responsibility

- Monitor BP, the drug should be withheld if the patient becomes hypotensive.
- Advice frequent mouth rinses and good oral hygiene for dry mouth.

Methylphenidate (Ritalin)

Methylphenidate, dextroamphetamine and pemoline are sympathomimetics.

Indications

- Attention-deficit hyperactivity disorder
- Narcolepsy
- Depressive disorders
- Obesity

Mechanism of Action

Sympathomimetics cause the stimulation of alpha and beta-adrenergic receptors directly, as agonists and indirectly by stimulating the release of dopamine and norepinephrine from presynaptic terminals. Dextroamphetamine and methylphenidate are also inhibitors of catecholamine reuptake, especially dopamine re-uptake and inhibitors of monoamino oxidase. The net result of these activities is believed to be the stimulation of several brain regions.

Dosage

Starting dose is 5-10mg per day orally; maximum daily dose is 80 mg/day.

Side Effects

Anorexia or dyspepsia, weight loss, slowed growth, dizziness, insomnia or nightmares, dysphoric mood, tics and psychosis.

Nurse's Responsibilities

- Assess mental status for change in mood, level of activity, degree of stimulation and aggressiveness.
- Ensure that patient is protected from injury.
- Keep stimuli low and environment as quiet as possible to discourage over stimulation.
- To decrease anorexia, the medication may be administered immediately after meals. The patient should be weighed regularly (at least weekly) during hospitalization and at home while on therapy with CNS stimulants, due to the potential for anorexia/weight loss and temporary interruptions of growth and development.
- To prevent insomnia administer last dose at least 6 hours before bedtime.
- In children with behavioural disorders a drug 'holiday' should be attempted periodically under the direction of the physician to determine effectiveness of the medication and the need for continuation.
- Ensure that parents are aware of the delayed effects of Ritalin. Therapeutic response may not be seen for 2-4 weeks; the drug should not be discontinued for lack of immediate results.
- Inform parents that OTC (over-the-counter) medications should be avoided while the child is on stimulant medication. Some OTC medications, particularly cold and hay fever preparations contain certain sympathomimetic agents that could compound the effects of the stimulated and create drug interactions that may be toxic to the child.

- Ensure that parents are aware that the drug should not be withdrawn abruptly. Withdrawal should be gradual and under the direction of the physician.

Electroconvulsive therapy

Electroconvulsive therapy is a type of somatic treatment first introduced by Bini and Cerletti in April 1938. From 1980 onwards ECT is being considered as a unique psychiatric treatment.

Electroconvulsive therapy is the artificial induction of a grandmal seizure through the application of electrical current to the brain. The stimulus is applied through electrodes that are placed either bilaterally in the fronto-temporal region, or unilaterally on the non-dominant side (right side of head in a right-handed individual).

Parameters of Electrical Current Applied

Standard dose according to American Psychiatric Association, 1978:

- Voltage – 70-120 volts
- Duration – 0.7-1.5 seconds

Type of Seizure Produced

- grandmal seizure – tonic phase lasting for 10-15 seconds
- clonic phase lasting for 30-60 seconds

Mechanism of Action

The exact mechanism of action is not known. One hypothesis states that ECT possibly affects the catecholamine pathways between diencephalons (from where seizure generalization occurs) and limbic system (which may be responsible for mood disorders), also involving the hypothalamus.

Types of ECT

Direct ECT: In this, ECT is given in the absence of anaesthesia and muscular relaxation. This is not a commonly used method now.

Modified ECT: Here ECT is modified by drug-induced muscular relaxation and general anaesthesia.

Frequency and Total Number of ECT

Frequency: Three times per week or as indicated.

Total number: 6 to 10; up to 25 may be preferred as indicated.

Application of Electrodes

Bilateral ECT: Each electrode is placed 2.5-4cm above the midpoint, on a line joining the tragus of the ear and the lateral canthus of the eye.

Unilateral ECT: Electrodes are placed only on one side of head, usually non-dominant side (right side of head in a right-handed individual).

Unilateral ECT is safer, with much fewer side effects particularly those of memory impairment.

Indications

a. Major depression: With suicidal risk; with stupor; with poor intake of food and fluids; melancholia with psychotic features with unsatisfactory response to drugs or where drugs are contraindicated or have serious side-effects.
b. Severe catatonia (functional): With stupor; with poor intake of food and fluids; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
c. Severe psychosis (schizophrenia or mania): With risk of suicide, homicide or danger of physical assault; with depressive features; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
d. Organic mental disorders:
    - organic mood disorders
    - organic psychosis
e. Other indications: ECT is preferred to antidepressants therapy in some cases, such as for clients with cardiac disease; when tricyclics are contraindicated because of the potential for dysrhythmia and congestive heart failure; and for pregnant women, in whom antidepressants place the foetus at risk for congenital defects.

Contraindications

A. Absolute:
- Raised ICP (intracranial pressure)

B. Relative:
- cerebral aneurysm
- cerebral hemorrhage
- brain tumour
- acute myocardial infarction
- congestive heart failure
- pneumonia or aortic aneurysm
- retinal detachment

Complications of ECT

Life-threatening complications of ECT are rare. ECT does not cause any brain damage.

Fractures can sometimes occur in elderly patients with osteoporosis. In patients with a history of heart disease, dysrhythmias and respiratory arrest may occur.

Side effects of ECT

- Memory impairment
- Drowsiness, confusion and restlessness
- Poor concentration, anxiety
- Headache, weakness/fatigue, backache, muscle aches
- Dryness of mouth, palpitations, nausea, vomiting
- Unsteady gait
- Tongue bite and incontinence.

ECT Team

Psychiatrist, anesthesiologist, trained nurses and aides should be involved in the administration of ECT

Treatment Facilities

There should be a suite of three rooms:

1. A pleasant, comfortable waiting room (pre-ECT room).
2. ECT room, which should be equipped with ECT machine and accessories, an anesthetic appliance, suction apparatus, face masks, oxygen cylinders with adjustable flow valves, curved tongue depressors, mouth gags, resuscitation apparatus and emergency drugs. There should be immediate access to a defibrillator.
3. A well equipped recovery room.

Role of the Nurses

a. Pre-treatment evaluation

- Detailed medical and psychiatric history, including history of allergies.
- Assessment of patient's and family's knowledge of indicators, side-effects, therapeutic effects and risks associated with ECT.
- An informed consent should be taken. Allay any unfounded fears and anxieties regarding the procedure.
- Assess baseline vital signs.
- Patient should be on empty stomach for 4-6 hours prior to ECT.
- Withhold night doses of drugs, which increase seizure threshold like diazepam, barbiturates and anticonvulsants.
- Withhold oral medications in the morning.
- Head shampooing in the morning since oil causes impedance of passage of electricity to brain
- Any jewellery, prosthesis, dentures, contact lens, metallic objects and tight clothing should be removed from the patient's body.
- Empty bladder and bowel just before ECT.

- Administration of 0.6mg atropine IM or SC 30 minutes before ECT, or IV just before ECT.

b. Intra-procedure care

- Place the patient comfortably on the ECT table in supine position.
- Stay with the patient to allay anxiety or fear.
- Assist in administering the anesthetic agent (thiopental sodium 3-5mg/ kg body weight) and muscle relaxant (1mg/kg body weight of succynylcholine).
- Since the muscle relaxant paralyzes all muscles including respiratory muscles, patent airway should be ensured and ventilatory support should be started.
- Mouth gag should be inserted to prevent possible tongue bit.
- The place(s) of electrode placement should be cleaned with normal saline or 25 percent bicarbonate solution, or a conducting gel applied.
- Monitor voltage, intensity and duration of electrical stimulus given.
- Monitor seizure activity using cuff method.
- 100 percent oxygen should be provided.
- During seizure monitor vital signs, ECG, oxygen saturation, EEG etc.
- Record the findings and medicines given in the patient's chart.

c. Post-procedure care.

- Monitor vital signs
- Continue oxygenation till spontaneous respiration starts.
- Assess for post-ictal confusion and restlessness.
- Take safety precautions to prevent injury (side-lying position and suctioning to prevent aspiration of secretions, use of side rails to prevent falls).
- If there is severe post-ictal confusion and restlessness, I.V. diazepam may be administered.
- Reorient the patient after recovery and stay with him until fully oriented.
- Document any findings as relevant in the patient's record.

Psychosurgery

Psychosurgery is defined by APA's Task Force as "a surgical intervention, to sever fibres connecting one part of the brain with another, or to remove, destroy, or stimulate brain tissue, with the intent of modifying behaviour, thought or mood disturbances, for which there is no underlying organic pathology".

Indications

- Severe psychiatric illness.

- Chronic duration of illness of about 10 years.
- Persistent emotional disorders.
- Failure to respond to all other therapies.
- High risk of suicide.

Major Surgical Procedures

- Stereotactic subcaudate tractotomy.
- Stereotactic limbic leucotomy.
- Stereotactic bilateral amygdalotomy

Nursing care for a patient undergoing psychosurgery is the same as for any neurosurgical procedure.

4.0 **Conclusion**

The essence of this unit is to expose the learners to different pharmacological treatment of psychiatric patients. You must have gone through some therapeutic modalities in this unit. Electroconvulsive therapy was also discussed in the unit, the mechanism of action, indications, contraindications, complications, side-effects and the role of the nurse in the management of a patient undergoing ECT.

5.0 **Summary**

You have acquired knowledge on therapeutic modalities in psychiatry with particular reference to somatic therapies and I hope your exposure has enriched you greatly.

Tutor Marked Assignment

(1) Explain the meaning of Electroconvulsive therapy.

(2) Describe your role as a nurse in the management of a patient undergoing ECT.

Answer to Exercise

- Warn patients on the danger of ingesting tyramine-rich foods.
- Report promptly if occipital headache, nausea, vomiting, chest pain or other unusual symptoms occur
- Instruct the patient not to take any medication without prescription.
- Caution the patient to change his position slowly to minimize orthostatic hypotension
- Strict monitoring of vital signs especially blood pressure

7.0 References / Further Readings

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Unit 2: Psychological Therapy

Table of Contents

1.0 Introduction

This unit is on psychological therapies as part of the therapeutic modalities in psychiatry. The psychological therapies to be discussed shall include psychoanalytic, behaviour, cognitive therapies, hypnosis, abreaction, relaxation, individual, supportive, group, family and marital therapies.

2.0 Objectives

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

- describe psychoanalytic therapy
- explain behavioural therapy
- describe cognitive therapy
- discuss relaxation therapies
- differentiate between individual, group, family and marital therapies

Main content

Psychological therapies

There are several kinds of psychological therapies:

- Psychoanalytic therapy
- Behaviour therapy
- Cognitive therapy
- Hypnosis
- Abreaction therapy
- Relaxation therapies
- Individual therapy
- Supportive therapy
- Group therapy
- Family and marital therapy

Psychoanalytic therapy

- Psychoanalysis was first developed by Sigmund Freud at the end of the 19th century. The most important indication for psychoanalytical therapy is the presence of long-standing mental conflicts, which may be unconscious but produce symptoms. The aim of therapy is to bring all repressed material to conscious awareness so that the patient can work towards a healthy resolution of his problems, which are causing the symptoms.
- Psychoanalysis makes use of free association and dream analysis to affect reconstruction of personality. Free association refers to the verbalization of thoughts as they occur, without any conscious screening. The psychoanalyst searches for patterns in the material that is verbalized and in the areas that are unconsciously avoided (such areas are identified as resistances).
- Analysis of the patient's dreams helps to gain additional insight into his problems and the resistances. Thus dreams symbolically communicate areas of intrapsychic conflict.
- The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation.
- The process is complicated by the occurrence of transference reactions. This refers to the patient's development of strong positive or negative feelings towards the analyst and they represent the patient's past response to a significant other, usually a parent. The therapist's reciprocal response to the patient is called countertransference. Such reactions must be handled appropriately before progress can be made.
- The roles of the patient and psychoanalyst are explicitly defined by Freud. The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. He is frequently in a recumbent position on a couch during therapy to induce relaxation, which facilitates free association. The psychoanalyst is a shadow-person. He reveals nothing personal, nor does he give any directions to the patient. His verbal responses are for the most part brief and noncommittal, so as not to interfere with the

associative flow. He departs from this style of communication when an interpretation of behaviour is made to the patient.

- By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is also able to relate to others uninhibited by neurotic conflicts.
- Psychoanalytical therapy is a long-term proposition. The patient is seen frequently, usually five times a week. It is therefore time consuming and expensive.

Behaviour therapy

It is a form of treatment for problems in which a trained person deliberately establishes a professional relationship with the client, with the objective of removing or modifying existing symptoms and promoting positive personality, growth and development.

Behaviour therapy involves identifying maladaptive behaviours and seeking to correct these by applying the principles of learning derived from the following theories:

- Classical conditioning model by Ivan Pavlov (1936)
- Operant conditioning model by BF Skinner (1953)

Major Assumptions of Behaviour Therapy

Based on the above-mentioned theories, the following are the assumptions of behaviour therapy:

- All behaviour is learned (adaptive and maladaptive).
- Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced.
- Maladaptive behaviour can be unlearned and replaced by adaptive behaviour if the person receives exposure to specific stimuli and reinforcement for the desired adaptive behaviour.
- Behavioural assessment is focused more on the current behaviour rather than on historical antecedents.
- Treatment strategies are individually tailored. Behaviour therapy is a short duration therapy.

Behaviour therapy is a short duration therapy, therapists are easy to train and it is cost-effective. The total duration of therapy is usually 6-8 weeks. Initial sessions are given daily but the later sessions are spaced out. Unlike psychoanalysis where the therapist is a shadow person, in behaviour therapy both the patient and therapist are equal participants. There is no attempt to unearth an underlying conflict and the patient is not encouraged to explore his past.

Behaviour Techniques

(A) Systematic desensitization: It was developed by Joseph Wolpe, based on the behavioural principle of counter conditioning. In this patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response. The negative reaction of anxiety is inhibited by the relaxed state, a process called reciprocal inhibition.

It consists of three main steps:

1. Relaxation training
2. Hierarchy construction
3. Desensitization of the stimulus.

1. Relaxation training: there are many methods which can be used to induce relaxation, some of them are:

- Jacobson's progressive muscle relaxation
- Hypnosis
- Meditation or yoga
- Mental imagery
- Biofeedback

2. Hierarchy construction: Here the patient is asked to list all the conditions which provoke anxiety. Then he is asked to list them in a descending order of anxiety provocation.

3. Desensitization of the stimulus: This can be done either through imaginary or in reality. At first, the lowest item in hierarchy is confronted. The patient is advised to signal whenever anxiety is produced. With each signal he is asked to relax. After a few trials, patient is able to control his anxiety gradually.

Indications:

Phobias
Obsessions
Compulsions
Certain sexual disorders

(B) Flooding: The patient is directly exposed to the phobic stimulus, but escape is made impossible. By prolonged contact with the phobic stimulus, the therapist's guidance and encouragement and his modeling behaviour reduce anxiety.

Indication: Specific phobias

(C) Aversion therapy: Pairing of the pleasant stimulus with an unpleasant response, so that even in absence of the unpleasant response the pleasant stimulus becomes unpleasant by association. Punishment is presented

immediately after a specific behavioural response and the response is eventually inhibited.

Unpleasant response is produced by electric stimulus, drugs, social disapproval or even fantasy.

Indications:

Alcohol abuse
Paraphilias
Homosexuality
Transvestism

(D) Operant conditioning procedures for increasing adaptive behaviour

1. Positive reinforcement: When a behavioural response is followed by a generally rewarding event such as food, praise or gifts, it tends to be strengthened and to occur more frequently than before the reward. This technique is used to increase desired behaviour.
2. Token economy: This programme involves giving token rewards for appropriate or desired target behaviours performed by the patient. The token can be later exchanged for other rewards. For example, on inpatient hospital wards, patients receive a reward for performing desired behaviour, such as tokens which they may use to purchase luxury items or certain privileges.

(E) Operant conditioning procedures to teach new behaviour

1. Modeling: Modeling is a method of teaching by demonstration, wherein the therapist shows how a specific behaviour is to be performed. In modeling the patient observes other patients indulging in target behaviours and getting rewards for those behaviours. This will make the patient to repeat the same behaviour and earn rewards in the same manner.
2. Shaping: In shaping the components of a particular skill, the behaviour is reinforced step by step. The therapist starts shaping by reinforcing the existing behaviour. Once it is established he reinforces the responses which are closest to the desired behaviour and ignores the other responses.

   For example, to establish eye-to-eye contact, the therapist sits opposite the patient and reinforces him even if he moves his upper body towards him. Once this is established, he reinforces the person's head movement in his direction and this procedure continues till eye-to-eye contact is established.
3. Chaining: Chaining is used when a person fails to perform a complex task. The complete task is broken into a number of small steps and each step is taught to the patient. In forward chaining one starts with

the first step, goes on to the second step, then to the third and so on. In backward chaining, one starts with the last step and goes on to the next step in a backward fashion. Backward chaining is found to be more effective in training the mentally disabled.

(F) Operant conditioning procedures for decreasing maladaptive behaviour

1. Extinction/Ignoring: Extinction means removal of attention rewards permanently, following a problem behaviour. This includes actions like not looking at the patient, not talking to the patient, or having no physical contact with the patient etc., following the problem behaviour.

   This is commonly used when patient exhibits odd behaviour.

2. Punishment: Aversive stimulus (punishment) is presented contingent upon the undesirable response. The punishment procedure should be administered immediately and consistently following the undesirable behaviour with clear explanation.

   Differential reinforcement of an adaptive or desirable behaviour should always be added when a punishment is being used for decreasing an undesirable behaviour. Otherwise the problem behaviours tend to get maintained because of the lack of adaptive behaviours and skill defect.

3. Timeout: Timeout method includes removing the patient from the reward or the reward from the patient for a particular period of time following a problem behaviour. This is often used in the treatment of childhood disorders. For example, the child is not allowed to go out of the ward to play if he fails to complete the given work.

4. Restitution (Over-correction): Restitution means restoring the disturbed situation to a state that is much better than what it was before the occurrence of the problem behaviour. For example, if a patient passes urine in the ward he would be required to not only clean the dirty area but also mop the entire/largest area of the floor in the ward.

5. Response cost: This procedure is used with individuals who are on token programmes for teaching adaptive behaviour. When undesirable behaviour occurs, a fixed number of tokens or points are deducted from what the individual has already earned.

(G) Assertiveness and social skill training: Assertive training is a behaviour therapy technique in which the patient is given training to bring about change in emotional and other behavioural pattern by being assertive. Client is encouraged not to be afraid of showing an appropriate response, negative or positive, to an idea or suggestion. Assertive behaviour training is given by

the therapist, first by role playing and then by practice in a real life situation. Attention is focused on more effective interpersonal skills.

Social skills training helps to improve social manners like encouraging eye contact, speaking appropriately, observing simple etiquette and relating to people.

Cognitive therapy

Cognitive therapy is a psychotherapeutic approach based on the idea that behaviour is secondary to thinking. Our moods and feelings are influenced by our thoughts. Self-defeating and self-depreciating patterns of thinking result in depressed mood. The therapist helps the patient by correcting this distorted way of thinking, feelings and behaviour.

The cognitive model of depression includes the cognitive triad:

1. A negative view about self
2. A negative view about the environment and
3. A negative view about the future

These negative thoughts are modified to improve the depressive mood. Cognitive therapy is used for the treatment of depression, anxiety disorder, panic disorder, phobic disorder and eating disorders.

Hypnosis therapy

The word 'hypnotism' was first used by James Briad in the 19th century. Hypnosis is an artificially induced state in which the person is relaxed and unusually suggestible. Hypnosis can be induced in many ways, such as by using a fixed point for attention, rhythmic monotonous instructions etc.

Changes that occur during Hypnosis

- The person becomes highly suggestible to the commands of the hypnotist.
- There is an ability to produce or remove symptoms or perceptions.
- Dissociation of a part of body or emotions.
- Amnesia for the events that occurred during the hypnotic state.

Techniques

Patient is either made to lie down on a bed or sit in a chair. He is asked to gaze fixedly on a spot. Therapist makes monotonous suggestions of relaxation and sleep. The patient however is not asleep and can hear what is being said, answer questions and obey instructions.

This therapy is useful in:

- Abreaction of past experiences.
- Psychosomatic disorders.

- Conversion and dissociative disorders.
- Eating disorders.
- Habit disorders and anxiety disorders.

Abreaction therapy

Abreaction is a process by which repressed material, particularly a painful experience or conflict, is brought back to consciousness. The person not only recalls but also relives the material, which is accompanied by the appropriate emotional response. It is most useful in acute neurotic conditions caused by exreme stress (Post-traumatic stress disorder, hysteria etc).

Although abreaction is an integral part of psychoanalysis and hypnosis, it can also be used independently.

Method

Abreaction can be brought about be strong encouragement to relieve the stressful events. The procedure is begun with neutral topics at first, and gradually approaches areas of conflict. Although abreaction can be done with or without the use of medication, the procedure can be facilitated by giving a sedative drug intravenously. A safe method is the use of thiopentone sodium i.e. 500mg dissolved in 10 c.c. of normal saline. It is infused at a rate no faster than 1 cc/minute to prevent sleep as well as respiratory depression.

Ralaxation therapy

Relaxation produces physiological effects opposite those of anxiety: slowed heart rate, increased peripheral blood flow and neuromuscular stability.

There are many methods which can be used to induce relaxation.

Jacobson's Progressive Muscle Relaxation

Patients relax major muscle groups in fixed order, beginning with the small muscle groups of the feet and working cephalad or vice versa.

Mental Imagery

It is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant relaxed memories. Such images allow patients to enter a relaxed state or experience a feeling of calmness and tranquility.

Use of Tape-recorded Exercises or Instructions

This allows patients to practice relaxation on their own.

Meditation or Yoga

It is concentrating on the spirit by using certain postures to prepare the body to sit motionless, remain alert and focus on one particular point.Yoga is highly useful in reducing stress and treating anxiety.

Bio-feedback

Bio-feedback is based on the idea that the autonomic nervous system can come under voluntary control through operant conditioning. Thus it helps people to control usually involuntary physiological functions so as to change them, for instance, by relaxing. People learn to control these functions by hearing or seeing signals from instruments that produce information about various measures such as muscle tension, blood pressure, etc. This feedback helps the patient to control such responses.

Uses of bio-feedback include treatment of enuresis, and treatment of a host of ailments brought on by stress such as migraine headaches, tension headaches, idiopathic hypertension, cardiac problems etc.

Individual therapy

Psychotherapy can be defined as the treatment of problems of an emotional nature, in which a trained person deliberately establishes a professional relationship with the patient to remove, modify or retard existing symptoms, mediate disturbed patterns of behaviour and promote positive personality growth and development.

Individual psychotherapy is conducted on a one-to-one basis, i.e. The therapist treats one client at a time. The patient is encouraged to discover for himself the reasons for his behaviour. The therapist listens to the patient and offers explanation and advice when necessary. By this he helps the patient to come to a greater understanding of himself and to find a way of dealing with his problems.

Indications: Stress-related disorders, alcohol and drug dependence, sexual disorders and marital disharmony.

Supportive therapy

In this, the therapist helps the patient to relieve emotional distress and symptoms without probing into the past and changing the personality. He uses various techniques such as:

- Ventilation: It is a free expression of feelings or emotions. Patient is encouraged to talk freely whatever comes to his mind.
- Environmental modification/manipulation: Improving the well-being of mental patients by changing their living condition.

- Persuasion: Here the therapist attempts to modify the patient's behaviour by reasoning.
- Re-education: Education to the patient regarding his problems, ways of coping etc.
- Reassurance

Group therapy

Group psychotherapy is a treatment in which carefully selected people who are emotionally ill meet in a group guided by a trained therapist, and help one another effect personality change.

Selection

- Homogeneous groups.
- Adolescents and patients with personality disorders.
- Families and couples where the system needs change.

Advantages

Group therapy gives an opportunity for immediate feedback from a patient's peers and a chance for both patient and therapist to observe the patient's psychological, emotional and behavioural responses towards a variety of people.

Contraindications

- Antisocial patients.
- Actively suicidal or severely depressed patients.
- Patients who are delusional and who may incorporate the group into their delusional system.

Size

Optimal size for group therapy is 8 to 10 members.

Frequency and Length of Sessions

Most group psychotherapists conduct group sessions once a week.

Length of session is 45 minute/hour.

Approaches to Group Therapy

- The therapist role is primary facilitator; he should provide a safe, comfortable atmosphere for self-disclosure.
- Focus on the "here and now".
- Use any transference situations to develop insight into their problems.
- Protect members from verbal abuse or from scapegoating.
- Whenever appropriate provide positive reinforcement, this gives ego support and encourages future growth.
- Handle circumstantial patients, hallucinating and delusional patients in a manner that protects the self-esteem of the individual and also sets limits on the behaviours to protect the other group members.

- Develop ability to recognize when a group member is “fragile”; he should be approached in a gentle, supportive and non-threatening manner.
- Use silence effectively to encourage introspection and facilitate insight.
- Laughter and a moderate amount of joking can act as a safety valve, and at times can contribute to group cohesiveness.
- Role playing may help a member develop insight into the ways in which he relates to others.

Some Techniques Useful in Group Therapy

- Reflecting or rewording comments of group members.
- Asking for group reaction to one member’s statement.
- Asking for individual reaction to one member’s statement.
- Pointing out any shared feelings within group.
- Summarizing various points at the end of the session.

Psychodrama is a method of group psychotherapy in which personality makeup, interpersonal relationships, conflicts and emotional problems are explored by means of special dramatic methods. Psychodrama may focus on any special area of functioning (a dream, a family or a community situation), a symbolic role, an unconscious attitude or an imagined future situation.

Family and marital therapy

In family and marital therapy the focus of intervention is not on the individual but on the family unit. The family therapist works towards improving group interactions and helping each member to function better.

Indications

Family therapy is indicated whenever there are relational problems within a family or marital unit, which can occur in almost all types of psychiatric problems including the psychoses, reactive depression, anxiety disorders, psychosomatic disorders, substance abuse and various childhood psychiatric problems.

Components of Therapy

- Assessment of family structure, roles, boundaries, resources, communication patterns and problem solving skills.
- Teaching communication skills.
- Teaching problem solving skills.
- Writing a behavioural marital contract.
- Homework assignments.

4.0 **Conclusion**

Management of psychiatric patients is multidimensional, so this unit has looked into psychological therapies in the care of disorders of mental health individuals.

5.0 **Summary**

This unit has taken the learners through various psychological therapies like psychoanalytic therapy, behaviour therapy, cognitive, relaxation, individual therapies to mention but a few. The knowledge acquired in this unit will assist you in the management of psychiatric patients in your day to day professional activities.

Tutor Marked Assignment

(1) List five ways of psychological therapies
(2) Discuss any two of the five psychological therapies mentioned above.

7.0 **References / Further Readings**

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Unit 3: Therapeautic Mileu

Table of Contents

1.0 Introduction

In continuation of the therapeutic modalities, this unit will look into therapeutic mileu, therapeutic community and activity therapy in the management of mentally ill individuals. Therapeutic mileu is an environment that is structured and maintained as an ideal, dynamic setting in which to work with clients.

2.0 Objectives

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

- describe mileu therapy.
- explain how to maintain a milieu therapy
- state the components of a milieu therapy
- list the aims of activity therapy
- enumerate the components of activity therapy
- describe the implications of activity therapies for nursing practice.

Main content

Milieu therapy

The therapeutic milieu is an environment that is structured and maintained as an ideal, dynamic setting in which to work with clients. This milieu includes safe physical surroundings, all the treatment team members, and other clients. It is supported by clear and consistently maintained limits and behavioural expectations.

A therapeutic setting should minimize environmental stress such as noise and confusion, and physical stress. It provides a chance for rest and nurturance of self, a time to focus on the development of strengths, and an

opportunity to learn to identify alternatives or solutions to problems and to learn about the psychodynamics of those problems.

A therapeutic milieu is a "safe space", a non-punitive atmosphere in which caring is a basic factor. In this environment, confrontation may be a positive therapeutic tool that can be tolerated by the client. Nurses and treatment team members should be aware of their own roles in this environment, maintaining stability and safety, but minimizing authoritarian behaviour. Clients are expected to assume responsibility for themselves within the structure of the milieu as much as possible. Feedback from other clients and the sharing of tasks or duties within the treatment programme facilitate the client's growth.

The various components of the therapeutic Milieu include:

Maintaining Safe Environment

The nursing staff should follow the facility's policies with regard to prevention of routine safety hazards and supplement these policies as necessary. For example:

- Dispose of all needles safely and out of reach of clients.
- Restrict or monitor the use of matches and lighters.
- Do not allow smoking.
- Remove mouthwash, aftershave lotions and so forth, if substance abuse is suspected.
- Listed below are the most restrictive measures to be used on a unit on which clients who are exhibiting behaviour directly threatening or harmful to themselves or others may be present. These measures may be modified based on the assessment of the client's behaviour:
    - immediately on the client's admission, search the client and all of the client's belongings and remove potentially dangerous items, such as wire, clothes hangers, ropes, belts, safety pins, scissors and other sharp objects, weapons, and medications; keep these belongings in a designated place inaccessible to the client.
    - be sure mirrors, if glass, are securely fastened and not easily broken.
    - keep sharp objects (e.g scissors, pocket knives, knitting needles) out of reach of clients and allow their use only with supervisors; use electric shavers when possible (disposable razors are easily broken to access blades).
    - identify potential weapons (e.g. mop handles, hammers) and dangerous equipment (e.g. electrical cords, scalpels), and keep them out of the client's reach.
    - do not leave cleaning fluids, bleach, mops and tools, unattended

in client care areas.
    - do not leave medicines unattended or unlocked.
    - keep keys (to unit door, medicines) on your person at all times.
    - be aware of items that are harmful if ingested, for example, mercury in manometers.
    - search packages brought in by visitors, explain the reason for such rules briefly and do not make any exceptions.

The Trust Relationship

One of the keys to a therapeutic environment is the establishment of trust. Both the client and the nurse must trust that treatment is desirable and productive. Trust is the foundation of a therapeutic relationship, and limit-setting and consistency are its building blocks.

Building Self-esteem

Strategies to help build or enhance self-esteem must be individualized and built on honesty and on the client's strengths. Some general suggestions are:

- Set and maintain limits
- Accept the client as a person
- Be non-judgmental at all times
- Structure the client's time and activities
- Have realistic expectations of the client and make them clear to the client
- Initially provide the client with tasks, responsibilities and activities that can be easily accomplished; advance the client to more difficult tasks as he progresses
- Praise the client for his accomplishments, however small, giving sincere appropriate feedback for meeting expectations, completing tasks, fulfilling responsibilities and so on.
- Never flatter the client
- Use confrontation judiciously and in a supportive manner; use it only when the client can tolerate it.
- Allow the client to make his own decisions whenever possible. If the client is pleased with the outcome of his decision, point out that he was responsible for the decision and give positive feedback.
- If the client is not pleased with the outcome, point out that the client, like everyone, can make and survive mistakes, then help the client identify alternative approaches to the problem; give positive feedback for the client's taking responsibility for problem solving and for his efforts.

Limit-setting

Setting and maintaining limits are integral to a trust relationship and to a therapeutic milieu. Before starting a limit explain the reasons for limit-setting. Some basic guidelines for effectively using limits are:

- State the expectations or the limit as clearly, directly and simple as possible.
- The consequence that will follow the client's exceeding the limit also must be clearly stated at the outset.
- The consequences should immediately follow the client's exceeding the limit and must be consistent, both over time (each time the limit is exceeded) and among staff (each staff member must enforce the limit).
- Consequences are essential to setting and maintaining limits, they are not an opportunity to be punitive to a client.

In conclusion, the nurse works with other health professionals in an interdisciplinary team; the interdisciplinary team works within a milieu that is constructed as a therapeutic environment, with the aim of developing a holistic view of the client and providing effective treatment.

Therapeutic community

The concept of therapeutic community was first developed by Maxwell Jones in 1953. He wrote a book entitled "Social Psychiatry" which was first published in England. Later on when it was published in the United States, its title was changed to "Therapeutic Community".

Definition

Stuart and Sundeen defined therapeutic community as "a therapy in which patient's social environment would be used to provide a therapeutic experience for the patient by involving him as an active participant in his own care and the daily problems of his community.

Objectives

- To use the patient's social environment to provide a therapeutic experience for him.
- To enable the patient to be an active participant in his own care and become involved in daily activities of his community.
- To help patients to solve problems, plan activities and to develop the necessary rules and regulations for the community.
- To increase their independence and gain control over many of their own personal activities.
- To enable the patients to become aware of how their behaviour affects others.

Elements of Therapeutic Community

- Free communication.
- Shared responsibilities.
- Active participation.
- Involvement in decision making.
- Understanding of roles, responsibilities, limitations and authorities.

Components of Therapeutic Community

Daily Community Meetings

- These meetings are composed of 60-90 patients. All levels of unit staff are involved, including administrative personnel. Acute patients are not involved in the meetings.
- Meetings should be held regularly for 60 minutes
- Discussion should focus mainly on day-to-day life in the unit.
- During discussions patients' feelings and behaviours are examined by other members.
- Frank discussions are encouraged, these may take place with much outpouring of emotions and anger.

Patient Government or Ward Council

- The purpose of patient government is to deal with practical unit details such as house-keeping functions, activity planning and privileges.
- A group of 5-6 patients will have specific responsibilities, such as house keeping, physical exercise, personal hygiene, meal distribution, a group to observe suicidal patients etc. Staff members should be available always.
- All decisions should be feedback to the community through the community meetings.

Staff Meetings or Review

A staff meeting should be held following each community meeting (Patients are excluded and only staff are present). In this meeting the staff would examine their own responses, expectations and prejudices.

Living and Learning Opportunities

Learning opportunities are to be provided within the social milieu, which should provide realistic learning experiences for the patients.

Advantages of Therapeutic Community

- Patients develop harmonious relationships with other members of the community.
- Gains self-confidence.
- Develops leadership skills.

- Learns to understand and solve problems of self and others.
- Becomes socio-centric.
- Learns to live and think collectively with the members of the community.
- Lasting therapeutic community provides opportunities to participate in the formulation of hospital rules and regulations that affect patient's personal liberties like bedtime, meal time, weekend permission, and control of radio or T.V., social activities, late night privileges.

Disadvantages of Therapeutic Community

- Role blurring between staff and patient
- Group responsibility can easily become nobody's responsibility.
- Individual needs and concerns may not be met.
- Patient may find the transition to community difficult.

Role of the Nurse

- Providing and maintaining a safe and conflict free environment through role modeling and group leadership.
- Sharing of responsibilities with patients.
- Encouraging the patient to participate in decision-making functions.
- Assisting patients to assume leadership roles.
- Giving feedback.
- Carrying out supervisory functions.

In conclusion, therapeutic community is an approach which is:

- Democratic as opposed to hierarchical.
- Rehabilitative rather than custodial.
- Permissive instead of limited and controlled.

Activity therapy

Activity therapies include occupational therapy, recreational therapy, educational therapy, play therapy, music therapy, dance therapy, and art therapy.

Aims

- To assist the client in making the transition from the sick role to becoming a contributing member of society.
- To assist in diagnostic and personality evaluation.

- To enhance psychotherapy and other psychotherapeutic measures (the activity prescribed for the client often provides a nonverbal means for the client to express and resolve his feelings).

Occupational therapy

Occupational therapy is the application of goal-oriented, purposeful activity in the assessment and treatment of individuals with psychological, physical or developmental disabilities.

Goal

The main goal is to enable the patient to achieve a healthy balance of occupations through the development of skills that will allow him to function at a level satisfactory to himself and others.

Settings

Occupational therapy is provided to children, adolescents, adults and elderly parents. These programmes are offered in psychiatric hospitals, nursing homes, rehabilitation centres, special schools, community group homes, community mental health centres, daycare centres, half-way homes and deaddiction centres.

Advantages

- Helps to develop social skills and provide an outlet for self expressions.
- Strengthens ego defenses.
- Develops a more realistic view of the self in relation to others.

Points to be kept in mind

- The client should be involved as much as possible in selecting the activity.
- Select an activity that interests or has the potential to interest him.
- The activity should utilize the client's strengths and abilities.
- The activity should be of short duration to foster a feeling of accomplishment.
- If possible, the selected activity should provide some new experience for the client.

Process of Intervention

It consists of six stages:

1. Initial evolution of what patient can do and cannot do in a variety of situations over a period of time.

2. Development of immediate and long-term goals by the patient and therapist together. Goals should be concrete and measurable so that it is easy to see when they have been attained.
3. Development of therapy plan with planned intervention.
4. Implementation of the plan and monitoring the progress. The plan is followed until the first evaluation. If satisfactory, it is continued, or altered if not.
5. Review meetings with patient and all the staff involved in treatment.
6. Setting further goals when immediate goals have been achieved; modifying the treatment programme as relevant.

Exercise 1: Highlight the components of therapeutic milieu

Types of Activities

Diversional activities: These activities are used to divert one's thoughts from life stresses or to fill time. E.g. organized games.

Therapeutic activities: These activities are used to attain a specific care plan or goal. E.g. basket making, carpentry etc.

Suggested Occupational Activities for Psychiatric Disorders

Anxiety disorder: Simple concrete tasks with no more than 3 or 4 steps that can be learnt quickly. E.g. kitchen tasks, washing, sweeping, mopping, mowing lawns and weeding gardens.

Depressive disorder: Simple concrete tasks which are achievable; it is important for the client to experience success. Provide positive reinforcement after each achievement. E.g. crafts, mowing lawns and weeding gardens.

Manic disorder: Non-competitive activities that allow the use of energy and expression of feelings. Activities should be limited and changed frequently. Client needs to work in an area away from distractions. E.g. raking grass, sweeping etc.

Schizophrenia (paranoid): Non-competitive, solitary, meaningful tasks that require some degree of concentration so that less time is available to focus on delusions. E.g. puzzles, scrabble.

Schizophrenia (catatonic): Simple concrete tasks in which client is actively involved. Client needs continuous supervision and at first works best on a one-to-one basis. E.g. metal work, moulding clay.

Antisocial personality: Activities that enhance self-esteem and are expressive and creative, but not too complicated. Client needs supervision to make sure each task is completed.

Dementia: Group activities to increase feelings of belonging and self-worth provide those activities which promotes familial individual hobbies. Activities need to be structured, requiring little time for completion and not too much concentration. Explain and demonstrate each task, then have client repeat the demonstration.

Substance Abuse: Group activities in which clients uses his talents. E.g. involving client in planning social activities, encouraging interaction with others etc.

Childhood and adolescent disorders:

Children: Playing, story telling, painting, poetry, music etc.

Adolescents: Creative activities such as leather work, drawing, painting.

Mental retardation: Repetitive work assignments are ideal; provide positive reinforcement after each achievement. E.g. cover making, candle making, packaging goods.

Recreational Therapy

Recreation is a form of activity therapy used in most psychiatric settings. It is planned therapeutic activity that enables people with limitations to engage in recreational experiences.

Aims

- To encourage social interaction.
- To decrease withdrawal tendencies.
- To provide outlet for feelings.
- To promote socially acceptable behaviour.
- To develop skills, talents and abilities.
- To increase physical confidence and a feeling of self-worth.

Points to be kept in mind

- Provide a non-threatening and non-demanding environment.
- Provide activities that are relaxing and without rigid guidelines and time-frames.
- Provide activities that are enjoyable and self-satisfying.

Types of Recreational Activities

Motor forms: These can be further divided into fundamental and accessory; among the fundamental forms are such games as hockey and football, while the accessory forms are exemplified by play activity and dancing.

Sensory forms: These can be either visual e.g. looking at motion pictures, play etc., or auditory such as listening to a concert.

Intellectual forms: These include reading, debating and so on.

Suggested Recreational Activities for Psychiatric Disorders

Anxiety disorder: Aerobic activities like walking, jogging etc.

Depressive disorder: Non-competitive sports, which provide outlet for anger, like jogging, walking, running etc.

Manic disorder: One-to-one basis individual games like chess, puzzles.

Schizophrenia (paranoid): Concentrative activities like chess, puzzles.

Schizophrenia (catatonic): Social activities to give client contact with reality, like dancing, athletics.

Dementia: Concrete, repetitious crafts and projects breed familiarization and comfort.

Childhood and adolescent disorders: It is better to work with the child on a one-to-one basis and give him a feeling of importance. Some activities include playing, story telling and painting.

Adolescents fare better in groups; provide gross motor activities like sports and games to use up excess energy.

Mental retardation: Activities should be according to the client's level of functioning such as walking, dancing, swimming, ball playing etc.

Educational Therapy

Educational therapy is used when the client has problems which result from a great deal of misconception. The educational therapist provides reading and learning experiences that can do a great deal to eliminate his misconceptions and anxiety.

Biblio Therapy

It is described as the prescription of reading materials that will help to develop emotional maturity and sustain mental health. Some emotionally disturbed individuals are able to relate therapeutically to the experiences of others when they read about them, rather than experiencing them directly. It also provides a medium for discussions with others.

Play Therapy

Play is a natural mode of growth and development in children. Through play a child learns to express his emotions and it serves as a tool in the development of the child.

Curative functions

- It releases tension and pent-up emotions.
- It allows compensation for loss and failures.
- It improves emotional growth through his relationship with other children.
- It provides opportunity to the child to act out his fantasies and conflicts, to get rid of aggression and to learn positive qualities from the other children.

Diagnostic functions

- Play therapy gives the therapist a chance to explore the family relationships of the child and discover what difficulties are contributing to the child's problems.
- Play therapy allows to study hidden aspects of the child's personality.
- It is possible to obtain a good idea of the intelligence level of the child.
- Through play inter-sibling relationships can be adequately studied.

Types of Play Therapy

Individual vs. group play therapy: In individual therapy, the child is allowed to play by himself and the therapist's attention is focused on this one child alone.

In group play therapy other children are involved.

Free play vs. controlled play therapy: In free play the child is given freedom in deciding with what toys he wants to play.

In controlled play therapy, the child is introduced into a scene where the situation or setting is already established.

Structured vs. unstructured play therapy: Structured play therapy involves organizing the situation in such a way so as to obtain more information.

In unstructured play therapy no situation is set and no plans are followed.

Directive vs. non-directive play therapy: In directive play therapy, the therapist totally sets the directions, whereas in non-directive play therapy, the child receives no directions.

Play therapy is generally conducted in a play room. The play room should be suitably stocked with adequate play material depending upon the problem of the child.

Music Therapy

Music therapy is the functional application of music towards the attainment of specific therapeutic goals.

Advantages

- Facilitates emotional expressions.
- Improves cognitive skills like learning, listening and attention span.
- Exercise through body movement maintains good circulation and muscle tone.
- Social interaction is stimulated.

Dance Therapy

It is a psychotherapeutic use of movements, which furthers the emotional and physical integration of the individual.

Advantages

- Helps to develop body awareness.
- Facilitates expression of feelings.
- Improves interaction and communication.
- Fosters integration of physical, emotional and social experiences that result in a sense of increased self-confidence and contentment.

Art Therapy

The goal of art therapy is to help the patient express his thoughts, emotions and feelings through his drawings.

Importance of art therapy

- It is used as a diagnostic and therapeutic tool.
- It provides socially acceptable outlets for fantasy and wish fulfillment.
- It helps the patient to gain relief from anxiety by graphically representing conflicts and aggressive and traumatic material without guilt.

Implications of Activity Therapies for Nursing Practice

The nurse has an important role in enhancing the therapeutic effects of activity therapies. Some points to be kept in mind are:

- Close coordination between the nursing staff and the activity therapy department is essential.
- By engaging in these activities, the nurse not only has an opportunity to support the therapeutic efforts of the recreational therapist, but also has an invaluable opportunity to observe the client in different settings.
- Through her observations of the client's behaviour during these activities, the nurse will gain valuable information that she can subsequently utilize to therapeutic advantage in the working phase of the nurse-client relationship.

4.0 **Conclusion**

The needs of mentally ill individual are numerous as the illness may affect both the body and the mind of the patient, so meeting the needs can be

approached from somatic, psychological and activities point of the view, so this unit dealt with the use of milieu therapy, therapeutic community and activity in meeting the needs of psychiatric patients in our communities.

5.0 **Summary**

This unit looked into the use of environment in meeting the needs of individuals with disorders of mental health. I hope the knowledge gained from the unit can now assist you to answer the following tutor marked assignments.

Tutor Marked Assignments

(1) Discuss how a milieu therapy can be attained by you as a nurse to meet the needs of your clients.

Answer to Exercise

- maintain safe environment - Trust relationship
- Build self esteem - Limit setting

7.0 **References / Further Readings**

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MODULE 2

Unit 1: Community Mental Health Nursing

Table of Contents

1.0 Introduction

This unit will introduce the learners to community mental health nursing. Community mental health has developed a response to the realization that much of the effort expended in the past as treatment for mentally ill individuals encouraged chronicity rather than a return to a productive life. Thus, the current trend is to treat the individual immediately in the community, no matter how disturbed his behaviours may be. In this way, it is hoped that the development of chronic symptomatology and the rupturing of community ties through institutionalization can be avoided.

2.0 Objectives

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

- describe the aims of community mental health nursing
- list the methods used in practicing community psychiatry
- discuss the roles of community psychiatric nurse.

Main content

Introduction

The term community can be defined either as a political (geographic) unit or as a functional unit. People qualify as members of a geographic or political unit by holding rights of citizenship within the boundaries of specified territory or merely by living there.

Community Psychiatry is a new speciality- though a widely embracing one- within the field of psychiatry. It consists of the acceptance of responsibility by one or more Psychiatrists and others working with them for the prevention, early detection, and short-terms and long-term (including rehabilitative) treatment of metal disorders in a circumscribed population.

Community care consists of medical and social services provided by four main groups, namely, department of Health and Social Security Area Health Authorities, Local Authorities and Voluntary Organisations.

Community mental health is essentially a synonym for community psychiatry. The aim is to provide care for patients at centres located near their homes as at a stage when their disorder have not yet becomes severe or chronic , so that disruption of their lives is minimized. In most cases these are patients these prognosis is good. Both rehabilitative and primary preventive efforts are also emphasized; the latter through education and consultation.

Thus, the Community Mental Health was a revolutionary idea when it was introduced in the early 1960's. Its overall goal was helping people in their own community or neighbourhood to reach and maintain more satisfactory levels of functioning. It also aims to use the support of patient's relatives (family) and friends where possible and to put them in touch with the psychiatric services which exist for guidance and treatment of such patients.

The family is the principal "medium" by which the Community's "message" is transmitted. While acknowledging the importance of biological and others influences, the Community Psychiatrist place special emphasis on the fact that the emotional health of the individual and families depends on the healthy development and functioning of human communities.

Since the patient receives treatment within his own environment, the possibility of "lengthy rehabilitation" as in the case of patient admitted in a comprehensive psychiatric setting (Psychiatric Hospital) is reduced.

Community Mental care prevents unnecessary boredom often experienced by hospitalised patients. It is also worth mentioning that the social stigma attached to people with mental disorders is considerably reduced.

Attributes of a Community Mental Health/Psychiatric Nurse

- Awareness of self, personal and cultural values
- Non-judgmental attitude
- Problem solving skills
- Ability to cross service system (e.g. to work with school, other health care providers, employers, etc).
- Knowledge of community resources
- Willingness to work with the family or significant other identified by the client as support people.
- Understanding of the social, cultural and political issues that affect mental health and illness
- Knowledge of political activism

Goals of Community Mental Health Nursing

- To provide prevention activities to populations for the purpose of promoting mental health.
- To provide interventions as early as possible.
- To provide corrective learning experiences for client-groups who have deficits and disabilities in the basic competencies needed to cope in society, and to help individuals develops a sense of self-worth and independence.
- To anticipate when populations become at risk for particular emotional problems and to identify and change social and physiological factors that diversely affect people's interaction with their environments.
- To develop innovative approaches to primary prevention activities.
- To assist in providing mental health education to populations about mental health and illness and to teach people how to assess their mental health.

Community Mental Health Nursing Process

The key aspects of the assistance include:

- Impairments directly due to psychiatric disorder such as persistent hallucinations, negatively symptoms, social withdrawal, under-activity and slowness.
- Secondary social disadvantages such as unemployment, poverty and homelessness, as well as the stigma attached to psychiatric illness.

- Personal reactions to illness and social disadvantage such as low self-esteem and hopelessness, poor motivation and capacity for self-management and performance of social roles.
- Unpredictable behaviour, risk of harm to self and others, and liability to relapse.
- Financial circumstance of the client.
- Availability of community resources.
- Social circumstances to which the patient is likely to return.

The expected outcome of the assessment is a detailed outline of the person's present functioning highest level of functioning, highest level functioning and the needed services.

Intervention

Community psychiatric nurse must approach innervations with inflexibility and resourcefulness to need the broad range of needs of the patients with continued mental deficits. Interventions cannot be direct only towards discrete psychiatric symptoms, but must also facilitate client's access to various community resources providing for basic needs such as housing nutrition, etc. Since people suffering from mental illness often remain in or return to the community following treatment, nurses mist be able to the assess the presence of continued mental health problems and plan and implementation interventions within the confines of the resources available in the community.

Carr *et al.* (1984) have identified the following roles for nurses working in community mental health services:

Consultative roles: This means giving advice to other professionals in the community about the type and level of nursing care required for a given client group.

Clinician role: Providing direct nursing care to the patient in the community.

Therapeutic role: Employing psychotherapeutic and behavioural methods for management of patients.

Assessor/researcher role: The nurse assesses the care given to the client group, and may also assess the outcome ongoing care programs.

Educator: Creating awareness in the community about mental health and metal illness with special focus on vulnerable groups.

Trainer/Manpower facilitators: Training of paraprofessionals, community leaders, school-teachers and other care-giving professionals in the community.

Manager/Administrator: Management or resources, planning and coordination.
Domiciliary care: Services are provided to the client by visiting their homes. Services like administration of medications, assessment of the level of functioning and improvement of patient, monitoring of side-effects of drug, counselling of patients and family members are offered at the client's home setting.
Liaison role: Nursing working in the community help the clients and the family members by bridging the gap between the client and the hospital, client and the employers and also by networking in the community for resources development.
Preventive roles: These preventive roles are under primary, secondary, and tertiary levels.
Other areas of community health psychiatric nursing

- Social skills training
- Assertive management and relaxation
- Bereavement counselling
- Group meetings
- Community out-reach work services
- Child care services
- Adult care and elderly care services

Some Tips to be kept in mind when working in the Community
1. Identification of Patient in the Community: Talk to important people like, village panchayat members, local leader, teachers, and educated youth members of services agencies like angawadi mahila mandals, etc. and request them to tell you about individuals:

- Who talk nonsense and act in manner considered stranger or abnormal.
- Who have becomes very quiet and do not talk or mix with other people
- Who claim to hear voice or see things that others cannot hear or see.
- Who are suspicious and claim that others are trying to harm them.
- Who have become unusually cheerful, crack jokes and say that they are very wealthy and superior to others when it is not really so.
- Who have become very sad lately and cry without reason.
- Who talk about suicide or have made an attempt at suicide.
- Who get processed by god or spirit or who are said to be the victims of black magic or evil power

- Who are dull, mentally not grown up like other of their age and slow since birth.

When you visit homes, enquire about members suffering form mental illness. Ask the above mentioned questions tactful without offending them and obtain information about the existence of a patient in them in that family, neighbourhood or among their relatives.

When you go to school, enquire from teachers and students about children who suffer from fits, behavioural and learning problems.

2. Refer the immediately in the following conditions
   - The patients is severely ill, violent or unmanageable at home
   - History of recent head injury
   - Repeated convulsions (continuous or more than 3 times a day)
   - Distributed behaviour after delivery
   - The client has attempted suicide or is threatening to commit suicide
   - Distributed behaviour in people with known diabetes or hypertensions
   - People who show abnormal behaviour after taking alcohol or may other intoxicating substance.

3. Follow-up care with special emphasis on medication regimen, improvement made, and side effects, patient's occupational function

4. Be prepared to answer certain common questions asked regarding mental illness.
   - Is mental illness hereditary?
   - Is mental illness contagious?
   - Do ghosts, black magic, curse cause mental-illness?
   - Is mental illness treatable?
   - Can patients take up responsibilities after recovery?
   - Can marriage cure mental illness?

5 Remember
   - Do not give false assurance or make false promises, just tell them you will do your best to help them.
   - Do not make any decisions for the family.
   - Do not criticize or blame
   - See that they develop confidence in their abilities.
   - Do not make them dependent on you
   - Avoid half-heated attempts; hard work yields good results.

Psychiatric Services In Community Psychiatry

Various ways (methods) are used in practising community psychiatry:

(a) Psychiatric service in General Hospital: They furnish strategic application of community psychiatry. Here, the hospital serves as the community psychiatry. In this setting, psychiatric staff members can interact closely with their medical and paramedical colleges. People turn more readily to non-Psychiatrist physicians for help with their physiologic difference than to anyone else. Furthermore, any illness is psychologically stressful both to the patient and to his family; and many physical illnesses are provoked at least in part by emotional tension. As in other psychiatric treatment setting, continuity of care can be maintained as people are transferred form outpatient to impatient to artificial hospitalization (night or day hospital) and then back to outpatient

(b) Day Hospital (in the Hospital or on separate premises): Day hospital may be provided within the community. They are either attached to an hospital or stand on their own. Patients are brought by their relations to receive psychiatric treatment, depending on patient's condition; HW stays in the say hospitals for example morning till evening with relatives.

Patient may even be admitted for a short-term treatment with the relative in attendance.

(c) The field of child and family psychiatry serve as models for much of what takes place in community psychiatry. The therapist treating an emotionally disturbed child recognizes that other members of the family play a part in his patient's disturbance. Parents may be urged to obtain individuals therapy, or they may be regarded essentially as consultees. The child's problems are then discussed with the parents in such a way as to ease the parent's tensions and enlist them as colleagues in treating the child.

(d) Psychiatric Social workers form the hospital do follow-up of patients in assessing situations in the environment, treating and advising the community on health grounds.

(e) Day centres are also established for care of the elderly, for chronic Schizophrenia, for the mentally handicapped.

(f) Child Guidance Clinics are established in the community to take care of physical, emotional and psychological cares of children. The psychiatrist pay visit to the institutions.

(g) Social clubs in the Community aid treatment and prevention of psychiatric conditions. The alcoholics for example form themselves into clubs, they sheer opinions and receive advice form medical team.

(h) Village system care-neighbouring villages are used in some cases. Patients and relatives say there and receive treatment in the hospital.

Role Of The Community Psychiatric Nurse

- In community Mental Health today, Psychiatric nurse with a generalist background are prepared to attempt to meet the needs of "total patient". Their flexibility enhances the developmental nature of this growing specialty. Community mental nurses are action oriented. As in all Community health, the focus is one primary prevention. The nurse does not wait for the patient to become "ill" first, rather, the emphasis on prevention. Problems are dealt with in the setting where they began; an attempt is made not to remove the person from the community.
- Among other things, the nurse who is a clinical specialist in Psychiatric nursing serves as an individual and group therapist and consultation and liaison person to community agencies and hospital units.
- The community Psychiatric nurse makes home visits and serves as a resources person, educator, administrator and researchers.
- The community Psychiatric nurse communicates clearly with other health members to maintain their significant professional contributions.
- She assists the relatives in the management of the patient by helping them to prepare for the patient's return to the community, - providing support for the family, noting signs of stress within the family and taking appropriate remedial action.
- She is also concerned with giving health education within the community
- The nurse is concerned with the administration and supervision of drugs at home or health centre, and recognition of side-effects.
- She plays a role in running groups/social clubs which provide support after patient's discharged home.
- The community Psychiatric nurse is also concerned with provision of community of hospital in-patient or outpatient treatment.
- At times she runs a "supportive", and works with outpatient.

Levels Of Prevention

In the 1960s, psychiatric Gerald Caplan described levels of prevention specific to psychiatry. He defined *primary prevention* as an effort directed towards reducing the incidence of mental disorders in a community. Secondary prevention refers to decreasing the duration of disorder while tertiary prevention refers to reducing the levels of impairment.

Primary Prevention
Primary prevention seeks to prevent the occurrence of mental disorders by strengthening individual, family and groups coping abilities.

Role of a nurse in primary prevention
Community mental health nurse are in a key position to identify individual, family and group needs, conflicts and stressors. Thus, they play a level of prevention

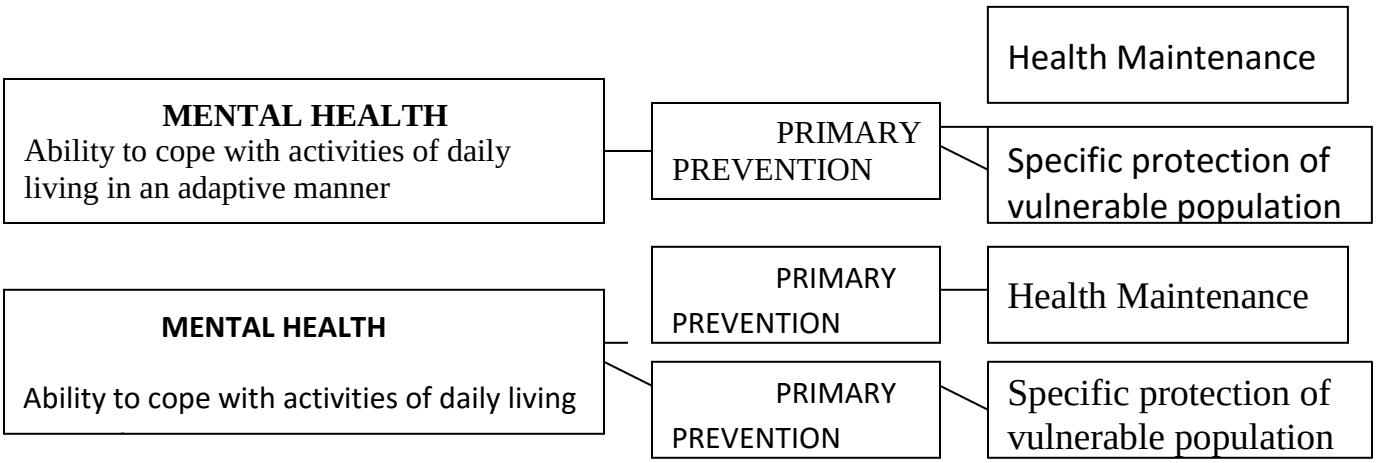

Fig. 1: Levels of prevention (This paradigm was developed by Bloom, 1979)

Major role in identifying high-risk groups and preventing the occurrence of mental illness include:

- Antenatal care to the mother an educating her regarding the adverse effects of irradiation, certain drugs and prematurely.
- Ensuring timely and efficient obstetrical assistance to guard against the ill effects of anoxia an injury to the newborn at birth.
- Dietary corrections of those infants suffering from metabolic disorders.
- Fostering bonding behaviours
- Teaching growth the and development to parents and teachers.
- Correction of endocrinal disorders.
- Consulting with parents about appropriate disciplinary measures
- Promoting open health communication in families.

- Rendering crisis counselling to the parents of physically and mentally handicapped children.
- Identifying the problems of scholastics performance and emotional disturbances among school children and going timely intervention. School teachers can be taught to recognize the beginning symptoms of problems.
- Ensuring harmonious relationship among the members of the family and teaching healthy adaptive techniques at the time of stress-producing events.
- Extending mental health education services at Child Guidance Clinics about child rearing practice; at parent-teachers association regarding the triad relationship between teacher, child and parent; and at various extramural health agencies regarding integration of mental health into general health practice.
- Strengthening social support for the frustrated ages and helping them to retain their usefulness.

Secondary Prevention

Secondary prevention targets people who show early symptoms of mental health disruption but regain premorbid level of functioning through aggressive treatment.

Role of a Nurse in Secondary Prevention

- Case finding through screening and periodic examination of population at risk, monitoring of client etc. thus in clinics, schools, home health care and the work place community mental health nurse detect early sign of increase level of anxiety, decreased ability to cope with stress and failure to perceive self, the environment and/or reality accurately and provide direct service appropriate
- Consultation and referral services.
- Early and effective treatment for patient, and if necessary, to family members as relevant; providing counselling services to caregivers of mentally ill patients.

Tertiary Prevention

Tertiary Prevention targets those with metal illness and helps to reduce the severity, discomfort and disability associated with their illness. In these terms community mental health nurses play a vital role in monitoring the progress of discharged patients in halfway homes, houses, etc.,

especially with regard to their medication regimen, coordination of care, and so on.

Exercise 1:
Summarize the Secondary level and the nurse's role

Roles of a nurse in tertiary prevention

- There are wide range of service that needs to be provided to patient as part of the tertiary prevention program. Nurses need to be familiar with the agencies in the community that provide these services. Collaborative relationship between mental health care providers and community agencies are absolutely essentially if rehabilitation is to succeed.
- An important intervention in the maintenance of patient in their own homes in the community is the Training in Community Living (TCL) program, designed by 'Stein' and 'Test'. In this model when a person is referred for a hospital admission the staff goes to the community with him rather than his going to the hospital to be with the staff. This real world experience with the patent enables the nurse to assess accurately the skills that the person breeds to learn and to mutually agree on realistic goals.

- Another aspect of community life that is more difficult to assess accurately and deal with effectively, is the stigma attached to mental illness. Many patient and their families try to avoid stigma by keeping the nature of the person's illness secret. The need for secrecy place additional stress on the family system because there us always the fear that the truth will be revealed. Nurses in the community are in a key position to monitor community attitudes and help in fostering a realistic attitude towards the mentally ill.
- For some patents, the emotional climate of the family to which they return can have a significant effect on their adjustment, and eventually, recovery from the debilitating effects off chronic metal illness. Families sometimes view mental illness as a weakness of

character that can be overcome by exertion of moral effort. This type of familial attitude may result in guilt on the part of the patient who believes that he has disappointed his significant other. Guilt leads to increase anxiety and decrease self-esteem. These are the conditions that interface with a high level of functioning. Therefore nursing working with families need to foster health attitudes towards the mentally ill member.

4.0 **Conclusion**

Community mental heath-psychiatric nursing which is the application of specialized knowledge to populations and communities to promote and maintain mental health, and to rehabilitate populations at risk that continue to have residual effects of mental illness. Psychiatric nursing in the community setting differs markedly from its hospital counterparts. The community setting requires that the psychiatric nurse posses knowledge about a broad array of community resources and be flexible in approaching problems related to individual psychiatric symptoms, family and support systems and basic livings needs such as housing and financial support.

5.0 **Summary**

You will agree with me that the method of treating mental illness have changed dramatically in the past century thus bringing about the shift in mental health care from the institution to the community and heralding the era of deinstitutionalization. This unit has taken you through these changes which make you more relevant in the management of mental disorders as a professional nurse.

Tutor Marked Assignments

Differentiate between institutionalized and deinstitutionalized management of mental health nursing in Nigeria

Answer to Exercise

Targets people who show early symptoms of mental health disruption but regain premorbid level of functioning through aggressive treatment.

Roles are:

- Case finding through screening and periodic examination of population at risk.
- Consultation and referral services.
- Early and effective treatment for patient,

7.0 References / Further Readings

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Unit 2: Legal Aspects of Mental Health Nursing

Table of Contents

1.0 Introduction

In one of your previous courses, you studied nursing ethics and jurisprudence, the course reflected on legal aspects of nursing profession. In this unit, you will also be taken through the legal aspects of psychiatry and psychiatric nursing, so the need to reflect and go back to the previous course on nursing ethics and jurisprudence.

The practice of psychiatric nursing is influenced by the law particularly in concern for rights of patients and the quality of care they are receiving. The relationship between psychiatric and law reflects on tension between individual rights and social needs, and the two areas have many similarities. Both psychiatric and law deals with human behaviours, the interrelationships between people and the responsibilities people assume based on these relationships. Both also have a role in society's desire for control of undesirable behaviours. Together, they mutually analyse when psychiatric treatment is therapeautic, custodial or incarceration.

2.0 Objectives

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

- state the similarities and dissimilarities between psychiatry and law
- explain the essence of law in psychiatry
- explain when and why the patient must be compulsorily admitted to hospital, detention for care and discharge

- state the legal and criminal responsibilities of mentally ill in Nigeria
- explain the concept of criminal responsibility
- discuss the concept of diminished responsibility

- state the role of psychiatrist and the law
- enumerate the rights of patients

Main content

Trends in Patients' Care and the Law

Mental (psychiatric) hospitals have ceased to be generally regarded merely as places of care and custody and their ability to treat and cure patients has been widely recognised. Unlocking of doors, removal of railings and reduction of other restrictions on personal liberty have become the common practice, and in this the mental hospitals have met with public support.

An increasing number of general hospitals provide accommodation for psychiatric patients for it is now recognised that they do not always need to be treated in special hospitals. This change of attitude to the mentally ill, which came about concurrently with rapid advances in treatment and new methods of hospital administration called for revision of outworn laws and statutory regulations.

In Britain, the repeal of section 315 of the lunacy Act made possible the admission of patients to mental hospitals without any formalities as 'informal' patients. The new Act removed the magistrate form any part in the legal detention of patients. Furthermore, it decreed that a patients suffering from a mental disorder, even if detained against his will, could be treated in a general hospital and do not only in a mental hospital as was previously the case.

Formerly, even a voluntary patient could not be admitted to a psychiatric hospital unless he was suffering from a 'psychiatric illness', although the latter term was not clearly defined in the regulations. There is now complete freedom to admit patients to any kind of hospital according to their clinical needs and the facilities available. There is no legal bar to a psychiatric hospital reserving wards for, say, maternity or general surgical cases, in the same way as there is no bar to a general hospital reserving wards or beds for psychiatric patients.

Of course this legal freedom is not likely to cause any great change in the function of hospitals, other than to bring more psychiatric patients into general hospitals. Patients with different kinds of psychiatric illness will continue to be treated in different clinics or hospitals, because those with mental illness need different treatment from those with mental subnormality.

Essence of Law in Psychiatry

It seems rather convenient to start by explaining why the law is so necessarily important in psychiatric. The answer lies partly in the nature of psychiatric illness itself, partly in the concept of responsibility and

accountability, and partly in the acceptance of the principle of the fundamental human right of freedom of movement of the individual.

Firstly, psychiatric illness, unlike other illness, is not always referable to a deviation from biological norms. Rather it may manifest in a behavioural pattern that constitute a deviation that is so gross and so bizarre that there is no difficulty among all and sundry in saying that the person involved must be mentally ill. In others, it requires the opinion of experts before any pronouncement of illness can be made.

Secondly, an individual with the types of behaviour specified above, attribute to illness, cannot be expected to be accountable for his own actions. In order to avoid incidents of this type, there should exist in each society laws to provide for the hospitalization (compulsory if necessary) of mentally disordered persons, and to ensure that they are not allowed to roam at large in the community. This is not to say that every mentally disordered persons, and to ensure that they are not allowed to roam at large in the community. This is not to say that every mentally disordered person must be hospitalized. The types of person that are of particular concern here are those who are unable to recognise or accept that they are ill and in need of treatment, those unable to look after themselves and at the same time do not have anybody to take responsibility for their welfare those with overt or potential destructiveness either to themselves or to others, or to property, and those with inability to control their behaviour especially when such behaviour is of a destructive.

An acceptable law must make provisions for the hospitalisation of the types of persons described above whilst at the same time taking into account the principle of the fundamental human right of freedom of movement. In addition, the law must ensure that, though certain personal and civil right of persons suffering from some types of illness may have to be curtailed, other rights are not unduly restricted. And it must make allowance for the effects of mental illness on a person's sense of responsibilities and accountability especially with respect to criminal behaviour. From these points of view, the law may be divisible into two groups. The first group, describe as "humanitarian" would consist of rules intended to protect the mentally ill person himself; whilst the second group, intended to protect the public, may be described as 'self-preservatory'.

Humanitarian

Thus the humanitarian rules would be concerned with:

1. Care or treatment of the individual:

a. Getting him, if necessary against his will to a place where he can be looked after and keeping him there until he is well enough to be released.
b. Protecting those who have to carry out (a) above; so that they are not deemed to be violating his fundamental human rights.
c. Ensuring that he is not deprived of his liberty for an unnecessarily long time.
2. Protection from undue criminal conviction.
3. Protection of his property and affairs whilst ill.

Self-Preservatory Rules

These rules would be concerned with the protection of the public form:

1. Mentally disordered persons who may find themselves in position of power in the governmental machinery. For example:
    a. Kings, Emperors, Presidents, Prime Ministers, Ministers and/or state Secretary (ies):
    b. Judges and Magistrates
    c. Other High government officials.
2. Mentally disordered persons who are not in crucial positions in the government but by virtue of their being loose in the society, are capable of inflicting harm on other people either by:
    a. direct/indirect assault on person;
    b. damage to property; or
    c. entering into marriage contract with unsuspecting persons.

The Law and the Mentally Ill in Nigeria (Compulsory Admission to Hospital, Detention for Care and Discharge)

The law which provided for the custody and removal of the mentally ill in Nigeria used to be called the Lunacy Ordinance.

(1) This law, which was first commenced on 21st December 1916, was a transcription of the English law, which was over 100years old and which was repealed and replaced by an Act of Parliament known as the Mental Act of 1959.
(2) At about this time, with the creation of self-governing regions in Nigeria, the Lunacy Ordinance was revised and incorporated into the Laws of each region as the Lunacy Law.
(3) And in Eastern and Northern Nigeria in 1963, (4, 5) The Law. In all three regions are similarly worded except in a few minor details. The description which follows therefore, applies to all of them although the Lunacy Law of Western Nigeria is used as an example.

The sections of the Lunacy Law which are of relevance for discussion here are sections 10-18. only these will be discussed. Section 10 of the Lunacy Law in Western Nigeria States that, "whenever a Medical Officer has cause to suspect that any person is a lunatic and considers it expedient that such person should be placed forthwith under observation in an asylum, he may grant a certificate of emergency, and shall cause such a person to be taken to an asylum and it shall be lawful for such a person to the asylum specified, and for the superintended of the asylum to receive and detain such a person in the asylum: 'Provided that no such person shall be detained in an asylum under any such certificate for a longer period than (7) seven days except with the authority of a magistrate'

Section 11-16 requires that an information be given on oath to a magistrate who may then examine the person suspected to be mentally disordered, and hold an inquiry as to this person's state of mind. There are regulations governing the conduct of such an inquiry. The magistrate may issue a warrant of arrest of the suspected persons. He should appoint a qualified medical practitioner to examine the patient, and complete a statutory certificate. Depending on the opinion of the magistrate may then complete another certificate authorising the compulsory admission of the patient. Where there is no qualified medical practitioner within the magisterial district the magistrate must be complete a warrant in term of form F (see Appendix) to a magistrate in a district where there is a qualified medical practitioner.

The latter magistrate must then go through the procedure of conducting an inquiry into the state of mind of the suspected person all over again. But he will be required to complete a different compulsory admission of the patient into the asylum.

The Discharge Procedure under the Lunacy Law (Sections 17 and 18) provides for only two people who may order the discharge of only two people who may order the discharge of a compulsorily admitted patient. These are magistrate and the governor of the state. But the magistrate can only order the discharge of a patient 'has been granted by the superintendent of the asylum in which the person is detained, or by any two qualified medical practitioners of whom one at least shall be a Medical Officer'.

The governor, on the other hand, 'may order the discharge from any asylum of any person detained therein under this law whether recovered or not and may allow any lunatic to be absent on trial for such period as he thinks fit, and may at any time grant an extension of such period'. And 'In respect of any lunatic absence on trial, the governor may order the payment out of the

revenue of any sum not exceeding the sum of two pounds per month (or about ₦ 300.00) to the person taking charge of such lunatic'.

Observations

In spite of its revision in 1959, the Lunacy Law remains couched in a language which reminiscent of Pre-Renaissance concepts of mental disorders and which must militate against the willingness of mental health personnel in this country to apply the law. It is therefore not surprising that it is difficult to find any psychiatric establishment in this country where the law is put into practice.

While the majority of patients can be treated informally, there will always be a group of patients whose illness makes them a potential source of danger to themselves or to others but who are so lacking in insight that they will not voluntarily seek the care, protection and treatment they require. This group includes, among others, the severely mentally disordered persons who live on and roam the streets, the streets of our towns and cities i.e. vagrant psychoses. For this category of patients the law must evolve a system that will facilitate a smooth and speedy admission procedure so that the treatment which these patients' need may be promptly instituted. That the personal liberty of the individual is not unduly jeopardized is safeguarded in the fundamental human right of Freedom of Movement in the constitution of the Federal Republic of Nigeria (6). Section 21 (i.e.) provides that no person shall be deprived of his personal liberty save in certain circumstances which involve persons suffering from infectious diseases, persons of unsound mind, persons addicted to drugs or alcohol or vagrants. And in these cases, deprivation of personal liberty must be for the purpose of their care or treatment or the protection of the community.

In terms of smoothness of practice for mental health personnel, the early institution of badly needed treatment and the convenience of the mentally disordered patient, section 10 (cited above) is about the only satisfactory provision available in this law. In order to detain a patient for longer than seven days, one must go through a legal procedure (Sections 11-16) which, in the light of Nigeria judicial system, may be very cumbersome and discouraging.

Perhaps such a cumbersome procedure as is demanded by Sections 11-16 above may help to safeguard the personal liberty of the suspected patient as envisaged by the provisions of the constitution of the federation by ensuring that he may never be compulsorily admitted until a detailed inquiry has been conducted to confirm a disordered mental state. It is, however, obvious that

the advantages associated with such a procedure far outweigh any advantage it may possess.

Suggested Modifications

Modification of the Law, both in terms of its language and the procedure laid down for the compulsory admission of the psychiatric patient seems long overdue. The need for change is buttressed by the fact that a considerable advancement in psychiatric knowledge has taken place, and progress made in the provision of mental health care in Nigeria since the Lunacy Ordinance was introduced in 1916.

Firstly, there is a need for an overhaul of the terminology. The terms "lunacy", "lunatic", "asylum", "insanity" should be replaced. These words not only reflect an antiquated notion of the nature of mental illnesses, they also carry with them negative social values. A considerable proportion of the unfavorable attitudes the public manifests towards the mentally ill originate from fears of mental illness as a terrible and shameful social condition.

The procedure stipulated in Sections 11-16 which necessitates in the issue of warrant for the arrest of the patient the holding of a summary trial involving his exposure to public spectacle detention in prison pending decision on his state of mind is distastefully stigmatizing to the patient as well as to his family. These sections of the law need to be abolished and be replaced by more enlightened and humanitarian ones. The 1957 Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which sat under the chairmanship of Lord Percy of Newcastle stated *inter alia*, 'mental disorders of all kinds must be viewed primarily as a matter of protecting society'. In other words, it is largely a medical rather than a legal concern. The English Mental Health Act 1959 is based on this commission's report.

Dr. Issac Ray, an American Psychiatrist who lived in the 19th century, has enumerated the essential and basic components of enlightened and humanitarian laws governing the involuntary hospitalization of the mentally ill (7). He stated these components as follows:

"In the first place" – the law should put no hindrance in the way of prompt use of those instrumentalities which are regarded as most effectual in promoting the comfort and restoration of the patient".

Secondly, it should avoid all unnecessary exposure of private trouble, and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment. It would be objective enough to any legal provision that it failed to secure these objectives in the completes possible manner.

The Law and the mentally ill in Nigeria II

Introduction

When a mentally ill individual first manifests an act that will later be perceived as psychiatric symptom, the act is not always recognized as a symptom of illness but rather as a deviation from social norms. (1) This is particularly so with major mental illnesses. It follows, therefore that in order to avoid imposing punishment for an offence committed by a mentally disordered person, the society must formulate laws to guide those who administer justice in our law courts.

The Nigerian Criminal Code Ordinance

The law which provides for the determination of legal and criminal responsibility of the mentally ill in Nigeria is embodied in the Nigerian Criminal Code Ordinance. (2) which is based on a Criminal Code drafted by the renowned English criminal lawyer, Sir Fitzjames Stephens, in 1878 it was proposed to replace the Common Law in England but was never enacted by the British Parliament. It was instead introduced into Queensland in Australia in 1899 and into Nigeria in 1916 following the unification of the north and south. (3) With the creation of self-governing regions around 1959, the Criminal Code Ordinance was revised and incorporated into the laws of the Western and Eastern Regions as "Criminal Code Law". In Northern Nigeria, due to the prevailing Moslem religion there, the Criminal Code Ordinance redrafted and brought into operation in September, 1960 as the Penal Code Law. (4) According to Richardson (5); the Northern Nigeria Penal Codes were based on the equivalent Sudan Codes which were in turn modelled upon the Indian Penal Codes.

The sections of the Nigerian Criminal Code Ordinance which are of relevance to the theme of this discussion here are Sections 27, 28 and 327.

'Section 27

Every person is presumed to be of sound mind and to have been of sound mind at any time which comes in question until the contrary is proved.

'Section 28

A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to control his actions, or capacity to know that he ought not to do the act or make the omission.

A person whose mind, at the time of his doing or omitting to do an act is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real

state of things had been such as he was induced by the delusions to believe to exist.

‘Section 327

Any person who attempts to kill himself is guilty of a misdemeanour and is liable to imprisonment for one year.

Despite its intention to avoid conflict with the Holy Qu’ran and Sunna, the Northern Nigerian Penal Code has retained a number of offences contained in the Nigerian Criminal Code Ordinance so that nothing which is an offence under the Criminal Code ceases to be an offence in Northern Nigeria. Thus, Section 231, which deals with ‘attempting to commit suicide’, is essentially the same as Section 327 of the Nigerian Criminal Code. Similarly, Section 51 in the Penal Code, which gives the legal definition of insanity, contains almost all the elements of Section 28 of the Nigerian Criminal Code.

Observations

The above Laws are of concern to the medical profession from certain points of view:

(a) The desire of the physician to ensure that his mentally abnormal patient is not unjustly convicted for an offence of which he is accused.

(b) The compatibility of the Laws with the modern trend in psychiatric knowledge.

In order to examine the Law from these points of view it would be fruitful, at this stage, to examine the meaning of ‘criminal responsibility’.

The Concept of Criminal Responsibility

According to Jacobs (1971), ‘a person is responsible for something if he can be called upon to answer questions about it’. Thus responsibility, either in law or morals, constitutes an instrument of social control. In criminal law, the general rule is that liability requires “mens rea”, lawyers Latin for a guilty mind, and “actus reus” – wrongful intention. The interpretation of these requirements usually involves a subjective inquiry into the actual state of mind of the accused at the time of offence committed. Since the criminal law seeks to punish the offender for the offence committed. It is absolutely important that the law lays down criteria for distinguishing, on ground of supposed mental abnormality, between those who are, and those who are not, responsible for their actions.

Mental Illness and Criminal Responsibility in the Nigerian Criminal Code

Section 28 of the Nigerian Criminal Code gives the legal definition of insanity but it places the onus of proof of mental abnormality on the accused, through Section 27. Such a proof is based on informed advice from the medical profession by the production of medical evidence and/or cross-

examination of a medical witness. The onus however, is not as great as that placed on the prosecution to prove its case beyond all reasonable doubts. Sometimes a positive family history of mental abnormality may constitute sufficient admission. For example, in the case of Rex. vs Edem Ugo Inyang the judges ruled that, "Evidence of insanity of ancestors or blood relations is admissible. Medical evidence is not essential".

Section 28 of the law emphasizes that the mental abnormalities should have existed at the material time when the offence was committed. It does not matter if such abnormality was temporarily or permanently although the former may be difficult to establish. For example, in Rex. vs. Edem Ugo Inyang the high court judge had ruled that the accused as sane at the time he committed the offence. At the Appeal Court, J.I.C Taylor, in arguing on behalf of the appellant, distinguished between 'partial insanity' and 'total insanity'. By 'partial insanity', he meant that the appellant was subject to periods of insanity, during one of which he killed the deceases. 'Total insanity' meant permanent insanity. But the Appeal Judges in disagreeing with Taylor's submission, stated: "It is clear that the learned Judges' summing up of the appellant when he struck the deceased, no matter whether that state of mind was a temporary or permanent one".

The principle followed in most English speaking countries was laid down in 1843 in the McNaughten Rules Walker (1968). McNaughten was a paranoid who attempted to assassinate the British Prime Minister, Sir Robert Peel, being under the delusion that only by shooting the Prime Minister could he escape from the persecution, which had been dogging him for many years. He shot and killed the Prime Minister's Private Secretary, apparently mistaking him for Peel. The argument of McNaughten's lawyer, Cockburn, sought to rely on lack of control and the jury had no hesitation in acquiring his client. The public reaction to the case led the House of Lords to pose five questions to the judges in Britain on the question of insanity. The judges' answer to the third and fourth questions embody the McNaughten Rule as follows:

"The jurors ought to be told in all cases that every man is to presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction and that to establish a defense on the grounds of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong".

Thus the McNaughten Rules take into consideration only the cognitive aspects of the individual's behaviour and ignores the emotional and volitional aspects. The accused person must be suffering from a defect of reason… so as to know… if he did not know that he was doing what was wrong. If it were strictly applied, it would be almost impossible to find anyone to whom the Rules would apply. The Nigerian Criminal Code whilst incorporating the McNaughten Rules in its Sections 27 and 28 has gone far further in taking cognizance of the individual's volitional state. Thus, the capacity to control his actions… which is in Section 28 is not found in the McNaughten's Rules.

There has been one instance in Nigerian medico legal history in which the Nigerian Criminal Code (Section 28) was compared with the McNaughten Rules. This was in the case of Rex. vs. Omoni which is regarded as the standard case on our law of insanity. This comparison shows that the Nigerian Legislature had not only departed from the phraseology of the English Judges 1845 but had also introduced two entirely new factors: "natural mental infirmity" and "capacity to control his actions". In trying to elicit the exact meaning of the phrase "natural mental infirmity", the West African Court of Appeal (WACA) Judges Rex. vs. Omoni stated, "We must ascribe to them (i.e. the words "natural mental infirmity" an intention to distinguish between 'mental disease' and 'natural mental infirmity', for otherwise the last words would be redundant. The words 'natural mental infirmity' mean, therefore, in one's opinion, 'a defect in mental power neither produced by own default nor the result of disease of the mind'.

The only category of mental abnormality which falls into this class is that group known as mental subnormality or mental retardation. Thus, it would seem that a mentally retarded person cannot be held to be criminally responsible for his offences. In Britain, on the other hand, a mental defective would still be found guilty although, under the Mental Deficency Acts of 1913 and 1927, the courts would be empowered to place him under guardianship or to send him to an institution for mental defectives instead of passing sentence on him.

Let us examine the phrase 'to deprive him of capacity to control his actions'. The W.A.C.A. Judges observed that these words not only departed from the Rules in McNaughten's case, but were in direct conflict with the line of English decisions subsequent thereto, in which the Judges of England have declined to accept the defense of irresistible impulse' which these words appear to have introduced into the laws of Nigeria. The Judges further observed, 'As to the wisdom of introducing or maintaining this departure from English Law, it is one for the legislature to judge; this court can only

apply this law as one finds it'. They went on to quote Hewart in the case of Rex. vs. Kopach, where the learned Lord Chief Justice said, 'The complaint against the Judge is that he did not tell the jury that something was the law which was not the law. It is the fantastic theory of uncontrollable impulse which if it were to become part of our criminal law, would be merely subversive. It is not yet part of the Criminal Law and it is to be hoped that the time is far distant when it will be made so.

Obviously these judges were averse to the concept of "uncontrollable impulse". It is notable that in this respect the Nigerian Law has been ahead of the British Law which places emphasis on the cognitive aspects of the individual's behaviours only, and refuses explicitly to recognize the importance of volitional factors. Thus the Nigerian Criminal Code, by virtue of the clause 'incapacity to control his actions', seem to exonerate persons suffering from disorders like kleptomania states of epilepsy associated with automatism or certain abnormal metabolic states in which the individual may behave in an uncontrollable manner e.g. hypoglycemic states.

It appears however that the judges in Nigerian Courts have been reluctant to give recognition to the full meaning of this phrase. Although a plea of 'uncontrollable impulse' may be made, it is not considered as sufficient proof of insanity. In the case of Rex. vs. Ashigifuwo (11), the judges ruled that 'mere absence of any evidence of motive for a crime is not a sufficient ground upon which to infer mania'. In Rex. vs Inyang (1) they stated 'where there was sufficient evidence indicative of insanity rather than the opposite, the absence of any evidence of motive may become relevant to the point at issue and material to it'.

The inclusion of the second part of Section 28 may represent a setback in the Nigerian Law. The interpretation of this paragraph seems to be that the mere presence, per se, of delusion in the accused person is sufficient ground to absolve him from the offence charged. Aguda (1965) has attempted to clarify this paragraph by giving the following example as an illustration:

A sees Z and Z's wife in his house and A, under the insane delusion that the woman was his wife and that Z was committing adultery with her, kills Z.

The rule says that A's criminal responsibility should be considered on the basis of the fact as he supposed them to be. If the facts would have amounted to a killing as a result of provocation, then he will be convicted of manslaughter. Although it is arguable whether A, in the above example, would be said to be suffering from a delusion or an illusion, we could agree for the purposes of this discussion that he was in fact suffering from a delusion. The argument that A would be liable to conviction for manslaughter seems to indicate that the law makers have definitely failed to

be guided by informed psychiatric knowledge on this issue. According to Jaspers (1959), 'since time immemorial, delusion has been taken as the basic characteristic of madness'. To be mad was to be deluded. Delusion manifests itself in judgements; delusions can only arise in the process of thinking and judging. To this extent, pathologically falsified arguments are termed delusions, it is, therefore, apparent that the person who is deluded (whether 'on some specific matter or matters') cannot but be entitled to the benefit of the first paragraph of Section 28. fortunately, the practical application of this part of Section 28 is strictly limited. Aguda (1965) pointed out that most cases could be disposed off under the first part of this section. The inclusion of the second paragraph is thus unnecessary.

The Concept of 'Diminished Responsibility'

The Nigerian Law does not recognize the concept of 'diminished responsibility', which became incorporated in the English Law in the Homicide Act of 1957 (14). This concept dates back to 835 Walker (1968). In the case of William Braid who pleaded guilty to some unrecorded offence, Dr. Trail was examined, after the accuser's mind had diminished his responsibility, although it did not take it away entirely. "It seems to have been based on the concept of 'partial insanity' put forward in Scotland by Sir George Mackenzie who lived between 1636-91 Walker (1968). He argued that since the law granted total immunity to those who were shown to suffer from total insanity, it should by rule of proportions, moderate the punishment if those with partial insanity. Although partial insanity was not usually recognized as a defense, it was taken into account after conviction, by the practice of allowing, or advising, the jury to recommend a pardon. One wonders if this was what Taylor was trying to achieve when he tried to distinguish between 'partial insanity' and 'total insanity' in the appeal of this client (Rex. vs. Inyang spurs).

Regular use of the concept of 'diminished responsibilities' did not, occur until 1867 in Aberdeen, when Lord Dees tried Dingwall, a 45-year-old chronic alcoholic, who stabbed his wife to death after a drinking bout. Lord Dees, in directing the jury, ask the jury to consider, among other factors that the prisoner appeared to have been peculiar in his mental constitution and to have had his mind weakened by successive attacks of disease (he had had repeated attacks of delirium tremens). Lord Dees was of the opinion that the weakness of his mind was not inadmissible in deciding whether the offence should be classed as murder or culpable homicide. The state of mind of a prisoner, he thought, might be an extenuating circumstance, although not such as to warrant an acquittal on grounds of insanity. The result was the

substitution of a lesser penalty than death. Lord Dees and his fellow judges in Scotland continued to steer juries into similar verdicts and by 1909, the phrase ‘diminished responsibility’ was actually being used by judges.

It is arguable that the development of the concept of ‘diminished responsibility’ in Scottish Courts was the result of accident of history. The McNaughten Rules which were in force in England at that time were not applicable to Scotland. Thus the boundary between murder and culpable homicide was less clearly defined in Scotland. However, the advantages of this concept are obvious:

1. A greater number and types or degrees of mental abnormality could be taken into account.
2. Whereas English Law allowed only two possibilities that the prisoner was or was not so insane as not to be accountable for his act or omission, Scots law allowed a third; that he was sufficiently disordered to deserve mitigation of the usual punishment though not complete exemption. That is, he was not in complete control of his own mind.
3. The effect enabled the judge to pronounce either a sentence of life-imprisonment, imprisonment for a specified term, a fine, a probation order, or an absolute or conditional discharge.

In Nigeria, where the death penalty is still in force, the inclusion of ‘diminished responsibility’ would no doubt prevent the execution of a sizeable number of convicted persons who could only be classified as ‘partially insane’ thus not qualifying for acquittal under Section 28, for example, Lambo (1962) made a study of persons convicted for criminal offences which included murder or multiple murders by members of the prescribed Odozi Obodo and Leopard Men societies. He found that the criminal behaviour by such persons could be regarded as one of the components of a psychiatric syndrome which he termed “Malignant Anxiety”.

Aguda (1965), thinks that the defence of irresistible impulse covers ‘diminished responsibility’ and even more. This is doubtful. He argues that whereas the defense of diminished responsibility is restricted to cases of homicide the defense of irresistible impulse under the Nigerian Criminal Code is applicable to all offences. It is true that for example, the kleptomaniac in Nigeria may be able to obtain an acquittal with a defense of irresistible impulse, but this does not necessarily mean that all or majority of mentally ill persons accused of a criminal offence suffer from irresistible impulse. There is still a considerable class of persons who commit homicide while suffering from some form of mental illness which is significant in the

commitment of the offence but the nature of which does not entitle them to total acquittal under Section 28 of the Criminal Code. The provision of a defense of diminished responsibility would enable such persons to be given a lesser penalty than death. The Northern Nigeria Penal Code does not recognize the defense of irresistible impulse, or that of diminished responsibility.

Attempting to Commit Suicide

Section 327 of the Criminal Code which deals with attempted suicide is overdue for abrogation. Persons who commit suicide or attempt suicide are usually mentally ill, some of them severely so. In a study of 38 patients with self-poisoning and self-injury admitted to University College Hospital, Ibadan, only 21 percent were found to have no evidence of psychiatric illness (Ebie, 1972). If a person succeeds in committing suicide the law cannot reach him to try him. But if he fails to die, then he may be sent to jail for one year. It is thus arguable whether such a person is being tried because he failed or because he ever attempted suicide in the first place. Section 327 is that it seems to be imposing a moral judgment on the individual. Suicide used to be a crime in England but this is no longer so since the passing of the Suicide Act of 1961.

It cannot be argued that the imposition of a penalty for attempted suicide is based on the rationale that it would help to deter people from committing this act. There is evidence to suggest that Nigeria has one of the lowest suicide rates in the world. Asuni (1961) found an incidence of less than 1 in every 100,000 in Western Region Nigeria (now Ondo, Ekiti, Osun, Oyo, Ogun, Edo and Delta states). This was lower than the lowest figure recorded anywhere else in the world. There are reasons to believe that this rate is due, not to the punitive intent of Section 327, but to other factors. Imposition of a penalty is more likely to make people conceal the fact of an attempted suicide or increase their determination to ensure that they successfully carry out the act. Hence people in need of care would be reluctant to come forward for the help they badly need.

The Role of Psychiatrists and the Law

In the course of all these, I have often wondered whether a psychiatrist is the most qualified person to deal with this sort of subject or whether it does not actually belong in the territory of legal practitioners. The law is, fundamentally a complete artefact – a collection of man made rules enacted by legislators or rulers of a country with or without taking into account the predominant current social feelings at the time each rule becomes enacted. The people who administer the law (lawyers, police, magistrates, judges) are therefore interested in medical aspects only to enable them ensure that

justice (as in implicit in the Law) is done. Thus they are more interested in say for example, the time of death in the case of a murder, the state of mind of the accused at the time of offence alleged etc. There is little interest in aetiological factors or pathogenesis or the phenomenology of the illness or disease in question. And they tend to expect accurate, unambiguous answers from medical witnesses. Unfortunately in the area of psychiatry, such clear cut answer cannot always be offered. This is a situation that has tended to make the law courts cautious with psychiatric testimonies.

This subject of law and psychiatry is an interdisciplinary one in which both psychiatry and law overlaps and should ideally involves the corroborative effort of both the lawyer and the psychiatrist. Otherwise a person seeking to tackle such a subject single-handedly should, ideally be both a lawyer and a psychiatrist rolled into one person. Doctors, on the other hand tend to be interested in the Law, only when they find themselves confronted with certain problems in medical practice. For example, the legal definition of death, or performing a life saving surgical procedure on a patient or his relatives. And the interest ceases once the problem has been solved.

The medical profession as a body has a duty in educating the community and advising the lawmakers on these aspects of the Law relating to health. And there is a need for the lawmakers to acknowledge this. In playing these educational and advisory roles, objectives and scientific facts based on research should be placed above the personal beliefs of the doctor so that a Roman Catholic doctor faced with say, a move to liberate the law on abortion does not allow his religious beliefs to becloud his objectivity and scientific attitude.

Rights of Patients

Patient's Rights, generally include:

1. Right to keep personal effects (not harmful).
2. Right to independent psychiatric examinations.
3. Right to get his consent (or be informed) pre-procedure or any operation.
4. Right to treatment – to refuse or accept – Consider his mental state.
5. Right to marry and divorce.
6. Right to be employed, if possible.
7. Right to education.
8. Right to fair hearing in the court.
9. Right to periodic review.
10. Right to referral or discharge.
11. Right to compensation.

12. Right to contractual relationship.
13. Right to freedom from mechanical restraints or seclusion.
14. Right to request (and sign) for discharge – if he's not too psychotic.

4.0 **Conclusion**

It should be noted that despite the similarities in psychiatry and law, there existed some dissimilarities which include, that psychiatry is concerned with the meaning of behaviour and personal life satisfaction, law addresses the outcome of behaviour and has developed a system of rules and regulations to facilitate orderly social functioning. These differences are not the same in terminology when it is recognized that insane and legal- commitments are predominantly legal, not psychiatric terms.

5.0 **Summary**

You will agree with me that sound understanding of this unit will assist you in your professional services to humanity wherever you service is needed. Now you can attempt the following tutor marked assignments.

Tutor Marked Assignment

(1) Account for the similarities and dissimilarities between psychiatry and the law.

(2) What is the relevance of this unit to the development of nursing profession in Nigeria?

7.0 **References / Further Readings**

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