MENTAL HEALTH FOR MIDWIVIES

By

ZAWEDDE ALICE

COURSE OUT LINE

- Concepts of mental health and mental illness
- Classification of mental illness
- Etiological factors of mental illness
- General signs and symptoms
- Assessment of the mental ill patient
- Common mental/psychiatric conditions in midwifery practice

Basic Key Concepts In Mental Health

- Define the following terms

➢Mental health

➢Psychiatry

➢Mental illnesses/disorders

➢Psychosocial problems

- **Mental Health** is the state of psychological, social, spiritual and physical wellbeing of the mind that enables an individual to think ,feel, perceive, relate, and being able to adapt to his/her environment and make reasonable choices that are beneficial to his/her life (WHO 2001).
- The WHO defines mental health as "a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

- **Mental Disorders (psychiatric d/os)** these are disorders that involve disturbance in thinking, emotions and behavior that cause distress or impairment in personal, social and interpersonal relationship.
- The term "**disorder** " is used in place of "illnesses" or " disease" it means a grouping of clinically recognizable set of symptoms or behaviors associated with distress that interfere with an individual's psychological, social, and behavior functioning.

- **Psychosocial disorder;** are those disorders that have an interrelationship between psychological and social dysfunction. They are often not severe enough to be called mental disorders but they can be severe to call for intervention.
- **Psychiatry-** is a branch of medicine that deals with the study of the mind and its mental processes.

Concepts of mental health and illness

Mental health:

- A balance in a person's internal life and adaptation to reality. **OR**
- This is a state of well being in which a person is able to realize his potential and adapt to reality.

Mental illness.

- A state of imbalance characterized by a disturbance in a person's thoughts, feelings and behavior.

Psychiatric nursing:

- Specialized area of nursing practice that focuses on prevention and treatment of human responses to mental health problems and psychiatric disorders.

CLASSIFICATION OF MENTAL ILLINESS

Mental illness can be classified using;

- *DSM 5 (Diagnostic and statistical manual of Mental disorders)*
- *ICD (International statistical classification of diseases).*

DSM 5

- This is a taxonomic and diagnostic tool published by American psychiatric association (1994)
- DSM states that a mental disorder is a syndrome characterized by clinically significant disturbance in an individuals cognition, emotion, regulation, and behavior that reflects dis function in the psychological, biological or developmental processes underlying mental functioning.

Classification according to DSM 5 and ICD11

1.Neurodevelopmental disorders

These include the following;

a. Intellectual disabilities (mild, moderate, severe & profound).

b. Communication disorder (language d/o , speech sound d/o, stuttering, social pragmatic communication d/o,,& unspecified communication d/o)

Autism Spectrum Disorders

a. Specify if it is associated with a known medical or genetic or environmental factors.

b. Specify if with or with out a companying intellectual impairment with or with out language impairments.

Attention-Deficit/Hyperactive Disorder

a. Attention deficit hyperactive d/o.

b. Specify learning Disorder.

c. Motor d/o

d. Tic d/o

e. Other neurodevelopmental d/os.

- **2.Schizophrenia Spectrum and Other Psychotic Disorders.**
  - **It affects the persons thinking, feeling and behaviour**

a. Schizotypal personality d/o.

b. Delusional d/o

c. Brief psychotic disorder.

d. Schizophreniform disorder.

e. Schizophrenia

f. Schizoaffective

g. Substance/medication- induced psychotic d/o

f. Psychotic d/o due to another medical condition.

g. Catatonic associated with another mental d/o

h. Unspecified catatonia

i. Other specified Schizophrenia spectrum and other psychotic d/o.

ii. Unspecified Schizophrenia spectrum and other psychotic d/o.

3.Bipolar and Related Disorders

a. Bipolar 1 disorder
b. Bipolar 11 disorder
c. Cyclothymic disorder
d. Substance related /Medication-induced Bipolar and related d/o
e. Bipolar and related disorder due to another medical condition.
f. Other specified Bipolar and Related d/o
g. Unspecified Bipolar and related d/o

4. Depressive Disorders

a. Disruptive mood dysregulation d/o

b. Major Depressive d/o

c. Persistent depressive d/o (Dysthymia).

d. Premenstrual Dysphoric d/o

e. Substance/medication-induced depression d/o

f. Depressive d/o due to another medical condition

g. Other specified depressive d/o

h. Unspecified depressive d/o

5. Trauma and stress Related disorders

a. Reactive Attachment Disorder

b. Disinhibited Social Engagement Disorder

c. Post traumatic stress Disorder

d. Acute Stress Disorder Adjustment Disorder

e. Adjustment Disorder

f. Other specified trauma and stress related d/o

g. Unspecified trauma and stress related d/o

6. Dissociative Disorders

- Dissociative Identity Disorder
- Dissociative amnesia
- Depersonalization/ Derealization Disorders
- Other specified Dissociative Disorder
- Unspecified Dissociative Disorder

8. Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (functional neurological symptom disorder)
- Psychological Factor Affecting other Medical Conditions
- Factitious disorder
- Other specified somatic symptom and related disorder
- Unspecified somatic symptom and related disorder

9. Feeding and Eating Disorder

- Picas
- Rumination Disorder
- Avoidant
- Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Bing Eating Disorder
- Other specified feeding/eating Disorders
- Unspecified feeding/eating Disorder

10. Elimination Disorders

- Enuresis
- Encopresis
- Other specified Elimination disorders
- Unspecified Elimination disorder

11. Sleep –Wake Disorders

- Insomnia Disorder
- Hyper somnolence Disorder
- Nacolopsy

12.Breathing-Related Sleep Disorders

- Obstructive Sleep Apnea Hypopnea
- Central Sleep Apnea
- Sleep- Related Hypoventilation
- Circadian Rhythm Sleep –Wake Disorders
- Advanced sleep Phase type
- Irregular sleep-wake type
- Non 24-hour sleep-wake type
- Shift work type
- unspecified type

13. Sexual Dysfunctions

- Delayed Ejaculation
- Erectile Disorder
- Female orgasmic Disorders
- Female Sexual Interest/Arousal Disorder
- Genito-Pelvic Pain/penetration Disorder
- Male Hypoactive Sexual Desire Disorder
- Premature Ejaculation
- Substance /medication-induced sexual dysfunction
- Other specified sexual dysfunction d/os
- Unspecified sexual dysfunction d/os

14.Substance-Related and Addictive Disorders

Alcohol-Related Disorders

- Alcohol-Related Disorder
- Alcohol Intoxication
- Alcohol withdrawal

Caffeine-Related Disorders

- Caffeine intoxication
- Caffeine withdrawal

Cannabis Disorders

- Cannabis intoxication
- Cannabis withdrawal

Opioid-Related Disorders

- Opioid use disorder
- Opioid intoxication
- Opioid withdraw

Sedative, Hypnotic or Anxiolytic Use disorder

- Sedative, Hypnotic or Anxiolytic intoxication
- Sedative, Hypnotic or Anxiolytic withdraw

Stimulant-Related Disorders

- Stimulant intoxication
- Stimulant withdraw

Tobacco Use Disorders

- Tobacco withdraw

Other unknown –related disorders substance

- Other unknown substance intoxication
- Other unknown substance withdraw

Non substance –Related Disorders

- Gambling

Neurocognitive disorders

- Delirium

14. Major or Mild Neurocognitive Disorders

- Major or mild neurocognitive disorder due to Alzheimer's disease.
- Major or Mild Frontotemporal Neurocognitive disorder.
- Major or mild neurocognitive disorder with Lewy Bodies.
- Major or Mild Vascular Neurocognitive Disorder
- Major or mild neurocognitive disorder due to Traumatic Brain injury.
- Substance /Medication-induced Major or Mild Neurocognitive Disorder
- Major or mild neurocognitive disorder due to HIV Infection
- Major or mild neurocognitive disorder due to Prion Disease
- Major or mild neurocognitive disorder due to Parkinson's Disease

15. Personality Disorders

Cluster A Personality Disorders

- Paranoid personality d/o
- Schizoid personality d/o
- Schizotypal personality d/o

Custer B Personality Disorders

- Antisocial personality d/o
- Borderline personality d/o
- Histrionic personality d/o
- Narcissistic personality d/o

Cluster C Personality Disorders

- Avoidant personality d/o
- Dependent personality d/o
- Obsessive-Compulsive Personality d/o

Other personality Disorders

- Personality change due to Another Medical Condition

Paraphilic Disorders

- Voyeuristic d/o
- Exhibitionistic d/o
- Frotteuristic d/o
- Sexual Musochism d/o
- Sexual Sadism d/o
- Fetishistic d/o
- Transvestic d/o

Other Mental Disorders

- Other specified mental d/o due to another medical condition.
- unspecified mental d/o due to another medical condition.
- Medicine induced movement d/os
- Other conditions that may be a focus of clinical attention
- Abuse and Neglect
- Child psychological abuse
- Adult maltreatment and neglect problems
- Spouse or partner violence, sexual
- Spouse or partner neglect
- Spouse or partner Abuse, psychological
- Adult Abuse by nonspouse or non partner

- Educational and occupational problems
- Housing and economic problems
- Other problems related to social environment
- Problems related to crime or interaction with the legal system.
- Other health service encounters for counseling and medical advice.
- Problems related to other psychosocial, personal and environmental circumstances.
- Other circumstances of personal history
- Problems related to access to medical and social health care.
- Nonadherence to medical treatment

ICD

- International statistical classification of disease
- Initiated and recognized by WHO(1992)
- Contains codes for diseases, signs and symptoms, abnormal findings, external causes of injury and disease.

ICD

- F0- organic disorders including symptomatic mental disorders eg dementia, and amnesia.
- F1- Mental and behavoour disorders due to psychoactive substance use
- F2- schizophrenia, schizotypical and delusional disorders eg schizophrenia, delusional disorders.
- F3- Mood(affective disorders) eg mania, depression, bi polar.
- F4-Neurotic, stress related disorders eg Obsessive compulsive disorder, post traumatic stress disorder, etc.
- F5-Behavioural syndrome associated with physiological disturbances and physical factors eg eating disorder, non organic sleep disorder.
- F6-Disorders of personality and behavior in adults eg paranoid disorder, Schizoid, etc.
- F7-Mental retardation i.e (mild, moderate, severe mental retardation).
- F8-Disorders of psychological development e.g speech and language disorders
- F9- Behavioral and emotional disorders with onset occurring usually in childhood e.g social anxiety, conduct disorder, childhood emotional disorder, etc.

ATIOLOGY OF MENTAL ILLINESS

- The actual cause in un clear but there are predisposing factors.
- This can be grouped into three; ie;
- ***Intrinsic factors***
- ***Extrinsic factors***
- ***The daily ups and downs.***

INTRINSIC FACTORS:[predisposing]

- This is what the person is born with and is related to one's genetic make up. They include;

1.**Heredity**- Passed on from one generation to the other.

2. **Chemical substances(nuero transmitters)** eg hormones. If over produced or under produced, they can alter behavior. Eg under production of thyroxine may lead to depression and mental retardation in adults and cretinism in children while over production may lead to delusions and hallucinations in adults.

3.**Personality**- This refers to characteristics that differentiate one person from another. Eg a person who is outgoing, relates freely with others, easily makes friends but with un predictable mood changes is likely to become ill with manic-depressive disorder. The one who usually worries so much may suffer from depression while the one with too much fear may suffer from anxiety.

Contn:

4. Age: The more one grows old, the more the brain tissue degenerates. This may contribute to conditions like senile dementia.

5.sex

EXTRINSIC/ EXTERNAL/ENVIRONMENTAL FACTORS[precipitating]

- This includes acquired/ physical ill health that may result into mental illness. They include:
- **Infections** eg HIV/AIDS, meningitis, sleeping sickness, malaria, typhoid fever and brain abscess.
- Metabolic disorders eg D/M.
- **Brain trauma** eg due to accidents, or during child birth.
- **Excessive/prolonged consumption** of alcohol and habit forming drugs like marijuana, cocaine morphine and pethidine.
- **Abnormal growth** eg brain tumors.
- **Malnutrition** which deprives the brain of essential nourishments thus interfering with optimal growth and development especially in children.

Contn

- ***DAILY UPS AND DOWNS:[perpatuating]***

This refers to negative events that occur in our day to day living.Also known as psychosocial stressors.

These interfere with our way of thinking, feeling and interaction with people. They include;

- **Loss** eg death of a close person, loss of a job or property and divorce.
- **Disputes** eg with in a family including domestic violence, isolation, rejection.
- **Disasters** eg wars, famine, land slides, drought and floods.
- **Poverty** which may be due to un employment.
- **Change in status roles** eg from being single to married, child to a heir, childless to a parent, being an in charge to a full time student.

GENERAL SYMPTOMATOLOGY TO MENTAL DISORDERS

- **(Signs and symptoms of mental illnesses)**
- How can you tell that some one is mentally sick?
- These can be divided into two ;the no obvious signs and the obvious signs.

- Symptoms of mental illnesses are exaggerations of normal patterns of human behavior in everyday life.
- The diagnosis of a mental illness should not be based on only one symptom but rather a group of symptoms that have persisted for a long period of time causing persistent interference with social and occupational functioning of the individual.
- These symptoms can broadly be divided into the no obvious signs and the obvious signs.

No obvious signs

- Most people suffer from mental illness but show no obvious signs and symptoms.
- However, a small minority of individuals show obvious mental illness.

Signs and symptoms in a mentally ill person who appears normal

- Unexplained persistent headaches
- Multiple body pains
- Self neglect
- Loss of interest in social activities
- Palpitations
- Lack of self care becoming shabby in appearance
- etc

Signs and symptoms in persons with obvious mental illness.

- This can be described under the following categories;
- Speech
- Thought
- Mood/ Emotion
- Perception
- Cognition
- Intellect
- Personality
- Appearance and behavior

OBVIOUS SIGNS INCLUDE;

1. General appearance and behavior

- One can identify mental disorders from a persons appearance; on may have poor grooming, neglected body hygiene, over grown hair and nails, or over dressed
- Behavior refers to how a person reacts to present situation; a person may be withdrawn, hostile, uncommunicative.
- Grooming and posturing
- Facial expression
- Any injuries, deformities, scars etc.

2 Speech this is the way we put statements when we are talking.

- The symptoms of mental disorders in relation to speech are;

➢ **Rate/speed**; speaking to fast(rapid speech) or to slow (slurred speech).

➢ **Volume;** volume may be low, in whispers, or inappropriately loud or difficult to understand

- **Content;** appropriateness of the speech it may be relevant or irrelevant. E.g.

- **word salad** saying words that do not connect.
- **Neologism** patient makes up words of whose meaning are only known to him. Or un existing word whose meaning is only known to the patient.
- **Echolalia** ; repeating every thing a health worker says

3.Disorders of movement
this is the way the patient moves their limbs and body.

i. Psychomotor retardation (slow movement and speech).

ii. Restlessness, (purposeless movements).

iii. Echopraxia, imitating other people's behaviors/ actions

iv. Bizarre posturing (involuntarily taking on abnormal postures for a long time e.g. mannerisms

4. Mood and Affect

- **Mood** is a state of ones inner sustained feelings or emotions. In mental disorders mood may be ; irritable, elated (extreme happiness), or extremely sad or depressed.
- **Affect** refers to the out ward facial expression of feelings or emotions , Affect may be appropriate, inappropriate, labile or flat

5. **Thinking/ Though,** this is the ability to process information in ones mind and these include stream, form and content

i. **Stream of thought**, it refers to the amount and speed of things one reports about. Disorders include;

❖**Pressure of thought-** thoughts are rapid, abundant and varied. Patient will feel overwhelmed by these thoughts hence causing (flight of ideas).

❖**Poverty of thoughts-** patient will report feeling, unable to sustain thinking. (very few thoughts).

❖**Thought block-** patient suddenly his mind goes blank or empty therefore patient will lose track of his/her own thoughts.

ii. **Form of thought**; this refer to the logical order of the flow of ideas or how ideas are connected or related to each other.

- **Loosening of association-** refer to lack of connectedness between ideas.
- **Perseveration-** persistent repetition of the same word(s) or ideas irrespective of the nature of question or conversation.
- **Echolalia-**is the repetition of the exact word(s) being said by the interviewer.
- **Abstract thought-** it is the ability to interpret complex information according to expected ability.

iii. Content of thought; this refers to the quality of message being transmitted/what the patient is thinking about.

I. **Delusions-** these are false beliefs that are firmly held and cannot be changed by rational arguments or evidence and are not shared by people from the same social cultural and religious background and experience. Examples of common delusions include;

- **Grandiose delusions:** patient believes he/she is somebody great/important, knowledgeable or powerful contrary to society truth.

- **Delusions of guilty and worthlessness-patient** believes he is not worthy to live even though there is nothing to justify it.
- **Delusions of jealousy-** person believes that the spouse /partner is being unfaithful even though there is no evidence.
- **Religious delusions-** the individual believes he/she has a special link with God.
- **Nihilistic delusions-** patient believes that specific parts if his/her body are missing.

- **Delusions of control, influence or phenomena-** believes the person performs activities as a result of an extreme force. This include;

a. **Thought insertion-** patient will report that his ideas are not his own they have been inserted / put into his mind by another person or force.

b. **Thought withdrawal-** patient states that his ideas, thoughts are being taken away for use.

c. **Thought broadcasting-** patient feels that his/her ideas are being broadcasted live by other people on radio, television newspaper any form of social media.

2. phobias- these are excessive fears over objects /situations/ natural environment. e.g. fear of caterpillars, fear of heights etc.

3. obsessions- these are excessive pre-occupations with an ideas or an activity e.g.; excessive orderliness, cleanliness etc..

6. Perception

This is a process through which we become aware of our environment through the five senses (hearing, seeing, smelling, tasting and touching,

- The following are perceptual disorder and these include;

i. **Illusions** –refer to misinterpretation of a sensory stimulus eg mistaking a rope for a snake. Illusions are common in conditions that impair consciousness.

ii. **Hallucinations**-refer to perception without sensory stimulus. Symptoms present in all sensory stimulus as follows;

a) **Auditory hallucinations**– hearing voices or sounds other people cannot. This is the commonest type of hallucination.

b) **Visual hallucinations-** seeing things which other people cannot see.

c) **Olfactory hallucinations** -smelling things which other people cannot smell.

d) **Gustatory hallucinations-** a sense of taste which other people cannot test.

e) **Tactile hallucinations-** feeling crawling sensations on top of the skin. (**Somatic hallucinations** underneath the skin).

. **De-realization** – it refers to the experience that everything in the surrounding is changed and is strange.

iv. **De-personalization**-refers to the patients experience that he or she seems to have changed, some of his/her body parts look different.

7. Cognition- (Awareness and Memory)

This is a special form of consciousness that refer to the status of being knowledgeable about the environment.

- This include the following areas;

a) **Level of consciousness-this** refers to the state of alertness of a person. Disturbances of consciousness include; lethargy, or drowsiness, to comma, delirious, etc.

b) **Orientation-** refers to a state in which an individual is aware of his current place in time (time ,day, date month & year), place (identify where he/she is) and person (identify people around him/her).

C). Memory- the ability to recall present, and past events and general knowledge.it manifests in form of forgetfulness and inability to remember important things. It includes the following disorders;

i. **Disorders of immediate memory**;, inability to remember events that have just happened.

ii. **Disorder of short term memory**; inability to remember events that have just happened with in 15 minutes.

iii. **Disorder of memory long term**; inability to remember things that occurred long ago.

d**). Attention-** refer to the ability to focus ones mind on a task at hand. This can be observed during an interview.

e**). Concentration-** the ability to sustain this focus. This can be assessed through serial 5,7 ,asking names ,months of the year etc.

f**). Intellect-** refers to the ability to receive, process, interpret and use information and other forms of experience for survival and adaptation in life. It is also the ability to learn and retain new information. (if you found a child with a razor blade what would you do?).

g). **Insight-** refers to individuals awareness of his /her situation and illness.

i. Insight- this means patient is aware of the sickness and appreciates help/ takes medicine.

ii. Partial insight- patient does not accept the illness but accepts to take treatment.

iii. Lack of insight- patient does not accept sickness and refuses treatment.

f) Other areas include;

A. Relationships- isolation, social withdraw, poor interpersonal relationship.
B. Appetite and weight
C. Sleep disorders
D. Sexual disorders

PSYCHIATRIC ASSESSMENT

- Psychiatric assessment/interview is important in diagnosing mental illness since the detection of a number of mental disorders relies a lot on the psychiatric interview rather than specific laboratory investigations.
- The Psychiatric assessment consists of three major areas;

i. General assessment/history taking,

ii. Medical/physical examination

iii. Mental state examination.

PART 1; GENERAL HISTORY TAKING

- **The Psychiatric history should include the following;**

A. Patients demographics such as:

- Name
- Age
- Sex
- Occupation
- Tribe
- Religion
- Marital status
- Level of education
- Next of kin and the informant.
- Address, village, district, phone contacts etc.

B■ Source of referral and circumstances surroundings admission

- Who referred the patient i.e. police, Relative, health worker etc.
- Who escorted the patient and how the patient was on arrival, for example was he chained or was he unkempt or clean on arrival?

Reasons of referral

- These are psychiatric signs and symptoms that have made relatives/people concerned therefore force them to bring patient for admission
- These should be short statements; it should not exceed three days complaint.
- Or it can be a reason as to why the patient was brought for an admission.

C. **Presenting complaints**

- These are short psychiatric complaints/symptoms that a patient has presented with since day one.
- They should be short statements.
- They should be well numbered in the chronological order.
- The duration each symptom has lasted should be stated.

D. HISTORY OF PRESENTING COMPLAINTS

- The patients presenting complaints (as above) are fully explored in details.
- The complaints should be diagnostic in nature.
- Rule out all psychiatric disorder in details including their causative factors that may be biological/ physical disorders or psychosocial
- Be orderly as you group symptoms for each disorder separately using paragraphs.
- Rule out possible differentials
- Rule out complication which could be physical or psychosocial
- **N.B By the end of this you should be able to have an idea of the a diagnosis as well as possible differentials**

E, Past Psychiatric history

- State the episode of mental illness.
- State number of admission
- State previous admissions, where patient was admitted. the treatment given and the outcome,
- State the number and nature of previous episodes, the presentation and how long the episodes lasted.
- State what forms of other treatments that were sought such as traditional healers, Faith healers etc.
- State whether there was normal functioning in between episodes or whether there has been gradual deterioration in the level 0f functioning as this could be diagnostic.
- State the nature of investigations done and the results

F. Past medical/surgical/gynecological history

- State past major medical illnesses or admissions for any serious illnesses Including a drug history.
- State any surgical illnesses, major operations, trauma or blood transfusions
- Their current medical states
- State any current chronic illnesses such as HIV/AIDS, hypertension or diabetes as well as the medication patient is on.

G. Family History

- For each family member (Parents and siblings) state their current condition in terms of age, occupation, marital status, health status as well as the relationship with the patient.
- Find out if any member of the family has ever had mental illness, h/o suicide, h/o epilepsy, h/o sudden disappearances in family.
- State the relationship between the family members with the patient the nature of mental illness as well as present functioning
- Find out history of or drug and or alcohol abuse in the family.

H. Personal history

- History from the time mother conceived if applicable.
- History at the time of birth as well as early childhood.

- State the schools attended the performance at school, relationship with teachers and other students, positions of leadership, nature of leisure activities as well as highest level of education and why.

- Sexual history including initial sexual contacts, sexual abuse, and past as well as current sexual partners and reasons for separation. Menarche and LNMP should always be asked in females

CONTINUED

- Marital history and children, including the age, education or occupation and who is taking care of them in case they are still young.

- Employment history including previous jobs, reasons for change of jobs and relationships with employers and fellow employees as well as information about the current job.
- Forensic history should explore for any legal issues, criminal charges or problems with the law.
- Pre-morbid personality including character, predominant mood, morals and religious attitudes as Habits, hobbies and leisure activities

PART 2

- Medical/physical examination
- General examination
- Do a through systemic examination
- Fully investigate and r/o possible physical illnesses.

PART 3;
MENTAL STATE EXAMINATION

- As of the obvious signs and symptoms of mental illnesses

PSYCHIATRIC EMERGENCIES

DEFINITION

- Emergency: Is a situation that requires immediate attention.
- Psychiatric Emergency: Is a condition which puts the life of the patient, the health worker and the community at risk and it calls for immediate attention.
- Or
- Is a situation where a patient is at risk because of intensive personal distress, suicidal intention, self-neglect or poses risk to others.

Examples of Emergencies

- Aggression and violence
- Suicidal attempts.
- Status epileptics
- Mass hysteria
- Delirium tremens.
- Food refusal
- Catatonic stupor
- Puerperal psychosis
- Severe depression
- Escape attendances
- Manic excitement

SUCIDAL TENDANCIES

- **SUICIDE**: Is a deliberate act of ending one's life or self-destructive behavior.
- People commit suicide using different means e.g.
- Eating position
- Hanging by use of a rope
- Intentional accidents
- Intentional gunshots
- Intentional drug abuse
- Drowning
- Stabbing one's self up death using a knife or spear.
- Self-starvation
- Swallowing battery cells

CATEGORIES OF SUCIDE.

- Complete suicide: the person successes in ending his/her life.

- Attempted suicide: person tries to end life but fails or rescued

RISK FACTORS FOR SUCIDE/ WHY

- Loss of dear ones, job, divorce
- Chronic illness or chronic pain
- Alcohol and drugs
- Gender i.e. male are more prone to commit succeed because they are naturally aggressive
- Underlying mental illness
- To punish others

RISK FACTORS FOR SUCIDE/ WHY

- Familiar suicide liniments i.e. it follows in families
- Strong auditory hallucinations and commanding in nature
- Disfiguring conditions as a result of accidents being burnt by acid
- Physical illnesses like HIV, cancer
- Constant loss like items.

TYPES OF SUICIDE

- **Paradoxical**: some body conceals the plan of killing him/her self.
- **Suicide pact**: Two people agree to kill themselves.
- **Mass suicide**: many people agree to kill themselves.
- **Copycat suicide**: a group of suicide occur at the same time in the geographical area.
- **Vengeance suicide**: this is where one kills him or herself to punish others

MANAGEMENT OF SUICIDE

- **AIMS OF MANAGEMENT**
- TO prevent self-harm
- To restore the patients functional state
- To restore patient’s self esteem

- Suicide is a psychiatric emergency and if any attention is not given promptly the patient will lose life.
- Admit the patient in an open place near the nurse’s station for close monitoring and observation.
- Find out the cause of suicidal ideation and counsel the patient to drop the idea of committing suicide.
- Make a caution card for the patient, alert all people that the patient wants to commit suicide but don’t label the patient.

- Observe the patient for 24hrs i.e. handover the patient to the incoming nurse and sign on the caution card.
- Remove all the dangerous objects e.g. rope, sharp objects which the patient can use to kill himself.
- Occupy the patient with productive work so that he/she can withdraw the suicidal ideation.
- Check the patient’s pockets for any sharp objects which the patient may use to kill him or herself.
- After eating count the spoons and forks because the patient may stay with one and uses it to kill him or herself.

- Make sure you have they keys to the ward because the patient may use them to lock you up or lack himself up and kills him or herself.
- Re-assure the patient and relatives and talk about the patient's condition to come up with solution.
- Initiate treatment for the patient i.e. sedate the patient using lagactile 200mg.
- Loroxyl 25-75mg, imipramine 25mg-75mg, mood stabilizers; carbamazepine, lithium carbonate, sodium valproate

MANAGEMENT OF SUICIDE (ATTEMPTED SUICIDE

- Assess the suicidal potential by;
- Determining the severity i.e. what method to use, suicidal thoughts.
- Copying pattern, strength and resources available that could assist in crisis.
- Psychological treatment i.e. develop a listening and understanding skill.
- Indicate concern and establish trust in this person (create support).
- Explore what really happened/identify the cause.
- Encourage the person to express him/herself

- Ask if the person has any future plan i.e. with no future plans is likely to commit suicide.
- Any person who has ever attempted to commit suicide before is likely to commit suicide again.
- **Note:**
- Married people are less likely to commit suicide then singles because they share problems and they come up with solutions.
- Men commit suicide than women and tend to use very dangerous means.
- ECT, if drugs fail, 2-3 shocks per week
- Rehabilitation to acquire skills to earn a living

PREVENTION OF SUICIDE

- Patients should be properly managed in the hospital i.e. show a good attitude to the patient while in the hospital
- Early identification of problems that may cause mental health disorders
- Early and proper treatment of physical and psychological problems
- Teach the community about factors that contribute to mental and physical illness
- People should learn to plan for their lives i.e. not someone to plan for them

- people should learn to be job creators but not job seekers
- people should learn to deal with difficult situations and effective copying mechanisms and stress management skills
- counselling to people with social and physical health problems
- people should learn to share problems
- Family should be helped to stay together

AGRESSION AND VIOLENCE

- These are severe forms of anger were the patient will be irrational, uncooperative, delusional and assaultive.
- **Violence**

refers to the state in which he patient develops excessive force to destroy property and disorganise whatever may be in the environment.

- **Aggression**

is a state in which the patient shows redness to attack, assault, harm or injure others.

SIGNS AND SYMPTOMS OF VIOLENT PATIENT

- Restlessness & flown face (wrinkles)
- Sweating i.e. noise, axilla and palms
- Verbal threats of violence.
- Worsening delusions or hallucination directed towards.
- Repeated violent behavior
- Banging doors or tables.
- Shouting or whispering
- Fast breathing
- Palpitations (increased heart beat)
- Pupils of the eye are dilated.

CAUSES OF AGRESSION AND VIOLENCE.

- hallucination i.e. the patient may hear voices telling him to behave that way
- delusions e.g. paranoid in which the patient may think that fellow patient or staff has been sent for him or grandiosity
- organic psychiatric disorders like delirium, dementia
- acute stress reaction
- panic disorder
- provocation either by nurse or fellow patient
- personality disorders
- poor nurse patient relationship

- alcohol and drug abuse
- pre or post- Icto phases of epilepsy
- forced confinement
- denial, delayed or poor meals
- forced medication
- denial of discharge
- denial of communication with family members or friends

MANAGEMENT OF VIOLENCE AND AGGRESSION

- **General principles of management**
- patient should not be hurt
- staff should not be hurt
- other patients or people around should not be hurt
- property should not be destroyed

MANAGEMENT OF AN OPEN VIOLENT EPISODE

- In case a violent patient is brought to the facility tied with ropes and chains, untie the patient so as to remove the humiliation of being tied in that manner
- in cases were violence occurs on ward, a number of staff has to be alerted availed and one to confrontation should in any way be prohibited.
- emergency education on the basic principles of management and sharing of personal and clear responsibilities during confrontation is done
- staff should have a pre-arranged plan as who should do what thus avoiding situations where everyone is diving for one arm or limb

- use a firm and kind approach to talk to the patient to see if he responds
- in case patient fails to respond to the sweet talk, he is confronted and swiftly transferred to the bed or floor where he can be immobilised by firmly joining the major joints, shoulders and limbs if possible
- physical battles with the patient should be avoided as much as possible
- shoes, gumboots, belts and neck ties should be loosened, removed or unfastened
- prepared medication usually a major tranquilizer like chlorpromazine CPZ 50-100 IM or a major sedative like Haldol 10-20mg IM or diazepam 10-20mg IV are given

PHYSICAL RESTRAIN

- About 3-5 nurses are needed.
- One nurse engages the patient in a talk but with a very polite voice another nurse comes from behind ad covers the patient’s face, the other nurse comes and tightly grasps the patient and medication a sedative is given.
- The nurse talking to the patient the changes his voice and informs the patient that know we are to use force.
- After sedating the patient isolate the patient for a while

- once patient is sedated, collect history carefully from relatives to identify the possible causes
- carry out thorough physical examination and investigations to rule out any medical condition or symptoms of dehydration and manage accordingly
- keep less furniture in the room and remove any sharp instruments, ropes, glass items, ties, strings or match boxes from the patients vicinity
- keep environmental stimuli such as lighting and noise levels minimum and limit interaction with others
- stay with the patient when hyperactivity increases to reduce anxiety and foster feelings of security

- Redirect violent behaviour with physical outlets such as exercises, outdoor activities etc.
- Encourage the patient to talk out his aggressive feelings rather than acting them out and the patient should promise not to resort to violence again. this can be done by making him sign a NO VIOLENCE ACT
- if the patient is not calmed by talking out and medication is refused, restraints may become necessary

- following application of restraints,, observe patient so see whether nutritional and elimination needs are met and this is done every after 15munutes
- following a restraint, the patient should not be released indefinitely however a gradual release is preferred to avoid precipitants to further violence
- when a patient has been released from a restraint, timely medication should be resumed as prescribe

- if this occurred on ward and it was due to hospital management the clinical team should meet to consider and review the general policies or consider general changes in ward policies

GUIDELINES FOR SELF- PROTECTION WHEN HANDLING A VIOLENT PATIENT

- never confront a potentially violent patient alone
- keep a comfortable distance away from the patent i.e. keep an arm length
- be prepared to move as a violent patient can strike out suddenly
- maintain a clear exit route for both staff and patient
- ensure that the patient has no weapon in his possession before approaching him
- if patient has a weapon, ask him to keep it on the table or floor rather than fighting him to take it away
- distract the patient momentarily so as to remove weapon e.g. throwing water in the patients face or yelling etc.
- sedate the patient and give prescribed antipsychotics

DELIRIUM

- Delirium is an acute organic mental disorder characterized by impairment of consciousness, disorientation and disturbances in perception and restlessness (acute agitation). This is one of the psychiatric emergencies that are very common in medical surgical inpatients and it is very common in post operative patients.

CAUSES OF DELIRIUM

- Vascular disorders such as hypertensive encephalopathy, cerebral arteriosclerosis, intracranial bleeding may lead to delirium.
- Infections such as cerebral malaria, encephalitis (inflammation of brain tissue), meningitis (inflammation of meninges may all cause delirium, septicemia)
- Space occupying lesions (Neoplasm’s) may cause delirium.
- Intoxication, this may be chronic intoxication with toxic drugs or may be acute as in poisoning.

SIGNS AND SYMPTOMS OF DELIRIUM

- Patients in delirium may present with any of the following signs and symptoms;
- Impaired consciousness- the patient may have clouding of consciousness ranging from drowsiness to stupor and coma or confusion.
- They may have impaired level of attention and concentration that they may find it difficult in shifting, focusing and sustaining attention.

SINGNS AND SYMPTOMS

- There may be disturbance of cognition that is impairment of abstract thinking and comprehension, impairment of immediate and recent memory that is the patient being unable to recall anything during the interview
- They have perception disturbances especially illusions (misinterpretation of real stimuli) or visual hallucinations-seeing things that other people do not see
- They may have emotional disturbances that is they may be depressed, anxious, fearful, irritable, euphoria (excessively happy), apathy (lack of emotional expression)

SIGNS AND SYMPTOMS CONTINUE

- They may have disturbance of the sleep- awakening cycle that is may have insomnia or in severe cases total sleep loss or reversal of sleep wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams, or nightmares which may continue as hallucinations after awakening.
- They may have psychomotor disturbances with hypo or hyperactivity, aimless grabbing or picking at the bed clothes

MANAGEMENT OF DELIRIUM

- Identification of the cause and immediate correction is very important for example administer oxygen for hypoxia.
- You can give 50m/s of 50% dextrose in case of hypoglycemia
- I.V fluids for fluid for electrolyte balance

NURSING INTERVENTIONS

- Provide safe environment by restricting environmental stimuli, keep the unit calm and well illuminated. There should always be somebody at the patient's bedside reassuring and supporting
- Alleviate patient's fear and anxiety by removing any object from the room that seem to be a source of misinterpreted perception. As much as possible have the same person all the time by the patient's bedside this could be the same relative attending to the patient

- The nurse should meet the patient’s physical needs such as;
- Use of appropriate nursing measures to reduce high fever if present
- Maintaining a fluid intake and output chart
- Maintaining patient’s hygiene including mouth and body hygiene
- Monitoring vital signs and documentation care for the patient’s bowel and bladder

- Observe the patient for any extreme drowsiness and sleep as this may be an indication that the patient is slipping into a coma

Facilitate orientation

- Since the patients with delirium are disoriented, repeatedly explain to the patient where he is and what date, day and time it is.
- Introduce people with names even if the patient misidentifies them
- Have a calendar and wall clock in the room and tell the patient what day it is

DELIRIUM TREMENS

- This is an acute condition resulting from acute withdrawal of alcohol. It is a psychiatric emergency which commonly end up in general hospitals after a person who has been dependent on alcohol suddenly stops to take them. It only occurs in patients with alcohol dependency.

SIGNS AND SYMPTOMS OF DELIRIUM TREMENS

- Patients in delirium tremens may present with;
- disorientation
- vivid hallucinations and illusions
- agitation, restlessness and shouting
- evident fear
- prolonged insomnia
- tremors
- ataxia (staggering gait).

SYMPTOMS CONTINUE

- Physically the patient may present with:
- excessive sweating and raised blood pressure
- dilated pupils
- palpitations
- dehydration and electrolyte disturbances.

Delirium tremens may begin with convulsions in some 5% of cases. These convulsions are called Ram fits

HOW TO DIAGNOSE DELIRIUM TREMENS

- Positive history of excessive consumption of alcohol over a period of time
- Recent abstinence from or heavier intake of alcohol consumed at a special social gathering or event such as a party or ceremony
- Low grade fever of sudden onset
- Confusion of acute onset and its worse at night.
- Prominent hallucinations that is vivid and commanding in nature and of insult
- Hallucinations may be associated with persecutory delusions
- May experience coarse tremors which are severe

MANAGEMENT OF DELIRIUM TREMENS

- Keep the patient in a quiet and safe environment like a room.
- Avoid too many changes in nursing staff because this worsens the confusion.
- Ensure plenty of fluids intravenously if the patient cannot feed orally and maintain a fluid and electrolyte balance chart.
- Sedation is usually given with diazepam 10mg or lorazepam 4mg intravenously followed by oral administration. Follow doctor’s prescription for over administration of drugs may cause another addiction.
- .

MANAGEMENT CONTINUE

- Ensure adequate rest under sedation of the patient.
- Provide multivitamins especially vitamin B. Complex. Other forms of treatment depend on clinical presentations.
- For fits, diazepam is used or any other anticonvulsants For hallucinations (alcoholic hallucinosis) haloperidol us used but not chlorpromazine

PROGNOSIS

- Delirium tremens is associated with a mortality rate of 10-25% if improperly managed. Delayed recognition and treatment may lead to korsakoff's psychosis (this is a chronic condition presenting with confusion and memory loss).
- Delirium tremens is common in expectant mothers who use alcohol on a daily basis and may even give birth to babies with alcohol intoxication and such babies will be very small at birth and may fail to survive a condition called fetal alcohol syndrome

PANIC ATTACKS

- These are episodes of acute anxiety which occur as part of psychotic or neurotic illness.
- It is a psychiatric emergency characterized by palpitations, sweating, tremors, and feeling of choking, chest pain, and nausea, and abdominal distress, fear of dying, chills or hot flushes

SIGNS AND SYMPTOMSPANIC ATTACKS.

- Accelerated heart rate.
- Sweating
- Trembling
- Sense of shortness of breath
- Feeling of chocking
- Check pain/discomfort
- Nausea
- Dizziness
- Fear of dying
- Chills and lot flashes
- Palpitations
- Abdominal distress/discomfort

MANAGEMENT OF PANIC ATTACKS

- Mild cases of panic attacks can be effectively treated with cognitive behavioral therapy with more emphasis on relaxation and instruction on miss interpretation of physiological symptoms.
- Breathing exercises
- Expose to the fear
- Occupy the patient
- Give re-assurance first
- Administer diazepam10mg or lorazepam 2mg.
- Continue with counselling

EPILEPSY RELATED EMERGENCIES

- Status epilepticus
- This is a repeated attack of generalized tonic colonic fits without gaining consciousness in between.

These may be caused by;

- Sudden withdrawal of antiepileptic drugs
- Infections such as malaria Sudden
- stressful situation for example over working
- Starvation and poor electrolyte balance
- Hormonal changes as in pregnancy

MANAGEMENT OF STATUS EPILEPTICUS

- The management of status epileptics is very important to be handled with urgency since it is life threatening to the patient.
- Remove the patient from danger that is if the patient is near sharp instruments these should be removed.
- 1. If she is on the ground she should be protected from hurting the head.
- 2. Loosen tight clothing to allow a clear airway.
- 3. Do not restrain the jerking
- 4. Clear airway

MANAGEMENT CONTINUES

- 5. Do not give any thing by mouth
- 6. Position the patient in lateral position or semi prone position
- 7. Refer the patient to hospital for further management
- 8. While in the hospital I.V fluids, oxygen, I.V diazepam, and parenteral phenytoin are the emergency measures to be used.

EPILEPTIC FUROR

- This follows an epileptic attack whereby the patient may behave in a strange manner and become excited and violent. The patient may wander off and run into danger like being knocked down by a vehicle.
- **Management**
- Patient is sedated with Diazepam 10mg I.V followed by oral anticonvulsants Haloperidol 10mg I.V helps to reduce psychotic behavior.
- As she regains her understanding she should be reoriented.

CATATONIC STUPOR

- This is a psychiatric emergency characterized by mutism, negativism, stupor, ambitendency (feeling to do something and not to do), automatic obedience (a patient obeying every command), posturing, mannerisms (habitual involuntary movements), stereotypes (persistent mechanical repetition of speech or motor activity

MANAGEMENT

Since the patient is not active in all ways ensure that the patient is given appropriate nursing care because the patient's life is in danger by doing the following;

- 1. Ensure patient airway is clear.
- 2. Administer I.V fluids to ensure patient is not starved.
- 3. Collect history and perform physical examination
- 4. Draw blood for investigations before starting any treatment
- 5. Provide the rest of care as for unconscious patient.

HYSTERICAL ATTACKS

- A hysterical attack may mimic abnormality of any function, which is under voluntary control. This psychiatric emergency may present in the following forms;
- Hysterical fits where the patient experiences falls without loss of consciousness and do not hurt themselves
- Hysterical ataxia where the patient presents with abnormal posture and gait
- Hysterical paraplegia where the patient may have paralysis of one side of the body
- All presentations are marked by a dramatic quality and sadness of mood.

MANAGEMENT OF HYSTERICAL ATTACKS

- 1. Hysterical fits should be distinguished from genuine epileptic fits since they do not have warning signs, no tongue biting, no incontinence of urine and faeces, no loss of consciousness and they usually occur indoors or in safe places.
- 2. Since hysterical symptoms can cause panic among relatives, explain to them the psychological nature of symptoms. Re-assure that no harm would come to the patient.
- 3. Help the patient to realise the meaning of the symptoms and help him find alternatives ways of coping with stress