Post basic B.Sc Nursing
Mental Health Nursing
Unit-1

Father of psychiatry- Asclepiades
Father of Modern Psychiatry - Phillippe Pinel
First Psychiatric Nurse Miss Linda Richard
Father of American Psychiatric (in 1875- he wrote first psychiatric book)- Benjamin Kush.

Introduction

Mental health is a state of balance between the individual & the surrounding world

Definition

According to Kart Menninger -
The adjustment of human being to the world & to each other with the Maximum of effectiveness and happiness. The chief Characteristic of Mental health is the adjustment.

The American psychiatric association (APA) 2003
The Successful Performance of mental functions shown by productive activities, fulfilling relationship with other people, and the ability to adapt to cope with adversity. difficulty.

Robinson (1983)
A dynamic state in which thought, feelings and behavior that in age appropriate and Congruent with the local & cultural norms is demonstrated.

Mental Illness

According to DSM- IV -TR (APA 2000),
Clinically significant behavioral of psychological Syndrome or pattern that occurs in a person & in one that is associated with present distress a painful symptoms) or disabilities (eg. Impairment of functioning) or with a significantly increased risk of suffering death pain disability or an important loss of freedom and not merely an expectable and culturally sanctioned response to a particular event.

Psychiatry

According to Niraj Ahuja (1994)
Psychiatric disorder is defined as a disturbance of Cognition (thought) conation (action) or affect on any disequilibrium between the three.
According to DSM-IV
A mental disorder should be a manifestation of behavioral, psychological or biological dysfunction in a person.

Historical development / Evolution of Mental health services & Treatment

- Pythagoras - (850 - SIO BC) developed the concept that the brain is the Seat of intellectual activity.
- Hippocrates 460-370 BC) described Mental illness as hysteria, Mania and depression.
- Plato (427-347BC) identified the relationship b/w Ning wind & body.
- Asclepiades – (father of psychiatry) made use of Simple hygienic measures, diet. bath Massages in place of Mechanical restraints.
- Aristotle a Greek philosopher- emphasized on the release of repressed emotions for the effective treatment of rental illness. He suggests Catharsis & Music therapy for pt. with Melancholia.
- Augustine who believed that although God acted directly in human affairs, people were responsible for their own action.
- Renaissance in Europe (1300-1600 AD) This period represented the saddest chapter in the history of psychiatry when it was believed the demons were the cause of hallucination, delusion & sexual activity & the treatment was torture and even death.

Some important Milestones

- 1773 - First Mental hospital in the US was built in Williamsburg, Virginia
- 1793- First revolution in psychiatry. 1193
- 1812 - First American textbook in psychiatric was written by Benjamin Rush.
- 1908 - Clifford Beers, an ex- pt of mental hospital wrote the book "The mind that found itself: based on his bitter experience in hospital. The book Made a major contribution towards the improvement of condition in Mental hospital.
- 1912- Eugen Bleuler, a Swiss psychiatrist coined the term Schizophrenia".
- 1912- The Indian lunatic Act was Passed.
- 1920- Harriet Bailly (wrote first psychiatric nursing book named as nursing in mental illness.
- 1925- first psychiatric hospital was opened in Ranchi and Jharkhand.
- 1921- Insulin shock therapy used in Schizophrenia.
- 1936- Frontal lobotomy was advocated for the Management of epilepsy of psychiatric disorder.
- 1938- ECT is introduced by bini and carlettie
- 1946- Joseph Bhore Committee recommended for opening of new psychiatric hospital.
- 1949- Lithium carbonate is introduced as drug of Choice in Mania
- 1952 - First anti-psychotic Medication (Chlorpromazine) is used in psychosis.
- 1952- Pepleu theory introduces IPR Theory
- 1954 - All India institute of mental health was opened in Bangalore (today known as 'NIMHANS)
- 1956 - NIMHANS Start post- certificate course in mental health care for nurses with 6 Month duration
- 1963- The community Mental health centers Act was passed.
- 1965- Psychiatric was added in Bsc (n) as a Subject
- 1970- Slow & Steady reduction of beds in Custodial institution, growth in general Hosp. psychiatric unit & out pt. Services was seen
- 1975- M.sc (n) in psychiatric Started by RAK college in Delhi.
- 1978- ALMA -ATA conference recommended for Starting of Mental health care at PHC level
- 1981- Community Psychiatric centers were set up to experiment with primary Mental health care approach at Raipur Rani, Chandigarh, Sakalwara, Bangalore.
- 1952. The central council of Health, India's highest health policy making body accepted the NMH Policy and brought out the NHHP in India.
- 1955- Necrotrophic and psychotropic act began.
- 1987 Indian Mental health Act was passed
- 1990- Innovative approaches for treatment & rehabilitation of mental illness initiated.
- 1997- National Rights commission prepared a plan of action for improving the condition in Mental has in country.
- 2001- Current situation analysis (ESA) was done to evolve a comprehensive plan of action to energize the NMHP.
- 2001- National Human right Commission of India advised all the Chief Minister to Submit a certificate Starting no person with Mental illness are kept chained in ether govt and private institution.
- 2002- Survey of Mental health Resources carried out by the directorate general of health services, Ministry of health & family welfare.
- 2006- started psychiatry in GNM in separate subject.
- 2007- under the 11th year plan, center of excellence in the field of Mental health were established to upgrade & strengthening of Mental health hospital
- 2008- WHO mental health gap Action program was launched which aims at scaling up services for mental, neurological & Substance abuse disorder for countries especially with drinks low and middle income.
- 2013- WHO launched Mental health action Plan 2013-2020.
- 2013 - The mental health care Bill was introduced.
- 2014- Government constituted a committee to create policy for the country.

Development of Modern Psychiatric Nursing

- 1872- First training school for nurses based on the Nightingale system was established by the New England Hospital USA.
- 1921- Short training courses of 3 to 6 months were conducted in Ranchi.
- 1943 -Psychiatric Nursing was started for Male nurse (Tamil Nadu)
- 1952 - Dr. Hildegard Peplau defined the therapeutic roles of Nurses in Mental health setting.
- 1853- Maxwell Jones introduced therapeutic community.
- 1956- One year Post certificate course in psychiatry nursing was started at NIMHANS..
- 1958- All the wards in Agra Mental Hosp. were ordered to be kept open & all ward locks were removed from the Charge of the ward attendant.
- 1963-Journal of psychiatric Nursing & Mental Health Services was published.
- 1965- The INC included psychiatric nurse as a compulsory course in B.sc (n) program.
- 1967-The TNAI formed a separate committee to sit guidelines to conduct classes & clinical training for nursing student.
- 1973- Standards of psychiatric & MHN practice were enunciated to provide a means of improving the quality of care.
- 1975- MSC in psychiatric nursing started.
- 1986 - Psychiatric Nag was included in GNM
- 1991 - Indian Society of psychiatric Nurses started.
- 2010- ISPN published its Journal.

Principles of Mental Health Nursing

Introduction

There are general principles that apply to the care of all who show behavior disorders everyone has certain basic needs that must be met no matter what disease he is suffering from the principles are general which are applicable to mentally ill patients as well as physically ill where his illness is usually associated with emotional disturbance to some degree.

These principles are based on the concept that each individual has an intrinsic worth and dignity and he has potentially to grow.

The following principles are general in nature & from guidelines for emotional care of a patients.

1. ACCEPT THE PATIENT EXACTLY AS HE IS. •

Acceptance conveys the feelings of being loved and care: it provides the patient with an experience, which is emotionally neutral, where he finds unlearning of his sick behavior is less threatening before he can relearn the art of living with himself with others.

Acceptance does not mean complete permissiveness, but setting of positive behavior to convey to him the respect as an individual human being acceptance is expressed in the following ways

Acceptance is expressed in following ways:

A. Being non judgmental & non punitive
B. Being sincerely interested in the patient.
C. Recognizing & reflecting on feeling which patient may express.
D. Talking with a purpose
E. Listening
F. Permitting patient to express strongly held feelings

2. USE SELF UNDERSTANDING AS A THERAPEUTIC TOOL

Self-understanding method are

A. Exchanging personnel experience freely with our colleagues
B. Discussing our personal reaction with an experienced
C. Participating in group conference regarding our patient care.

3. USE CONSISTENT BEHAVIOUR TO INCREASE PATIENT'S EMOTIONAL SECURITY- Patient to be consistently and continuously exposed to an atmosphere of quiet acceptance. Permissiveness to be

limited e.g. with homicidal, suicidal, hyperactive and suspicious patients. Patient is allowed to feel as he does but limitations are put on his behavior. Attempt to win patient's liking is most

4. **GIVE REAASSURANCE RENCE TO PATIENTS IN ACCEPTABLE MANNER-** Reassurance is building patient's confidence or restoring his confidence. While giving reassurance, we must avoid saying to the patient 'you will get well, "nothing to worry"

5. **Reassurance can be given in following manner**- Be truly interested in patient's problem. Pay attention to the patient matter however significantly it may be. Allow him to be as sick as needs to be. Be aware how the patient actually feels. Sit beside patient when he does not want to talk. Accept patient's silence. Listen to problem without showing surprise. Agree with his problem and think with him to solve the problem.

6. **Change patient's behavior through emotional experience and not by rational interpretation**- Major focus in psychiatry is on feeling aspect and not on intellectual aspect. Telling and advising the patient is not effective in changing behavior. Role play and emotional drama and transactional analysis are few ways of creating emotional experience in a patient.

7. **AVOID UNECESSARY INCREASE IN PATIENT'S ANXIETY**- Anxiety is a feeling of fear for an unknown object or event. It is a threat to biological integrity of a person. Psychiatric patients have already some amount of anxiety so psychiatric nurses should not further increase their anxiety by: • Contradicting his psychotic ideas. • Demanding the patient to complete set task. • Making him to face repeated failure. • Using big sentences, professional terms while talking with him. • Care less conversation with patient

8. **DEMONSTRATE OBJECTIVE OBSERVATION TO UNDERSTAND AND INTERPRET THE MEANING OF PATIENT'S BEHAVIOUR**- We need to observe the patient when he says or does. Analysis of the observation should be done to draw thaw the motivation or purpose behind his talk or action. While working with patient learn his basic problems guess what he will do. Keep asking yourself what is the goal of patient and why he behaves like this. Be objective. Objectivity is not coldness but it is indifference and absence of feelings and ability not to let your own judgment confused

9. **MAINTAIN REALISTIC NURSE PATIENT RELATIONSHIP**- Realistic and professional relationship focuses on the personal and emotional needs of patient. It is therapeutically oriented and planned. It is always based on patient's needs. Nurse differentiate between patient's demands and actual needs. It is for purpose or bringing adaptive ness, integration and maturity in relations.

10. **MAINTAIN REALISTIC NURSE PATIENT RELATIONSHIP**- Realistic and professional relationship focuses on the personal and emotional needs of patient. It is therapeutically oriented and planned. It is always based on patient's needs. Nurse differentiate between patient's demands and actual needs. It is for purpose or bringing adaptive ness, integration and maturity in relations.

11. **AVOID PHYSICAL AND VERBAL FORCE AS MUCH AS POSSIBLE**- Any kind of force results in psychological trauma in patient. Restraining the violent patient is an e.g. of physical restrain.

If all needs to be used the following points to be kept in mind: •Carry out procedure quickly, firmly and effectively •Do not show anger while tying •Tell him the reason and tell that he will be allowed to mix with others when he get the control on him. •Attend his needs as usual never show him that he is being punished •After he becomes controlled never remind him again about the incidence.

12. **NURSING CARE IS CENTERES ON THE PATIENT AS A PERSON AND NOT ON CONTROL OF SYMTOMS**- Every is caused, understand the meaning behind the behavior. Two patients showing the same symptoms may have different needs'. one may have headache due to sleeplessness and other may have due to hypoglycemia. Analysis and study of symptoms is necessary to reveal their meaning and their significant to patient

13. **EXPLAIN ROUTINE PROCEDURE AT PATIENT'S UNDERSTANDING LEVEL**- Every patient has right to know what is being done and why it is being done on him. Every procedure should be explained at his understanding level to reduce his anxiety. Character of explanation depends on: patient's attention, level of anxiety, and level of ability to decide.

14. **MANY PROCEDURES ARE MODIFIED BUT BASIC REMAINS UNULTERED-** The nursing principles remain same such as: • Safety • Comfort • Individuality and privacy • Maintain therapeutic effectiveness, workmanship during procedure • Economy of time, energy and material.

MENTAL HEALTH TEAM

Also known as multidisciplinary team.
This team approach refers to collaboration between members of different disciplines who provide specific services to the patient.

1. **PSYCHIATRIST**- The psychiatrist is a doctor with post-graduation in psychiatry with 2-3 years of residence training. The psychiatrist is responsible for diagnosis, treatment & prevention of mental disorders, prescribe medicines & somatic therapy & function as a leader of the mental health team.

2. PSYCHIATRIC NURSE CLINICAL SPECIALIST

- The psychiatric nurse clinical specialist should have a master degree in nursing, preferably with post – graduate research work.
- She participates actively in primary, secondary & tertiary prevention of mental disorder & provides individual, group & family psychotherapy in a hospital & community setting.
- She also takes up the responsibility of teaching, administration & research, bedsides publishing work in a mental health setting.
- She takes up the role of a leader & can practice independently.

3. REGISTERED NURSE IN A PSYCHIATRIC UNIT

- The registered nurse undergoes a general nursing & midwifery program or B.Sc nursing / post-basic B.Sc nursing program with added qualification such as diploma in psychiatric nursing, diploma in nursing administration etc.
- This nurse is skilled in caring for the mentally ill, gives holistic care by assessing the patient's mental, social, physical, psychological & spiritual needs, making a nursing diagnosis, formulating, evaluating & rendering the appropriate nursing care.
- She/he co-ordinates with the clinical nurse specialist in a community mental health setting.
- She/he updates knowledge via continuing education, in- service education, workshops & courses conducted by open Universities.

4. CLINICAL PSYCHOLOGIST

- The clinical psychologist holds a doctoral degree in clinical psychology & is registered with the clinical psychologist's association.
- She/he conducts psychological, diagnosis tests, interprets & evaluates the finding of these tests & implements a program of behavior modification.

PSYCHIATRIC SOCIAL WORKER

- The psychiatric social worker is a graduate in social work & post-graduate in psychiatric social work. She/he assesses the individual, the family & community support system, helps in discharge planning, counseling for job placement & is aware of the state laws & legal rights of the patient & protects these rights.
- She/he is skilled in interview techniques & group dynamics.

5. PSYCHIATRIC PARA-PROFESSIONALS

- Psychiatric Nursing Aids/Attendants
- ECT technicians
- Auxiliary Personnel

- Occupational Therapist
- Recreational Therapist
- Diversional Play Therapist
- Creative Art Therapist
- Clergyman

- **Psychiatric Nursing Aids/Attendants:**
  They have high school training & are trained on the job.
  They aid maintaining the therapeutic environment & provide care under supervision.

- **ECT technicians:**
  They undergo training for 6-9 months.
  Their function is to keep ready the ECT under the supervision of a psychiatrist or anesthetist.

- **Auxiliary Personnel:**
  They are volunteer housekeeper or clerical staff & require in-service education to interact with the patient therapeutically.

- **Occupational Therapist:**
  Occupational therapist goes through specialized training.
  He /she has a pivotal role to play by using manual & creative techniques to assess the interpersonal responses of the patient.
  Patients are helped to develop skill in the area of their choice & become economically independent.
  They are helped to work in sheltered workshop.

- **Recreational Therapist:**
  The recreational therapist plans activities to stimulate the patient's muscle co-ordination, interpersonal relationship & socialization.
  These approaches are need-based.

- **Diversional Play Therapist:**
  Makes observation of a child / patient during his play.
  The behavior of the child while playing, the type of toys & his reaction toward the doll, beating, calling or throwing are the focus of attention.
  The therapist explores the behavior of the child & relates to conditions like phobia, child abuse, separation or any other condition.

- **Creative Art Therapist:**
  He/she is an art graduate & encourages the patient to express his work freely with colors & analysis the use of various colors, drawing of various scenes etc.
  This therapy helps in diagnosis & also in bringing the repressed feelings of the patient to the conscious level.
- **Clergyman**:
  These are religious persons who may be asked to come to the hospital unit once a week (depending on the patient's religious faith) & have a spiritual talk with the patient.

NATURE OF MENTAL HEALTH NURSING

- It is a profession possessing its unique history, ideology, knowledge and skills.
- It is both an art (nurse – patient relationship) and a science (skills for the purpose of gaining insight, effective change, healing mental and emotional wounds and promoting growth).
- Understands the principles of nursing and remain current in knowledge and practice.
  The Philosophy of Psychiatric Nursing Practice
- Every individual has intrinsic worth and dignity and is worthy of respect.
- Each person functions as holistic and react to environment as a whole.

- All behavior of an individual is meaningful. It can be understood from an internal frame of the patient.
- Behavior has perceptions, thoughts, feelings and actions.
- Individuals vary in their coping capacities.
- All are prone for health and illness.
- Nursing is aimed to promote wellness, maximize functioning and enhance self-actualization.
- IPR can produce change in growth of an individual.
- Psychiatric nursing is based on psychosocial and biophysical sciences.

Concept of Normal and Abnormal Behavior.

NORMAL BEHAVIOUR: - Word normal derived from Latin word Norma means rule .
Means followed the rule or pattern or standards.

Definition: - when the individual is able to function adequately and performs his daily living activities efficiently and feel satisfied with his life style called as normal behavior.

ABNORMAL BEHAVIOUR: - The word abnormal with prefix ,'ab'(away from)means away from normal. Abnormality is negative concept it means deviation from norm or standard or rules.

Definition: - Disturbances seen in behavior which manifests in Cognitive domain (thinking, knowing, memory) affective domain (emotion and feeling) and conative domain (psychomotor activity) individual express his mental distress through thought, feeling and action.

CHARACTERISTICS OF NORMAL BEHAVIOUR

- A perception of reality.
- A positive attitude towards one's self, acceptance of weakness and strengths.
- Capacity for with standing anxiety and stress.
- Adequate in work, play and leisure
- Willingness to use problem solving approaches in life process.
- Capacity to adapt oneself to current situation.

CHARACTERISTICS OF ABNORMAL BEHAVIOUR

- Change in person's thinking process, memory, perception and judgment.
- Work efficiency will be reduced.
- Forgetfulness.
- Unhappiness.
- unable to cope.
- worried, anxious disturbance in daily routine activities.
- No respect will be given to others or self.
- Lack of gratification.
- Lack of self-confidence.

Several models have been put forward in order to explain the concept of normal & abnormal behavior.

1. **Medical Model:-** Medical model considers organic pathology as the definite cause for mental disorder.

- According to this model abnormal people are the ones who have disturbances in thought, perception & psychomotor activities.
- These normal are the ones who are free from these disturbances.

2. **Statistical Model**:- It involves the analysis of responses on a test or questionnaire or observations of some particular behavior variables.

- The degree of deviation from the standard norms arrived at statistically, characterizes the degree of abnormality.
  Statistically normal mental health falls within two standard deviations (SDs) of the normal distractions curve

3. **Socio-cultural Model: -** The beliefs, norms, taboos & values of a society have to be accepted & adopted by individuals.

- Breaking any of these would be considered as abnormal.
- Normalcy is defined in context with social norms prescribed by the culture.
- Thus, cultural background has taken into account when distinguishing between normal & abnormal behavior.

4. **Behavioral Model: -** Behavior that is adaptive, is normal, maladaptive is abnormal.

Abnormal behavior is a set of faulty behaviors acquired through learning.

UNIT II
Classification and Assessment of Mental Disorders

INTRODUCTION

- Classification is a process by which complex phenomena are organized into categories, classes or ranks so as bring together those things that most resemble each other & to separate those that differ.
- Like any growing branch of medicine, psychiatric has been rapid changes in classification to keep upgrowing research data dealing with epidemiology, symptomatology, prognostic factors, treatment methods & new theories for causation of psychiatric disorder.
- At present there are two major classification in psychiatry, namely ICD 10 (1992) & DSM IV (1994).

ICD 10 (International Statistical Classification of Disease & Related Health Problems)- 1992

- This is WHO's classification for all diseases &related health problems.
- The chapter 'F' classifies psychiatric disorder as mental & behavioral disorders & codes them on an alphanumeric system from F00 to F99.The Main Categories in ICD 10.

- **F00 – F09 Organic, Including Symptomatic, Mental disorders**
- F00 – Dementia in Alzheimer's disease
- F01 – Vascular dementia
- F04 – Organic amnestic syndrome
- F05 – Delirium
- F06 – Other mental disorders due to brain damage &dysfunction & to physical disease
- F07 – Personality & behavioral disorders due to brain disease, damage & dysfunction
- **F10 – F19 Mental & behavioral Disorders due to Psychoactive Substance use**
- F10 – Mental & behavioral disorders due to use of alcohol
- F11 - Mental & behavioral disorders due to use of opioids
- F12 – Mental & behavioral disorders due to use of cannabinoids
- F13 – Mental & behavioral disorders due to use of sedatives & hypnotics
- F14 – Mental & behavioral disorders due to use of cocaine
- F16 – Mental & behavioral disorders due to use of hallucinogens

- **F20 – F29Schizophrenia, Schizotypal &Delusional Disorders**
- F20 – Schizophrenia

- F20.0 – Paranoid Schizophrenia
- F20.1 – Hebephrenic Schizophrenia
- F20.2 – Catatonic Schizophrenia
- F20.3 – Undifferentiated Schizophrenia
- F20.4 – Post-schizophrenia depression
- F20.5 – Residual Schizophrenia
- F20.6 – Simple Schizophrenia
- F21 – Schizotypal disorder
- F22 – Persistent delusional disorders
- F23 – Acute & Transient psychotic disorders
- F24 – Induced Delusional disorders
- F25 – Schizoaffective disorders

- **F30 – F39 Mood (affective) Disorders**
- F30 – Manic episode
- F31 – Bipolar affective disorder
- F32 – Depressive episode
- F33 – Recurrent depressive disorder
- F34 – Persistent mood disorder

- **F40 – F49 Neurotic, Stress-rapid & somatoform disorders**
- F40 – Phobic anxiety disorders
- F41 – Other anxiety disorders
- F42 – Obsessive – Compulsive disorder
- F43 – Reaction severe stress & adjustment disorders
- F44 – Dissociative (Conversion) disorders
- F45 – Somatoform disorders
- **F50 – F59 Behavioral syndromes associated with physiological disturbances & physical factors**
- F50 – Eating Disorders
- F51 – Non-organic sleep disorders
- F52 – Sexual dysfunction
- **F60 – F69 Disorders of adult personality & behavior**
- F60 – Specific personality disorders
- F60.0 – Paranoid personality disorders

- F60.1 – Schizoid personality disorders
- F60.2 – Dissocial personality disorders
- F60.3 – Emotionally unstable personality disorder
- F60.4 – Histrionic personality disorders
- F60.5 – Anankastic personality disorders
- F60.6 – Anxious personality disorders
- F60.7 – Dependent personality disorders
- F61 – Mixed & other personality disorders
- F62 – Enduring personality changes, not attributable to brain damage & disease
- F63 – Habit & impulse disorders
- F64 – Gender identity disorders
- F65 – Disorders of sexual preference

- **F70 – F79 Mental Retardation**
- F70 – Mild Mental Retardation
- F71 – Moderate Mental Retardation
- F72 – Severe Mental Retardation
- F73 – Profound Mental Retardation

- **F80 – F89 Disorders of psychological development**
- F80 – Specific developmental disorders of speech &language
- F81 – Specific developmental disorders of scholastic skills
- F82 – Specific developmental disorders of motor function
- F83 – Mixed specific developmental disorders
- F84 – Pervasive developmental disorders

- **F90 – F98 Behavioral & emotional Disorders with onset usually occurring in childhood & adolescence**
- F90 – Hyperkinetic disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood
- F94 – Disorders of social functioning with onset specific to childhood & adolescence
- F95 – Tic Disorders
- F98 – Other behavioral & emotional disorders with onset usually occurring in childhood & adolescence
- **F99 – Unspecified mental Disorders**

DSM IV (Diagnostic & Statistical Manual) – 1994

- This is the classification of mental disorders by the American Psychiatric Association (APA). The pattern adopted by DSM IV is of Multiaxial systems.
- A multiaxial system that evaluates patients along several versatile contains Five axes.

  Axis I & II make up the entire classification which contains more than 300 specific disorders

  The Five Axes of DSM IV are: -
- Axis I: Clinical psychiatric diagnosis
- Axis II: Personality disorder & mental retardation
- Axis III: General medical conditions
- Axis IV: Psychosocial & environmental problems
- Axis V: Global assessment of functioning in current& past one year

Indian Classification

In India Neki (1963), Wig &Singer (1967), Vahia (1961) & Varma (1971) have attempted some modification of ICD8 to suit Indian conditions.

A) Psychosis: -

1. Functional: - Schizophrenia
2. Affective: - Mania & Depression
3. Organic: - Acute or Chronic

B) Neurosis: - Anxiety neurosis Depressive neurosis Hysterical neurosis Obsessive-compulsive neurosis Phobic neurosis

C) Special disorders: Childhood disorders Personality disorders Substances abuses Psycho physiological disorders Mental retardation

Differences Between ICD10 & DSM IV: -

criteria	ICD 10	DSM IV
Origin	International	American psychiatric association
Presentation	Different version for clinical work, research and primary care	A single version
Languages	Available in all widely spoken languages	English version only
Structure	Single axis	Multiaxial
Content	Diagnostic criteria do not include social consequences of the disorder.	Diagnostic criteria usually include occupational and other areas of functioning.

Terminology

1. **Abreaction**- It is a emotional release or discharge of recalling a painful experience.
2. **Abstinence**- Voluntary refraining from behavior or the use of a substance that has caused problems in psychosocial, biologic, cognitive/perceptual or spiritual belief of life especially with regard to food, alcohol or drugs.
3. **Addiction**- Addiction is a term used to define a state of dependence or recurrent drug intoxication, characterized by psychological and physical dependence as well as tolerance.
4. **Aggression**- An action, verbal or physical, for dealing with frustration and anxiety caused by not achieving a desired goal.
5. **Agoraphobia**- Defined an anxiety about being in place or situations from which escape may be difficult
6. **Akathisia**- Subjective feeling of motor restlessness manifested by a compelling need to be in constant movement may be seen in EP adverse effect of antipsychotic medication.
7. **Akinesia**- Lack of physical movement.
8. **Ambivalence**- Co-existence of two opposing impulses toward the same thing in the same person at the same time.
9. **Amnesia**- Partial or total inability to recall past experiences, may be organic or emotional in origin.
10. **Anergia**- Lack of energy for day to day activities.
11. **Anhedonia**- Loss of interest in and withdrawal from all regular and pleasurable activities.
12. **Anorexia Nervosa**- An eating disorder, characterized by self-starvation, weight loss below minimum normal weight, intense fear of being fat.
13. **Apathy**- Dulled emotional tone associated with detachment or indifference.
14. **Aphasia**- Difficulty in formulation of words or loss of language ability or it is the disturbances in language output.
15. **Associative looseness**- Disturbance of thinking in which ideas shift from one subject to another in a oblique or unrelated manner
16. **Autistic thinking**- Thoughts, ideas or desired derived from internal, private stimuli or perceptions that often are incongruent with reality.
17. **Avolition**- Lack of motivation or inabilities to initiate tasks.
18. **Battering**- Is a harmful or offensive touching of another person.
19. **Bipolar Affective Disorder (BPAD)**- It is characterized by recurrent episodes of mania and depression in the same patient at different times.
20. **Bulimia**- The uncontrolled ingestion of large amount of food followed by inappropriate compensatory methods to prevent weight gain and for maintaining body shape.
21. **Catatonia**- A state of psychologically induced immobilization at times interrupted by episodes of extreme agitation.
22. **Circumstantiality**- A disorder of thinking process, determining tendency is maintained but the patient can reach the goal only after having exhaustively explored all unnecessary associations arising in his mind.
23. **Clang Association**- Meaningless rhyming of words often in a forceful manner. In this, rhyming is more important than the context of the word.
24. **Compulsion**- An irrational and repetitive impulse to perform an act.
25. **Confabulation**- Filling up of memory gaps with false but sometimes- plausible content to conceal the memory deficit.
26. **Conversion**- The transference of a mental conflict into a physical symptom to release tension or anxiety
27. **Crisis**- A situation in which customary problem solving or decision- making methods are not adequate.
28. **Cyclothymic**- Swings of mood of elation and depression.
29. **Defense Mechanism**- Unconscious mental processes that the ego uses to resolve conflicts, which will abolish anxiety and depression.
30. **Delirium**- An etiologically non- specific syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behavior, emotion and sleep- wake cycle.
31. **Delusion**- False belief not true to fact and not ordinarily accepted by other member's explanation.

32. **Dementia-** Diffuse brain dysfunction characterized by a gradual, progressive and chronic deterioration of intellectual function, judgment, orientation, memory, affect or emotional stability, cognition and attention.
33. **Denial**- Unconscious refusal to face thoughts, feelings, wishes, needs or reality factors that are consciously intolerable.
34. **Depersonalization**- Experience of un realness, feeling of separation, loss of feeling and personal identity.
35. **Derealization**- The feeling that the surrounding world is not real or is distorted. **36.Desensitization**- Diminished emotional responsiveness to a negative, aversive or positive stimulus after repeated exposure to it.
37. **Dissociation**- The act of separating and detaching a strong emotionally charged conflict from one's consciousness.
38. **Dysthymia**- A state of chronic low-level depression lasting for more than two years.
39. **Fugue**- Dissociative fugue is characterized by episodes of wandering away (usually from home).
40. **Grandiosity**- A person exaggerated conception of his or her importance, power of identity.
41. **Grief-** Appropriate emotional response to an external and consciously recognized loss.
42. **Hallucination-** A false perception, which is not a sensory distortion or misinterpretation, but which occurs at the same time as real perceptions.
43. **Hyperkinetic Attention Deficit Disorder-** Disorder common in children, onset before the age of 7 years and males more commonly affected (6-8 times more).
44. **Hypochondriasis-** Disorder characterized by preoccupation with the fear of developing a serious disease or the belief that one has a serious disease.
45. **Hypomania**- Distinct period of at least a few days of mild elevation of mood, sharpened and positive thinking and increased energy and activity level.
46. **Hysteria**- Characterized by many somatic symptoms that cannot be explained adequately on the basis of physical and laboratory examination.
47. **Ideas of Reference**- Incorrect interpretations of incidents and external events as having a particular or special meaning specific to a person.
48. **Illusion**- Misinterpretation of external stimuli.
49. **Impulsiveness**- Emotional instability and lack of impulse control.
50. **Labile**- Labile means moving from point to point or unstable.
51. **Libido**- Forces by which sexual instinct is represented in the mind.
52. **Malingering**- Internal productivity of false or grossly exaggerated psychological symptoms, motivated by extend incentives such as avoiding military duty, avoiding work etc.
53. **Mania**- Characterized by elevated expansive or irritable mood.

- ♣ Euphoria (Mild elevation of mood)
- ♣ Elation (Moderate elevation of mood)
- ♣ Exaltation (Severe elevation of mood)
- ♣ Ecstasy (Very severe elevation of mood)
- ♣ Echolalia- Repetition, echo or mimicking of phrases or words heard.
- ♣ Echopraxia- Repetition, echo, or mimicking of action observed even when asked not to do so.
- ♣ Euthymia- Normal range of mood.

54. **Neologism-** New word created by patient often combining syllables of other words, for idiosyncratic psychological reasons.
55. **Neuroleptic Malignant Syndrome**- Potentially life threatening characterized by muscular rigidity, fever, autonomic instability and an altered level of consciousness. **56.Nihilism**- A type of delusion and a false feeling that self, others, or the world is non- existent or coming to end.
57. **Obsession**- Pathological persistent of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort, associated with anxiety.
58. **Paranoia-** Chronic well- systematized delusional state without hallucination. **59.Perseveration**- Persistent and inappropriate repetition of the same thoughts, as judged by the patient's words or actions.
60. **Phobia**- Refers to the persistent, irrational, exaggerated and invariably pathological dread of a specific stimulus or situation.

Specific phobia ¬Social phobia ¬Acrophobia ¬Agoraphobia ¬Algophobia ¬Ailurophobia¬Erythrophobia ¬Pan phobia ¬Claustrophobia ¬Xenophobia ¬Zoophobia ¬Needle phobia

61. **Pica**- Persistent eating of non- nutritive substances for at least one month. **62.Tangentiality**- Refers to inability to have goal directed associations of thought, speaker never gets from desired point to desired goal.
63. **Waxy Flexibility (Cata flexibilities)-** Condition of a person who can be molded into a position that is then maintained, when an examiner moves the person's limb, the limb feels as if it were made of wax.

PSYCHOPATHOLOGY OF MENTAL DISORDERS

"Psychopathology is a term which refer to either a study of mental illness or mental distress, or the manifestations of behaviors and experiences which may be indicative of mental illness or psychological impairment, such as abnormal, maladaptive behavior or mental activity"

Psyche- mind /social

Pathos- traces disease

Logos- study

It refers to the study of the causes and nature of disease or abnormal behavior

Signs and Symptoms of Mental Illness

Signs are observations and objective findings elicited by the clinician

Symptoms are the subjective experience described by the patient, often expressed as chief complaints such as depressed mood or lack of energy.

Syndrome is a group of signs and symptoms that together make up a recognizable condition.

NEUROSIS

- A neurosis is a chronic or recurrent nonpsychotic disorder characterized mainly by anxiety, which is experienced or expressed directly or is altered through defense mechanisms; it appears to be a symptom such as an obsession, a compulsion, a phobia or a sexual dysfunction.
- Symptoms are distressing to the individual and is recognized as unacceptable and alien, reality testing is grossly intact.
- Behavior does not actively violate gross social norms.
- No demonstrable organic etiology.

PSYCHOSIS

- Loss of reality testing and impairment in mental functioning-manifested by delusions, hallucinations, confusion and impaired memory.
- Severe impairment in social and personal functioning
- With gross impairment in reality testing, persons incorrectly evaluate the accuracy of their perceptions and thoughts and make incorrect inferences about external reality, even in the face of contrary evidence.

DEVIATIONS FROM NORMAL BEHAVIOR

- ❖ Disturbances of consciousness
- ❖ Disorders of motor aspects of behavior
- ❖ Disorders of thinking
- ❖ Disorders of affect
- ❖ Disorders of perception
- ❖ Disorders of memory.

History taking an Assessment Method for Mental Disorders

HISTORY COLLECTION

Introduction

Psychiatry History Taking: It is the record of the Patient 's life. It allows to understand o who the patient is o where the patient has come from o where the patient is likely to go in the future.

Definition

The psychiatry history is the record of the patient's life; it allows a psychiatrist to understand who the patient is, where the patient has come from ,and where the patient is likely to go in the future.

IMPORTANCE

- Obtaining a comprehensive history from a patient and if necessary, from informed sources are essential to make a correct diagnosis and formulating a specific and effective treatment plan.

Purpose :-

- To describe adaptive and maladaptive behavior.
- To formulate priorities.
- To identify problems.
- To predict probable responses to potential interventions.
- To analyze the client's perceptions.
- Helps to develop nursing care plan.

BASIC PRINCIPLES OF HISTORY TAKING

- Introduce yourself
- Explain the purpose and approx. how long it will take
- Ask Open Ended Questions
- Allow the patient to Explain Things In his/her Own Words
- Encourage the patient to Elaborate and explain
- Avoid Interrupting
- Guide the Interview as Necessary
- Avoid Asking "Why?" Questions
- Listen and Observe for Cues
- You might need an informant

Components

1. Identification data
2. Informants
3. Chief complaints
4. H/o Present Illness
5. Treatment history
6. Past history of illness a) Medical/surgical illness

b) Past psychiatric history

7 Family history:

8. Personal history

a. Perinatal history
b. Childhood history
c. Educational history
d. Play history
e. Emotional problems during adolescence
f. Puberty
g. Obstetrical history
h. Occupational history
i. Sexual and marital history
j. Premorbid personality

1. Identification data

- Name
- Age
- Sex

- Marital status
- Religion
- Education
- Occupation
- Income Address
- Date of admission
- Hospital No
- Psychiatric ward
- Marital status

2. Informants

- The sources of the information
- Informant's name
- The reliability of the sources
- Relation to Patient
- Intimacy with the patient
- Interest of the patient'
- Does the Informant live with the patient?
- Duration of stay with the patient
- Intellectual and observational ability

3. CHIEF COMPLAINTS ON ADMISSION

- Presenting complaints and/or reasons for consultation should be recorded.
- Both the patient's and the informant's version should be recorded separately
- it should be recorded even if the patient is unable to speak and the patient explanation regardless of how bizarre or irrelevant

4. Chief complaints on admission
- Patient's problem or reason for the visit
- Recorded as the patient's own words
- Ask leading questions such as -"What brings you here today?" -How can I help you?"
- Examples: • "am having thoughts of wanting to harm myself" • "peoples are trying to drive me insane" • "I feel am going mad" • "am angry all the time "
5. Present Illness Present Illness

6. HISTORY OF PRESENT ILLNESS- Provides a comprehensive and chronological picture of the events. Probably the most helpful in making an accurate diagnosis.

7. History of present illness

- Duration- Weeks/months/years
- Mode of onset-Abrupt/acute/subacute/Insidious
- Course- (continuous / episodic/ fluctuating/ deteriorating/ improving/ unclear)
- Precipitating factors (death/ separation/ loss/ frightening experience/ any other)
- Aggravating and relieving factors, if any.

8. HISTORY OF PRESENT ILLNESS

- When the patient was well the last time should be noted.
- The time of onset
- When the symptoms are first noticed by the patient or by the relatives.

- The symptoms of the illness from the earliest time at which a change was noticed until the present time should be narrated chronologically, in a coherent manner.

9. HISTORY OF PRESENT ILLNESS

- The presenting chief complaints should be expanded.
- Any disturbances in the physiological functions like sleep, appetite, and sexual functioning
- Always enquire about suicidal ideation
- Important negative history should be recorded (e.g. no h/o head injury)
- Life chart-valuable display of course of illness

10. TREATMENT HISTORY
- Drugs- dose/route/side effects/complains
- ECT
- Psychotherapy
- Rehabilitation Year & Month Centre Duration Treatment
- Current medications
- What medications do you take regularly and since when?
- What medications have you had in the past?

11. PAST HISTORY PAST HISTORY

12. PAST HISTORY OF ILLNESS a) Past medical/surgical illness: b) Past psychiatric history

13. Past medical/surgical illness: History of chronic medical illness and details of medication received and the duration of illness, Hospitalization, Medical/neurological/surgical illness, Head injury/ convulsion/ Unconsciousness, Accidents/surgical procedure, DM/HTN/CAD/Visceral/ HIV positive

14. Past psychiatric history - Past psychiatric illness, H/o alcohol/substance abuse/dependence

15. Past psychiatric history –Had the patient suffered from any mental illness and undergone psychiatric treatment –Has the patient been hospitalized earlier for the treatment of mental illness –What was the nature of treatment she or he had been getting; drugs or ECT –Did the patient improve with the treatment

16. Any similar or other psychiatric problems in the past?
- Have you ever been admitted to a psychiatric hospital?
- What treatments have you had?
- Has there ever been a time that you felt completely well?

17. FAMILY HISTORY
a. Family structure
b. Family history of illness of Psychiatric illness- similar/other
c. Major medical illness
d. Alcohol/drug dependence/suicidal attempt
e. Current social situation
f. Home circumstances
g. Per capita income
h. Socioeconomic status
i. Head of the family-nominal & functional
j. Current attitude of the family members towards the patient’s illness
k. Communication pattern in the family
l. Cultural &religious values
m. Social support system available

18. No name age sex relationship with patient age/ mode of death Description of family members
- Are your parents still living? Are they well?
- Do you mind me asking how they died?
- What did your parents do?
- Do you have any brothers or sisters? Are you close to them?
- As far as you know, has anyone in your family ever had problems with their mental health?

19. Personal history

20. PERSONAL HISTORY

a. Perinatal history
b. Childhood history
c. Educational history
d. Play history
e. Emotional problems during adolescence Running away from home delinquency smoking drug use any other
f. Puberty
g. Obstetrical history
h. Occupational history
i. Sexual and marital history
J. Premorbid personality

MENTAL STATUS EXAMINATION

It represents cross section of the patient's psychological life wherein the nurse observes the patient's behavior & describes it in an objective, nonjudgmental manner. MSE is an evaluation of the patient's current state.

GENERAL APPEARANCE AND BEHAVIOR

General appearance: following physical characteristics should be observed
- Physique/ body built
- Looks comfortable/ uncomfortable
- Physical health
- Grooming & Dressing
- Hygiene & Self care
- Facial Expression
- Stooped posture seen in patients with depression and maniac patients

Attitude towards the examiner: Co-operative, attentive, interested/guarded/defensive/ hostile/ irritable/ aggressive/ friendly/ playful/ seductive/ evasive.

Rapport: Established/ Established and maintained, established and not maintained

Eye to eye contact: made but not sustained, made and sustained, not made adequate eye to eye contact.

PSYCHOMOTOR ACTIVITY:

Note if psychomotor activity is increased, decreased or normal/ restless/ agitated/ destructive/ self-injurious/ aggressive

Presence of abnormal involuntary movements like tics, tremors, akathisia **Observe for catatonic signs**: rigidity/ posturing/ stereotype/ echopraxia/ waxy/ flexibility/ negativism/ ambitendency/ automatic obedience.

Gait: Normal gait/ ataxic gait/ deliberate gait/ suspicious gait/ unsteady gait **Posture**: erect/ stooped

SPEECH

Relevance: whether the patient gives answers to the asked question

Coherence:

Volume: loud or soft
Tone: Emotional aspect of the person
Tempo: Energy level
Reaction time: Time taken to answer the question asked
Amount: Paucity, muteness and pressured speech

MOOD AND AFFECT

Mood is the patient's self-report of one's emotional state and reflects the patient's life situation. This should be assessed by both subjective report and objective evaluation.
Subjective: How are you feeling now? How is your mind?
Objective: Euthymic/ Dysphoric/ Depressed/ Expansive/ Euphoric/ Elated/ exalted/ anxious/ fearful/ irritable

AFFECT

The nurse must look for
The intensity/ depth of emotional experience
range of affective responses (full/ normal/ constricted/ restricted/ blunted/ flat/ apathetic)
Libility of affect (rapid and extreme changes in emotions)
Reactivity (changes in emotional expression in relation to environmental factors) Diurnal variation (present/ absent)

THOUGHT

Form of thought: loosening of associations. Neologism, autistic thinking, word salad
Stream of thought: flight of ideas, retarded thinking, circumstantiality, perseveration, thought blocking
Content of thought: look for the presence of delusions and overvalued ideas before making an inference. Note whether the delusions are single or multiple, type of delusions, content of delusions well systematized or poorly systematized and also mood, congruent or incongruent delusions.
Possession of thought: thought alienation – thought control, withdrawal, insertion and broadcasting.
Enquire whether there are obsessions or compulsions. If obsessions present elicit their nature-ideas, doubts, imagery, impulses and phobias. Clarify the nature of their compulsive acts, checking, counting and washing.

PERCEPTION

Two major types of perceptual problems are hallucinations and delusions. In hallucinations ask the following:
Sensory modality (auditory, visual, tactile, gustatory, olfactory)
Prominence (Clarity and intensity)
Diurnal patterns
Content of hallucination
Response of hallucination
Insight of hallucination
Mood Congruent/ incongruent

HIGHER COGNITIVE FUNCTIONS

Consciousness Consicousness/ confused/ Somnolence/ Clouding/ Disoriented/ Delirious/ Stuperous/ Comatose

ORIENTATION

Time: What time of day is it?
Is it morning, afternoon, evening or night?
How long is it since you had your breakfast/ lunch/ dinner/ tea?
What is the day today?
Place: What place it is? Is this a school, office, hospital or restaurant?
Person: Orientation to self is tested by asking the identity of the patient Enquiring about the identity of the patient's relatives or family members.

ATTENTION AND CONCENTRATION

Digit Span test
Patient is asked to repeat the numbers told by the examiner.
Eg. 5-7-9

2-4-7-5
1-6-0-5-4
3-6-7-1-0-5
4-7-9-4-8-2-1
6-0-1-5-9-3-2-4
Digit span is the highest number of digits repeated correctly. The same digits should not be presented more than once

SERIAL SUBSTRACTION TEST

The examiner a) Instruct the patient, b) gives an example of how to perform the test, c) note the response verbatim, d) note the time taken in seconds
Task: correct response and the time limit
20 -1 in 15 secs
40-3 in 60 secs
100-7 in 120 secs
Days and months may be asked for in backward or forward to the patient who is familiar with the order

MEMORY

Recent memory

a) 3 object test- the unrelated objects name can be given slowly to the patient which is not presented in the current environment. Then he is engaged in the conversation to avoid rehearsal and the response is noted. Recall is asked for other 3-5 minutes.
b) Asking the patient to recall the events in the last 24 hours e.g. details of the time and amount of meal, visitors to the hospital. Responses given are noted and cross checked from a reliable source.
Remote memory Collect information on life events like date of birth, no of children, name of family members, time since marriage or death of any family member, years of completing education
Information asked should be cross checked.

INTELLIGENCE

General fund of knowledge: information relevant to the patient's literacy age or occupation may be asked e. g. For literates Name of the prime minister, 5 rivers, 5 cities, capital of countries and current major events
For illiterates
Seasons, corps of fruits growing in particular seasons, prices of food grains or food items and prices of land

Comprehension

The ability to understand is checked by asking some specific questions of increasing difficulty
What will you do when you feel cold?
What will you do if it rains when you went to work?
What will you do if you miss a train or bus when you are on a journey?
What will you do when you realize that it will be too late when you reach the office?

Arithmetic ability

Give tests of addiction, subtraction, multiplication Vocabulary Ask patient to name the objects seen in the room, parts of objects etc.

JUDGEMENT

Personal Judgment
What you like to do in the future after getting discharge?
Test judgment:
Fire problem: What would you do if fire catches in the room where you are sitting now?
Letter problem: What would you do if you get an unposted letter on the road while you are walking?
Rain problem: What would you do if you are walking on the road and suddenly it rains?

Social judgment

See whether the patient is greeting the interviewer, following the social norms. **INSIGHT**
It is the patient understands of the nature of one's problem or illness.
Where are you now?
Are you admitted in the hospital?

Why are you admitted in the hospital?
Do you think that you are having mental illness?
Do you believe that medication can cure your illness?
Completely denies the problem (absent insight)
Attributes to physical causes
Aware of abnormal behavior
Understands reality of the problem but not taking the responsibility
Understands reality about the problem and believes in treatment
Recognizes personal responsibility and need for taking medications.
Grade the level of insight of your patient out of 6
e.g: 1/6, 2/6, 3/6, 4/6, 5/6, 6/6 Activities of daily living.

Unit- 3
Therapeutic Communication

INTRODUCTION

Communication refers to the reciprocal exchange of information, ideas, beliefs, attitudes between persons or among group of persons. It is goal directed process. In nursing it used in nursing process

DEFINITION OF COMMUNICATION

"Communication is process by which information is exchange between individual through common system of sign, symbol or behavior."

TYPES of COMMUNICATION

1. Verbal communication
2. Non-verbal communication

DEFINITION OF THERAPEUTIC COMMUNICATION

"In therapeutic communication the nurse directs the communications towards the patient to identify his current health problem, plan, implement & evaluation the action taken."

GOAL OF THERAPEUTIC COMMUNICATION

- Establish a therapeutic nurse-patient relationship.
- Identify the most important patient's needs.
- Assess the patient's perception of the problem.
- Facilitate the patient's expression of emotions
- Implement interventions designed to address the patient's needs

PRINCIPLES OR CHARACTERISTICSOF THERAPEUTIC COMMUNICATION

- The patient should be the primary focus of interaction.
- A professional attitude sets the tone of the therapeutic relationship.
- Use self-disclosure cautiously & only when it has a therapeutic purpose.
- Avoid social relationship with patientsν Maintain patient confidentiality.
- Assess the patient's intellectual competence to determine the level of understanding
- Implement interventions from a the predicable.
- Maintain a non-judgmental attitude.

- Avoid making judgment about patient's behavior.
- Avoid giving advice
- Guide the patient to interpret his or her experiences rationally

THERAPEUTIC COMMUNICATION TECHNIQUES

1. Listening
2. Broad opening
3. Restating
4. Clarification
5. Reflection
6. Humor
7. Information
8. Focusing
9. Sharing perceptions
10. Theme identification
11. Silence
12. Suggesting

1. listening: - It is an active process of receiving information. Response on the part of the nurse such as maintaining eye-to-eye contact, nodding, gesturing & other form of receptive non-verbal communication convey to the patient that he is being listened to & understood.
2. Broad openings: - Encouraging the patient to select to pics for discussion. E. g; "What are you thinking about?
3. Restating: - Repeating the main thought expressed by the patient. E.g; you say that your mother left you when you were five years old.
4. Clarification: - Attempting to put vague ideas or nuclear thoughts of the patient into words to enhance the nurse's understanding or asking the patient to explain what he means. E.g.; "I am not sure that what you mean could you tell me about that again.
5. Reflection: - Directing back the patient's ideas, feelings, questions & content. E.g.; "You are feelings tense & anxious & itis related to a conversation you had with your husband last night
6. Humor: - The discharge of energy through comic enjoyment of the imperfect. E.g.; "That gives a whole new meaning to the word „nervous", said with shared kidding between the nurse &the patient.
7. Information: -The skill of information giving. E.g.; "I think you need to know more about your medications.
8. Focusing: - Questions or statements that help the patient expand on a topic of importance. E.g.; "I think that we should talk more about your relationship with your father
9. Sharing perceptions: - Asking the patient to verify the nurse's understanding of what the patient is thinking or feeling.E.g.; "You are smiling, but I sense that you are really very angry with me
10. Theme identification: - This involving identification of under lying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship. E.g.; "I noticed that you said you have been hurt or rejected by man. Do you think this is an underlying issue?

11. Silence: - Lack of verbal communication for a therapeutic reason.ν E.g.; sitting with a patient & non-verbally communicating interest &involvement.

12. Suggesting: - Presentation of alternative ideas for the patient's consideration relative to problem solving.; "Have you thought about responding to your boss in a different way when her arises that issue with you? You could ask him if a specific problem has occurred

NON-THERAPEUTIC TECHNIQUES

- Reassuring
- Rejecting
- Giving approval
- Advising
- Defending
- Requesting
- Belittling the feeling of the patient.

These non-therapeutic techniques should be avoided.

Communication failures

- Failure to perceive the patient as human being
- Failure to recognize the level of meaning in communication
- Failure to listen
- Failure to interpret with knowledge
- Use of close ended question only
- Conflicting verbal, non-verbal
- Giving false reassurance
- Changing subject if not comfortable

Process recording

Introduction

Process recording are the written reports of verbal interactions with clients. They are verbatim (to the extent that is possible) accounts, written by the nurse or student as a tool for improving interpretation communication techniques.

Definition

Process recording is a written account recording of all that transpired, during and immediately following the nurse patient interaction.

It is recording of the conversation during the interaction or the interview between nurse and the patient in the psychiatric setup with the nurse inference.

Purpose

1. To critically analyze communication and its effect on behavior of the individual.
2. To gain the patients confidence and get this cooperation.
3. To establish rapport with the patient.
4. To study the patients psychological social and emotional behavior.
5. It helps to increase the ability to identify problems and develop skills in solving them.
6. It gives students an opportunity to gain the ease and function in written expression that are important for professional development.

Goals and objectives

- Establish a therapeutic nurse patient relationship.

- To give necessary health education to the patient.
- To obtain the identification data of the patient.
- To assess the insight of the patient

General guidelines

- Process recording is one method by which we can record the content of an interview.
- Record the conversation verbal time
- Use a recording device and obtain patients permission for using it this will in reviewing the session if needed.
- Each process recording should be concluded with a summary.

Pre- requisite of process recording

- Getting consent of the patient for the possibility of cassette recording.
- Confidentiality should be maintained.
- Physical setting, calm and quite environment.

Steps of process recording

- Preparation
- Record nurse patient interaction.
- written process recording may begin with taken during the interview.
- Identification data
- Present Complaint

Unit- iv
Management of Mental disorders

Neurotic Disorders
Introduction

Neurotic Disorder (Neurosis) is a less severe form of psychiatric disorder where, patient show either excessive or prolonged emotional reaction to any given stress. These Disorder are not caused by organic brain disease & however severe, do not involve Hallucination & Delusions.

Classification (ICD 10)

F40- F49: Neurotic, stress-related somatoform disorder
F40 Phobic anxiety disorders
F41 Other anxiety disorders
F42 Obsessive-compulsive disorder
F43 Reaction to severe stress, and adjustment disorders
F44 Dissociative (conversion) disorders

Anxiety Disorder are classified as following: -

- Phobic Anxiety Disorder
- Panic Anxiety Disorder
- Generalized Anxiety Disorder

Anxiety is a normal phenomenon, which is characterized by a state of apprehension or uneasiness arising out of anticipation of danger.

PHOBIC ANXIETY DISORDER: -

A Phobia is an unreasonable fear of a specific object, activity or situation. This irrational fear is characterized by various features.

Classification

F40.0 agoraphobia
F40.1 social phobia
F40.2 specific phobia
F40.8 other phobic anxiety disorder
F40.9 phobic anxiety disorder, unspecified

Types of Phobias

- Simple phobia
- Social phobia
- Agoraphobia

SIMPLE PHOBIA (Specific phobia)

It is an irrational fear of a specific object or stimulus. Simple phobia common in childhood.

SIGN AND SYMPTOMS OF SIMPLE PHOBIA: -

- Irrational and persistent fear of object or situation.
- Immediate anxiety on contact with feared objects or situation.
- Loss of control, fainting or panic response.
- Anxiety when thinking about stimulus.
- Possible impaired social or work functioning.

Social phobia

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

SIGN AND SYMPTOMS OF SOCIAL PHOBIA

- Hypertension
- Sweating, cold & clammy
- Blushing
- Palpitation
- Confusion
- Trembling hand and voice
- Urinary urgency

Agoraphobia

It is a characterized by an irrational fear of being in places away from the familiar setting of home, in crows, or in a situation that the patient cannot leave easily.

SIGN AND SYMPTOMS: -

- Overriding fear of open or public spaces.
- Avoidance of public places & confinement to home.
- Embarrassment.

COURSE: - The phobia are more common in women with an onset of early or late seconds. The course is usually chronic.

Diagnosis: - No specific Diagnosis test, diagnosis confirm by criteria met. (Simple, social, Agora) History of anxiety when exposed to or anticipating specific entity or situation.

Treatment

PHARMACOTHERAPY

- Benzodiazepines (For example Alprazolam, clonazepam, Lorazepam, Diazepam) ♦Antidepressants (For example Imipramine, phenelzine)

BEHAVIOUR THERAPY

1. Relaxation techniques (Progressive muscle relaxation, Deep breathing exercise, listening to calming music.
2. Through Role playing
3. Assertive training
4. Cognitive techniques (Remove negative thinking about feared objects)
5. Supportive Psychotherapy is a helpful to behavior therapy as following: -

♦ Group therapy
♦ Individual therapy
♦ Music therapy
♦ Dance therapy
♦ Talking therapy
♦ Family therapy
♦ Drama therapy

Nursing Management

1. ASSESSMENT

- Assess the symptoms of fear & factors.
- Observation of thought process, affects & communication.

2. NURSING DIAGNOSIS

- Fear related to specific stimulus or causing embarrassment to self in front of others, evidenced by behavior directed towards avoidance of feared object.
- Social isolation related to fear of being in a place from which one is unable to escape, evidenced by staying alone, refusing to leave the room/home.
- Reassure the patient that he is safe.
- Encourage patient to explore underlying feelings that may be contributing to irrational fears.
- Administer antianxiety medications as ordered by physician.
- Discuss with the patient sign and symptoms of increasing anxiety & give relaxation and positive reinforcement.

PANIC DISORDER

Panic attack:

- Is a brief period of extreme distress, anxiety, or fear that begins suddenly and is accompanied by physical and/or emotional symptoms.
- Panic disorder:

- Is involves spontaneous panic attacks that occur repeatedly, worry about future attacks, and changes in behavior to avoid situations that are associated with an attack.
- Neurochemical dysfunction behind panic disorder: May involve autonomic imbalance, decreased gamma-aminobutyric acid (GABA), increased adenosine receptor function, increased cortisol, diminished benzodiazepine receptor function, and disturbances in serotonin.
- Genetic factor:
- Studies of the association between psychiatric illness in first-degree relatives revealed a heredity of approximately 43% for panic disorder.
- The exact nature of the panic disorder genetic basis is unclear.
- However, some studies shows that Locus 13q22-32 and locus 9q31 are linked.

Cognitive symptoms Somatic symptoms

- Fear of dying.
- Fear of going crazy or of losing the control.
- Feeling of unreality, strangeness or detachment from the self (depersonalization).
- Chest pain or discomfort.
- Dizziness or fainting.
- Feeling of choking.
- Flushes or chills.
- Nausea or abdominal distress.
- Numbness or tingling sensation.
- Palpitation or accelerated heart rate.
- Sensations of shortness of breath.
- Sweating.
- Trembling or shaking.
- A panic attack involves the sudden onset of at least 4 of the 13 symptoms in the table. • Symptoms usually peak within 10 minutes.
- Panic attacks may occur in any anxiety distress.
- Most people within panic disorder anticipate and worry about another attack (anticipatory anxiety) and avoid the places or situations where they have previously panicked.
- A doctor's evaluation, based on specific criteria
- Because serious physical disorders often cause some of the same physical and emotional symptoms as panic attacks, doctors first make sure people do not have a physical disorder.
- Panic disorder is diagnosed when people have repeated unprovoked and unexpected panic attacks plus at least one of the following for at least 1 month:
- Persistent worry that they will have more panic attacks or worry about the consequences of the attack (for example, that they will lose control or go crazy)
- Changes in behavior due to the panic attacks (for example, avoiding situations that may cause an attack)
- Once doctors are confident that a person's symptoms are caused by a panic disorder, they try to avoid doing extensive tests when future panic attacks occur unless the person's symptoms or physical examination results suggest a new problem.
- Drugs that are used to treat panic disorder include:

1. Antidepressants (SSRIs or SNRIs are the preferred drugs because they are as effective as the other drugs but usually have fewer side effects)
2. Antianxiety drugs such as benzodiazepines (Benzodiazepines work faster than antidepressants but can cause drug dependence).

- Initially, will start of benzodiazepine and antidepressant. When the antidepressant starts working, the dose of benzodiazepine is decreased.
- Exposure therapy and cognitive behavioral therapy are types of psychotherapy, often helps diminish the fear.
- Panic disorder is a chronic disorder with a variable course.
- Appropriate pharmacologic therapy and cognitive-behavioral therapy, are effective in more than 85% of cases.

- About 10-20% of patients continue to have significant symptoms.
- Overall, the long-term prognosis is usually good.
- The suicide rate in individuals with panic disorder is also many times higher than the general population.
- These recommendations may help:
- Get treatment for panic attacks as soon as possible to help stop them from getting worse or becoming more frequent.
- Stick with treatment plan to help prevent relapses or worsening of panic attack symptoms.
- Get regular physical activity, which may play a role in protecting against anxiety.

GENERALISED ANXIETY DISORDER

- Generalized anxiety disorder (GAD) is usually characterized by chronic anxiety unrealistic and excessive anxiety and worry, that is uncomfortable to the point of interfering with daily life.
- A person with GAD worries excessively and feels highly anxious at least 50 per cent of the time for six months or more.

ETIOLOGY OF GAD

- As with many mental health conditions, the exact cause of generalized anxiety disorder isn't fully understood, but it may include genetics as well as other risk factors.

RISK FACTORS-

These factors may increase the risk of developing generalized anxiety disorder:

- Personality. A person whose temperament is timid or negative or who avoids anything dangerous may be more prone to generalized anxiety disorder than others are.

- Genetics. Generalized anxiety disorder may run in families.
- Being female. Women are diagnosed with generalized anxiety disorder somewhat more often than men are.

MEDICAL CONDITION: -

The following medical conditions have been associated to a greater degree with individuals who suffer from GAD than in general population:

- Abnormalities in the hypothalamic-pituitary-adrenal and hypothalamic-pituitary-thyroid axes.
- Acute myocardial infarction.
- Pheochromocytomas.
- Substance intoxication and withdrawal (cocaine, alcohol, marijuana, opioids).
- Hypoglycemia.
- Caffeine intoxication.
- Mitral valve prolapses.
- Complex partial seizures.

SIGN AND SYMPTOMS OF GAD

The symptoms of generalized anxiety disorder fluctuate. You may notice better and worse times of the day. Not everyone with generalized anxiety disorder has the same symptoms. But most people with GAD experience a combination of a number of the following emotional, behavioral, and physical symptoms.

EMOTIONALSYMPTOMS OF GENERALIZED ANXIETY DISORDER

- Constant worries running through your head
- Feeling like your anxiety is uncontrollable; there is nothing you can do to stop the worrying
- Intrusive thoughts about things that make you anxious; you try to avoid thinking about them, but you can’t

- An inability to tolerate uncertainty; you need to know what's going to happen in the future
- A pervasive feeling of apprehension or dread

BEHAVIOURALSYMPTOMS OF GENERALIZEDANXIETYDISORDER
- Inability to relax, enjoy quiet time, or be by yourself
- Difficulty concentrating or focusing on things
- Putting things off because you feel overwhelmed
- Avoiding situations that make you anxious

PHYSICAL SYMPTOMS OF GENERALIZEDANXIETYDISORDER
- Feeling tense; having muscle tightness or body aches
- Having trouble falling asleep or staying asleep because your mind won't quit
- Feeling edgy, restless, or jumpy
- Stomach problems, nausea, diarrhea

DIFFERENCE B/W NORMALWORRY AND GAD NORMAL "WORRY"
- Your worrying doesn't get in the way of your daily activities and responsibilities.
- You're able to control your worrying.
- Your worries, while unpleasant, don't cause significant distress.
- Your worries are limited to a specific, small number of realistic concerns.
- Your bouts of worrying last for only a short time period.

GENERALISED ANXIETY DISORDER
- Your worrying significantly disrupts your job, activities, or social life.
- Your worrying is uncontrollable.
- Your worries are extremely upsetting and stressful.
- You worry about all sorts of things, and tend to expect the worst.
- You've been worrying almost every day for at least six months.

DIAGNOSTIC CRITERIAFOR GAD

To help diagnose generalized anxiety disorder, your health provider may: -
- Do a physical exam to look for signs that your anxiety might be linked to an underlying medical condition
- Order blood or urine tests or other tests, if a medical condition is suspected
- Ask detailed questions about your symptoms and medical history
- Use psychological questionnaires to help determine a diagnosis

DSM-5 criteria for generalized anxiety disorder include:
- Excessive anxiety and worry about several events or activities most days of the week for at least six months
- Difficulty controlling your feelings of worry
- Anxiety or worry that causes your significant distress or interferes with your daily life
- At least three of the following symptoms in adults and one of the following in children: 1. Restlessness,

2. Fatigue,
3. Trouble concentrating,
4. Irritability,
5. Muscle tension or
6. Sleep problems

- Anxiety that isn't related to another mental health condition, such as panic attacks or post-traumatic stress disorder (PTSD), substance abuse, or a medical condition
- Generalized anxiety disorder often occurs along with other mental health problems, which can make diagnosis and treatment more challenging. Some disorders that commonly occur with generalized anxiety disorder include:

- Phobias
- Panic disorder
- Depression
- Substance abuse
- PTSD

TREATMENT AND DRUGS: -

- The two main treatments for generalized anxiety disorder are psychotherapy and medications. You may benefit most from a combination of the two. It may take some trial and error to discover which treatments work best for you.

PSYCHOTHERAPY

- Also known as talk therapy or psychological counselling, psychotherapy involves working with a therapist to reduce your anxiety symptoms. It can be an effective treatment for generalized anxiety disorder.
- Cognitive behavioral therapy is one of the most effective forms of psychotherapy for generalized anxiety disorder. Generally, a short-term treatment, cognitive behavioral therapy focuses on teaching you specific skills to gradually return to the activities you've avoided because of anxiety. Through this process, your symptoms improve as you build on your initial success.

MEDICATIONS The drugs used for GAD will be:

- Benzodiazepines
- Buspirone (anti-anxiety medication)
- Alpidem (Alpidem (Ananxyl) is an anxiolytic drug from the imidazopyridine family, related to the more well-known sleeping medication zolpidem)
- Tricyclic drug or beta-adrenergic antigens (e.g., propranolol).

NURSING MANAGEMENT: -

- The assessment for GAD will be on the basis of following essential features of disorders
- Excessive anxiety and worry about a number of events that the individual finds difficulty to control
- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind “going black”
- Irritability
- Muscle tension
- Sleep disturbance (difficulty – falling or staying asleep or restless, unsatisfying sleep).

NURSING DIAGNOSIS

- Panic anxiety related to real or perceived threat to biological integrity or self- concept evidenced by any or all of the physical symptoms identified by the DSM-IV-TR as being descriptive of GAD.
- Powerless related to impaired cognition evidenced by verbal expressions of no control over life situation and nonparticipation in decision making related to own care or life situation.
- Hopelessness
- Impaired social communication
- Irritability

PLANNING:

The following criteria may be used for measurement of outcomes in the care of the client with GAD. The same may be used as an objective, in which the client:
Is able to recognize signs of escalating anxiety.
Is able to intervene so that anxiety does not reach the panic level.
Is able to discuss long-term plan to prevent panic anxiety when stressful situation occurs.
Practices techniques of relaxation daily.
Engages in physical exercise three time a week
Perform activity of daily living independently.
Express satisfaction for independent functioning.

Is able to maintain anxiety at manageable level without use of medication.
Is able to participant in decision making, thereby maintaining control over life situation. Verbalized acceptance of life situations over with he or she has no control.

IMPLEMENTATION: -

- Maintain safety for the client and the environment.
- Assess own level of anxiety and make a conscious effort to remain calm. Anxiety is readily transferable from one person to another person.
- Recognize the client's use of relief behaviors (pacing writing of hands) as indicators of anxiety. Early intervention helps to manage anxiety before symptoms escalate to more serious levels.
- Inform the client of the important of limiting caffeine, nicotine, and other central nervous system stimulant. Limiting these substances prevents/ minimizes physical symptoms of anxiety, such as rapid heart rate.
- Teach the client to distinguish between that is connected to identifiable objects or sources (illness prognosis, hospitalization known stressors) and anxiety for which there is no immediate identifiable objects or source. Knowledge of anxiety and its related components increases the client control over the disorders.
- Instruct the client in the following anxiety reducing strategies. These helps lessen anxiety in a variety of ways and distract the client from focusing on the anxiety.
- Progressive relaxation technique
- Mindful meditation
- Slow deep-breathing exercise
- Focusing on a single object in the room
- Listening of soothing music and relaxation tapes -Visual imagery or natural related DVD productions

Obsessive compulsive disorder

It is an anxiety disorder. The person has recurring thoughts or images(obsessions) and/or repetitive, ritualistic-type behaviors that the individual is unable to keep from doing(compulsions). The person may try to suppress these thoughts or behaviors but is unable to do so. The individual knows that the thoughts or behaviors are irrational but feels powerless to stop.

Definition

The DSM-IV-TR describes obsessive- compulsive disorder (OCD) as recurrent obsessions or compulsions that are severe enough to be time consuming or to cause marked distress or significant impairment (APA,2000).

Obsessions - It is defined as unwanted, intrusive, persistent ideas, thoughts, impulses or images that cause marked distress.

Compulsions - It denote unwanted repetitive behavior patterns or mental acts that are intended to reduce anxiety, not to provide pleasure or gratification.

Obsessive-Compulsive Disorder Affects almost 3% of world's population. Start anytime from preschool to adulthood. Typically, between 20-24. many different forms of OCD – differ from person to person. cause of OCD is still unknown. Better when diagnosed early.

Classification ICD 9

- F42 OCD
- F42.0 Predominantly obsessive thoughts or ruminations.
- F42.1 Predominantly compulsive acts.
- F42.2 Mixed obsessional thoughts and act.
- F42.8 Other obsessive-compulsive disorder.
- F42.9 obsessive compulsive disorder, unclassified.

Etiology

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

Biochemical influences: A number of studies suggest that the neurotransmitter serotonin (5-HT) may be abnormal in individuals with major obsessive-compulsive disorder.

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

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

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

Clinical features

- Obsessional thoughts
- Obsessional images
- Obsessional rumination
- Obsessional doubts
- Obsessional impulses
- Obsessional rituals

Diagnosis

- Suggested by demonstration of ritualistic behavior that is irrational or excessive.
- MRI and CT shows enlarged basal ganglia in some patients.
- PET scanning shows increased glucose metabolism in part of basal ganglia.
- PET scans indicate differences in brain activity of OCD patients versus normal
- OCD found excessive with other diseases ν Common diseases: Depression, Schizophrenia.
- Depression is the most common
- Many people with OCD suffered from depression first
- 2/3 of OCD patients develop depression makes OCD symptoms worse and more difficult to treat
- People with OCD common diagnosed as Schizophrenic hard to separate obsessions from delusions

Treatment

- Only completely curable in rare cases
- Most people have some symptom relief with treatment
- Treatment choices depend on the problem and patients' preferences
- Most common treatments:
- Behavioral Therapy
- Cognitive Therapy
- Medication (Anxiolytic benzodiazepine)

Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

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

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

Nursing Diagnosis II

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

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

Evaluation

Evaluation of patient with obsessive, compulsive disorder may be done by asking the following questions:
Does the patient continue to display obsessive-compulsive symptoms?
Is the patient able to use newly learned behavior to manage anxiety?
Can the patient adequately perform self-care activities?

REACTION TO STRESS AND ADJUSTMENT DISORDER

This category includes:
Acute stress reaction
Post-traumatic stress disorder (PTSD)
Adjustment disorders.

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

Post-traumatic stress disorder (PTSD):

Post-traumatic stress disorder is characterized by hyperarousal, re-experiencing of images of the stressful events and avoidance of reminders. PTSD is of a reaction to extreme stressors such as floods, earthquakes, wat, rape or serious physical assault. The symptoms may develop after a period of latency, within 6 months after the stress or may be delayed.
The general approach is to provide emotional support, to encourage recall of the traumatic events. Benzodiazepine drugs may be needed to reduce anxiety.

Adjustment disorders: It is characterized by predominant disturbance of emotions and conduct. This disorder usually occurs within one month of a significant life change. Adjustment disorders are one of

the common psychiatric disorders seen in clinical practice. They are most frequently seen in adolescents and women. This disorder usually occurs in those individuals who are vulnerable due to poor coping skills or personality factors. The duration of the disorder is usually less than 6 months.

Treatment

- Antidepressants
- Benzodiazepines
- Supportive psychotherapy
- Crisis intervention
- Stress management training

Dissociative (conversion disorders)

Dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

- This remit after a few weeks or months, particularly if their onset is associated with a traumatic life event.
- Previously been classified as various types of "conversion hysteria".
- It constitutes about 14-20% of the all the neurotic disorders.

Classification

- F44.0 Dissociative amnesia
- F44.1 Dissociative fugue
- F44.2 Dissociative stupor
- F44.3 Trance and possession disorders
- F44.4 Dissociative motor disorders
- F44.5 Dissociative convulsions
- F44.6 Dissociative anesthesia and sensory loss
- F44.7 Mixed dissociative [conversion] disorders
- Other dissociative [conversion] disorders
- F44.9 Dissociative [conversion] disorder, unspecified

F44.0 Dissociative Amnesia

- Most common type
- Mostly in adolescents & young adults.
- Sudden inability to recall important personal information, particularly concerning stressful or traumatic experiences.
- This amnesia is of four types
- Circumscribed Amnesia: – Inability to recall all the personal events during a circumscribed period of time. – Usually corresponding with the presence of stressor.
- Selective Amnesia: – It is similar to CA but there is inability to recall only certain selective personal event in that particular period.
- Continuous Amnesia: – Inability to recall all personal events following the stressful events till the present time.
- Generalized Amnesia: – Inability to recall personal events of whole life, in the face of stressful life events.

F44.1 Dissociative fugue

- Dissociative fugue has all the features of dissociative amnesia, plus purposeful travel beyond the usual everyday range (episodes of wandering away).
- The persons usually adopt a new identity with complete amnesia for the earlier life.
- Onset is usually sudden and often in the presence of stress.

- Termination too is abrupt and is followed by amnesia for the episodes.

F44.2 Dissociative stupor

- Profound absence of voluntary movement and normal responsiveness to external stimuli such as light, noise, and touch, but examination and investigation reveal no evidence of a physical cause.
- In addition, there is positive evidence of psychogenic causation in the form of recent stressful events or problems.

F44.3 Trance and possession disorders

- Temporary loss of the sense of personal identity and full awareness of the surroundings.
- During the episodes the persons personality may be controlled by “Spirit”

F44.4 Dissociative motor disorders

- It is the commonest varieties with either paralysis or abnormal movements.
- The symptoms distribution is according the persons knowledge about the nervous system.
- Examination shows normal or voluntarily increased tone or reflexes.
- Paralysis can be mono, para or quadriplegia.
- Abnormal movements can range from tremors, choreiform movements and gait disturbances.
- These either occur or increase when attention is directed towards them.

F44.5 Dissociative convulsions

- Earlier it is known as hysterical fits.
- Dissociative convulsions may mimic epileptic seizures very closely in terms of movements.
- It is characterized by the presence of convulsive movements and partial loss of consciousness

F44.6 Dissociative anesthesia and sensory loss

- Characterized by sensory disturbances like glove & stocking anesthesia, hemi- anesthesia, blindness or contracted visual fields and deafness.
- Detailed examination shows absence of objective signs.

F44.8 Other dissociative [conversion] disorders

- Ganser's syndrome: – Commonly found in prison inmates. – It is characterized by wrong answers to questions or doing things incorrectly. – other dissociative symptoms such as fugue, amnesia often with visual pseudo hallucinations and a decreased state of consciousness.

F44.8 Other dissociative [conversion] disorders

- Multiple personality: – The person is dominated by two or more personalities of one is being manifest at a time. – One personality is not aware about the existence of others.

Causes

- Psychodynamic Theory: – Primary defense mechanism (Repression) – If the primary defense mechanism fails use secondary mechanism like dissociation & conversion.
- Behavioral theory: – Symptoms are learned response in the face of stress.

Treatment

- Behavior therapy: – Strong suggestion to return to normalcy. – Aversion therapy
- Supportive psychotherapy

- Psychotherapy with abreaction: – Hypnosis – Free association – IV thiopentone or diazepam.
- Drugs: – Very limited role – Short term Benzodiazepines.

Nursing management

• Nursing assessment:
– Behavioral changes such as degree of orientation
– Level of anxiety and possible coexistence of depression
– Degree of impaired social functioning
– History of suicidal gestures or self- mutilation
– Other psychiatric disorders difficult to differentiate from dissociative disorder

NURSING PRIORITIES
1. Provide safe environment; protect client/others from injury.
2. Assist client to recognize anxiety.
3. Promote insight into relationship between anxiety and development of dissociative state/other personalities.
4. Support client/family in developing effective coping skills and participating in therapeutic activities.

SOMATOFORM DISORDERS

These disorders are characterized by repeated presentation with physical symptoms which do not have any physical basis, and a persistent request for investigations and treatment despite repeated assurance by the treating doctors. In these disorders, manifestation of physical symptoms is caused by psychological distress.

These disorders are divided into following categories:
Somatization disorder
Hypochondriasis
Somatoform autonomic dysfunction
Persistent somatoform pain disorder.

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

Hypochondriasis: Hypochondriasis is defined as a persistent preoccupation with a fear or belief of having a serious disease despite repeated medical reassurance.

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

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

Diagnoses

- Physical workup to rule out medical and neurologic conditions.
- Complete patient history with emphasis on current psychological stressors.
- Tests to rule out underlying organic disease

Treatment Modalities

- Drug therapy

  Antidepressants

  Benzodiazepines.

  Psychological treatment:

- Supportive psychotherapy.
- Relaxation therapy.

Nursing Interventions (somatoform)

Before a somatoform determination, a physical examination and diagnostic testing are necessary to rule out any underlying pathology

Create an accepting safe and supportive atmosphere that allows open communication with the patient

Should focus on the whole person, including psychological, social and family factors in addition to the physical symptoms. It must be remembered that they are not consciously trying to be sick or avoid responsibilities.

OTHER NEUROTIC DISORDERS

To ICD10, the other neurotic disorders are neurasthenia, depersonalization-derealization syndrome and culture bound syndromes,

Neurasthenia is characterized by persisting and distressing complaints of increased fatigue after mental or physical effort.

Depersonalization is characterized by an alteration in the perception or experience of self, so that the feeling of temporarily changed or lost. e's own reality is

Derealization is an alteration in the perception or experience of the external world, so that the feeling of reality of external world is temporarily changed or lost.

Dhat syndrome is a culture-bound syndrome, which is prevalent in the Indian subcontinent, characterized by complaint of passage of whitish discharge (Dhat) in urine, multiple somatic symptoms, physical or mental exhaustion, anxiety or depression, and sexual dysfunction.

Treatment

Supportive psychotherapy

Counseling

Antidepressants.

PSYCHOTIC DISORDERS
(SCHIZOPHRENIA, AND MOOD DISORDERS)

HISTORY

Emil Kraepelin, an Eminent Psychiatrist in 1896 formed the concept of "Dementia praecox"

– Mental Deterioration In 1911 Eugen Bleuler coined the term "Schizophrenia" Skhizo - Split, Phren – Mind.

Kurt Schneider described 11 symptoms, Collectively Called as "First Rank Symptoms" (FRS) whose presence / absence of course of brain disease was diagnostic of schizophrenia.

DEFINITION

The schizophrenic disorders are characterized in general by fundamental & characteristic distortions of thinking & Perception, and by inappropriate or blunted affect. The most intimate thoughts, feelings & acts are often felt to be known or shared by others, & Explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts & actions in ways that are often Bizarre.

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, Emotions, Volitions & Faculties in the Presence of clear consciousness, which usually leads to social withdrawal.

ICD – 10 CLASSIFICATIONS

- F 20 – 29 Schizophrenia, Schizotypal & Delusional Disorders
- F20 Schizophrenia
- F20.0 Paranoid Schizophrenia
- F20.1 Hebephrenic Schizophrenia
- F20.2 Catatonic Schizophrenia
- F20.3 Undifferentiated
- F20.4 Post – Schizophrenic Depression
- F20.5 Residual Schizophrenia
- F20.6 Simple Schizophrenia
- F21 Schizotypal Disorder

EPIDEMIOLOGY

It is the most common of all Psychiatric disorders & is prevalent in all cultures across the world. 15% of new admissions in mental Hospitals are schizophrenic patients. Schizophrenic patients occupy 50% of all mental hospital Beds. About 3 – 4 / 1000 in every community suffer from schizophrenia.
About 1% of the general population have the risk of developing this disease in their life time
Equal in Men and Women
About 2/3 of cases are in the age group of 15 – 30 years
Very common in lower Socio – economic groups
MEN WOMEN Peak ages of onset are 15 – 25 years.

ETIOLOGY BIOLOGICAL THEORIES

Biochemical theories- Dopamine Hypotheses An excess of Dopamine – Dependent neuronal activity in the brain may cause schizophrenia Other Biochemical Hypotheses Abnormalities in the Neuro - transmitters (Nor epinephrine, Serotonin, Acetylcholine & Gamma – amino butyric acid [GABA])
Abnormalities in the Neuro - regulators (Prostaglandins & Endorphins)
Neuro structural theories Pre frontal Cortex & Limbic Cortex may never fully develop in the brains of persons with schizophrenia CT & MRI studies of brain structure shows o Decreased brain volume larger lateral & 3rd Ventricles o Atrophy in the Frontal lobe, cerebellum & limbic Structures o Increased size of Sulci on the Surface of brain

Genetic theories

- ♣ More common among people born of Consanguineous marriages
- ♣ Identical twins affected 50%
- ♣ Fragmental twins affected 15%
- ♣ Brother / Sister affected 10%
- ♣ One Parent affected 15%
- ♣ Both Parents affected 35%
- ♣ 2nd Degree Relatives affective 2 - 3%
- ♣ General Population 1%

Perinatal Risk Factors

- Maternal Influenza
- Birth during Late winter / Early spring
- Complications of Pregnancy particularly during Labor & Delivery

PSYCHODYNAMIC THEORIES- Developmental theories According to Freud, In Psychosexual Development Oral Stage – Regression present along with that Denial, Projection & Reaction Formation the Individual have poor ego boundaries, Fragile ego, Inadequate ego development, Super ego Dominance, Regressed id ego, Love – Hate relationships & Arrested Psychosexual Development

Family Theories Mother – Child Relationship: The mothers of schizophrenics as cold, over – protective & Domineering, thus retarding the ego development of the child. Dysfunctional Family System: Hostility between parents can lead to a Schizophrenic Daughter Double – Blind Communication: Parents Convey 2 or more conflicting & incompatible messages at the same time
Stress Vulnerability Model- Social Factors More Prevalent in areas of high social morbidity & Disorganization, especially among members of very low socio economic classes. Stressful life events also can precipitate the disease in Predisposed Individuals

PSYCHOPATHOLOGY
PHASES OF SCHIZOPHRENIA

Prodromal

- Decline in functioning that precedes 1st psychotic episode
- Socially withdrawn, irritable
- Physical complaints
- Newfound interest in religion / the occult Psychotic (acute phase)
- Positive symptoms
- Perceptual disturbances (e.g., auditory hallucinations)
- Delusions (usually secondary, delusion of reference common)
- Disordered thought process / content Residual (chronic phase)
- Occurs between episodes of psychosis
- Marked by negative symptoms (flat affect, social withdrawal)
- Odd thinking and behavior

CLINICAL FEATURES 4A'S OF SCHIZOPHRENIA

AFFECT (Flat/Blunt)
AUTISM
LOOSENING OF ASSOCIATION
AMBIVALENCE SCHIZOPHRENIA

SYMPTOMS
FIRST RANK SYMPTOMS

- θ Audible thoughts,
- θ Voices Arguing,
- θ Voices commenting on 1's action,
- θ Thought withdrawal,
- θ Thought Insertion,
- θ Thought Broadcasting,
- θ Made feelings,
- θ Made Impulses,
- θ Made Volitional acts,
- θ Delusional perception &
- θ Somatic Passivity

Other symptoms

- Thoughts & Speech Disorders
- Autistic Thinking
- Loosening of Association
- Thought Blocking
- Neologism
- Poverty of Speech
- Poverty of Ideation
- Echolalia
- Perseverance (Persistent repetition of words Beyond the Point of relevance)
- Verbigeration (Senseless Repetition of words / Phrases)
- Delusions (Persecution, Grandeur, Reference, Control, Infidelity, Somatic Delusions, Bizarre)
- Over Inclusion (Irrelevant items in speech)
- Impaired Abstraction
- Concreteness
- Ambivalence
- Hallucinations (Auditory, Visual, Tactile, Gustatory, Olfactory)
- Disorders of Affect • Apathy • Emotional Blunting • Emotional Shallowness • Anhedonia • Inappropriate Emotional Response
- Disorders of Motor Behavior • Increase / Decrease in Psychomotor activity • Mannerisms • Grimacing • Stereotypes • Decreased self-care

ABC SYMPTOMS OF SCHIZOPHRENIA, BASED ON CLINICAL FEATURES

A – Autistic Thinking, Ambivalence, Anhedonia
B – Blunted Affect
C – Catatonic Behavior, Concreteness
D – Delusions
E – Echolalia, Echopraxia, Eccentric Behavior, Excitement
F – Functioning in Work Is Decreased, Frank Incoherence
G – Grimacing, Grooming Is Poor, Giggling
H – Hallucinations, Hostility
I – Illogical Thinking, Impulsive Behavior, Irrational Ideas
J – Judgment Is Poor
L – Loosening of Association, Loss of Ego Boundaries and Insight

M – Mannerisms, Made Impulses, Feelings, Volition and Acts
N- Neologisms, Negativism
O – Oddities Behavior
P – Perseveration, Poverty of Speech and Ideation
R – Rigidity
S – Somatic Passivity, Suspiciousness, Stereotypes, Suicidal Ideas, Social Withdrawal.
T – Thought Block, Insertion, Broadcasting, Withdrawal, Thought Echo.
V – Verbigeration, Vague Hypochondriacal Features
W- Waxy Flexibility, Wandering Tendencies

CLINICAL TYPES OF SCHIZOPHRENIA

1. PARANOID SCHIZOPHRENIA

Paranoid means Delusional Paranoid Schizophrenia is at present the most common form of Schizophrenia It is characterized by following features Delusions of Persecution Conspired against, Cheated, spied upon, Followed, Poisoned / Drugged, maliciously maligned, harassed / Obstructed in the pursuit of long-term goals.
Delusions of Jealousy The person's sexual partner is Unfaithful Delusions of Grandiosity Irrational ideas regarding their own worth, talent, knowledge or power, may believe that they have a special relationship with famous persons, Assumption of the identity of a great religious leader Auditory Hallucinations Threaten or command the patient, Hallucinatory voices such as Whistling, humming, laughing
Other Features Disturbance of affect (Blunt), Volition, Speech & Motor Behavior It has good prognosis if treated early Personal deterioration is minimal Patients are productive and can lead a normal life

2. HEBEPHRENIC (DISORGANIZED) SCHIZOPHRENIA

It has an early & insidious onset and is often associated with poor premorbid personality The essential features include, ¬ Thought disorders, ¬ Incoherence ¬ Severe loosening of associations ¬ Extreme social impairment ¬ Delusions & hallucinations are Fragmentary & Changeable
Other oddities of behavior include, • Senseless Giggling, • Mirror gazing, • Grimacing • Mannerisms & so on… The course is chronic & progressively Downhill without significant remissions Recovery Classically never occurs One of the worst prognoses among all the subtypes.

CATATONIC SCHIZOPHRENIA

Cata means Disturbed It is characterized by, marked disturbance of motor behavior, FORMS: ϖ Catatonia Stupor ϖ Catatonia Excitement ϖ Catatonia Alternating between Excitement & stupor
Clinical Features of Excited Catatonia: ϖ Increased Psychomotor activity (Restlessness, Agitation, Excitement, Aggressiveness to at times Violent Behavior) ϖ Increased Speech production ϖ Loosening of Association ϖ Frank Incoherence ϖ Excitement becomes very severe and is accompanied by Rigidity, Pyrexia & Dehydration and can result in death Then it is known as Acute Lethal Catatonia Or Pernicious catatonia.
Clinical Features of Retarded Catatonia (Catatonia Stupor) ♣ Mutism ♣ Rigidity (Maintenance of rigid posture against efforts) ♣ Negativism ♣ Posturing (Voluntary assumption of an inappropriate & Often Bizarre Posture for long Periods of time) ♣ Stupor♣ Echolalia ♣ Echopraxia ♣ Waxy Flexibility (Parts of Body can be placed in positions for a long period of time, even if very uncomfortable) ♣ Ambitendency (A conflict to do or not to do) ♣ Automatic Obedience (Obeys every Command irrespectively)

3. RESIDUAL SCHIZOPHRENIA

Symptoms Include, Emotional Blunting, Eccentric Behavior o Illogical Thinking, Social Withdrawal, Loosening of Associations This category should be used when there has been at least one episode of schizophrenia in the past but without Prominent Psychotic Symptoms at Present.

4. UNDIFFERENTIATED SCHIZOPHRENIA

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

5. SIMPLE SCHIZOPHRENIA

Early & Insidious onset, Progressive Course & Presence of characteristic negative symptoms, Vague Hypochondriacal Features, Wandering Tendency, Self-Absorbed idleness, Aimless activity, It differs from residual schizophrenia in that there never has been an episode with all the typical psychotic symptoms, Prognosis is very poor.

6. POST – SCHIZOPHRENIC DEPRESSION

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

COURSE & PROGNOSIS

The classic course is one of the exacerbations & remissions It described as the most crippling & devastating of all illnesses Several studies have found that over the 5 – 10 years period after the 1st psychiatric Hospitalization for schizophrenia, only about 10 – 20 % of patients as having a good outcome More than50% of patients have a poor outcome, with repeated Hospitalizations.

PROGNOSTIC FACTORS IN SCHIZOPHRENIA GOOD PROGNOSTIC FACTORS POOR

Abrupt or Acute Onset Insidious Onset Later Onset Younger Onset Presence of Precipitating Factors Absence of Precipitating Factors Good Pre-morbid Personality Poor Pre-morbid Personality Paranoid & Catatonic Subtypes Simple & undifferentiated Subtypes Short Duration (<6months) Long duration (>2years) Predominance of Positive Symptoms Predominance of Negative Symptoms Family History of Mood Disorders Family History of Schizophrenia Good Social support Poor Social Support Female Sex Male Sex Married Single, Divorced / Widowed Out-patient treatment Institutionalization

DIAGNOSTIC EVALUATION

History Collection
Physical Examination
Neurological Examination
Mental Status Examination
Blood Investigations (Vitamin Deficiency, Uremia, Thyrotoxicosis, Electrolyte Imbalances, Agranulocytosis)
CT & MRI Scan (Shows Enlarged ventricles,
Enlargement of Sulci on the Cerebral Surface, Atrophy of the Cerebellum)

TREATMENT MODALITIES PHARMACOTHERAPY:

Conventional Anti-Psychotics Chlorpromazine 300-1500mg/day PO ; 50-100mg/day IM Fluphenazine decanoate 25-50mg IM Every 1-3 Weeks Haloperidol 5-100mg/day PO ; 5-20mg/day IM Trifluoperazine 15-60mg/day PO ; 1-5mg/day IM

Commonly Used Atypical Antipsychotics Clozapine 25-450mg/day PO Risperidone 2-10mg/day PO Olanzapine 10-20mg/day PO Quetiapine 150-750mg/day PO Ziprasidone 20-80mg/day PO
Antidepressants (Imipramine, clomipramine, Sertraline, fluoxetine)
Mood stabilizers (Lithium, Carbamazepine, Sodium Valporate) Anxiolytics (Diazepam, Lorazepam)

ELECTROCONVULSIVE THERAPY (ECT) Indications:

- Catatonia Stupor
- Uncontrolled Catatonia Excitement
- Severe Side-effects with drugs
- Schizophrenia Refractory to all other Forms of treatment Usually 8-12 ECTs are needed

PSYCHOLOGICAL THERAPIES

- Psychotherapy
- Group Therapy
- Behavior Therapy
- Social Skills training
- Cognitive Therapy
- Family Therapy

PSYCHOSOCIAL REHABILITATION

Activity therapy to develop work habit
Training in a new Vocation or retaining in a previous Skills
Vocational Guidance
Independent Job Placement

NURSING INTERVENTIONS

Observe behavior pattern, Posturing, Appearance, Psychomotor, Disturbance, Hygiene Identify the type of Disturbance the patient is Experiencing
Ask the patient about feelings while thought alterations are Evident
Note the Effect & Emotional tone of the patient & whether they are appropriate in relation to the thought or present situation
Assess the Speech Patterns associated with the Delusions
Assess for the Theme & Content of Delusional thinking. If the delusion is Persecution oriented, assess the nature of the threat & risk for Violence
Assess the ability to perform Self-care activity (sleep pattern & Interaction with other patients)
Determine any suicidal intent or recent attempts that have been made

NURSING DIAGNOSIS

Disturbed thought Process related to inability to trust, Panic anxiety, Possible Hereditary or Biochemical Factors evidenced by Delusional thinking, Extreme Suspiciousness of others
Ineffective health maintenance related to inability to trust, Extreme suspiciousness evidenced by poor diet intake, inadequate food & Fluid intake, difficulty in falling asleep Self-care deficit related to withdrawal, regression, panic anxiety, cognitive impairment, inability to trust evidenced by difficulty in carrying out tasks associated with hygiene, dressing, grooming, eating, sleeping and toileting
Potential for violence, self-directed or at others, related to command hallucinations evidenced by physical violence, destruction of objects in the environment or self-destructive behavior.
Risk for self-inflicted or life-threatening injury related to command hallucinations evidenced by suicidal ideas, plans or attempts.
Disturbed sensory - perception (auditory / visual) related to panic anxiety, possible hereditary or biochemical factors evidenced by inappropriate responses, disordered thought sequencing, poor concentration, disorientation, withdrawn behavior
Social isolation related to inability to trust, panic anxiety, delusional thinking, evidenced by withdrawal, sad, dull affect, preoccupation with own thoughts, expression of feelings of rejection of aloneness imposed by others.

Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by loosening of associations, echolalia, verbalizations that reflect concrete thinking and poor eye contact. Ineffective family coping related to highly ambivalent family relationships, impaired communication evidenced by neglectful care of the patient, extreme denial or prolonged over concern regarding his illness.

0THER PSYCHOTIC DISORDERS

The term psychosis is defined as gross impairment in reality testing, marked disturbance in personality with impaired social and occupational functioning and presence of characteristic symptoms like delusions and hallucinations

ICD - 10 CLASSIFICATION

- F22 Persistent Delusional Disorders
- F23 Acute and Transient Psychotic Disorders
- F24 Induced Delusional Disorders
- F25 Schizoaffective Disorders Capgras's Syndrome (Delusion Of Doubles)

PERSISTENT DELUSIONAL DISORDERS

It is relatively stable & chronic course, characterized by presence of well systematized delusions of non – Bizarre type The emotional response & behavior of the person is often understandable in the light of Delusions The behavior outside the limits of delusions is almost Normal

CLINICAL FEATURES:

- Persistent Delusions (At least for 3 Months)
- Absence of significant / persistent hallucinations
- Absence of organic mental disorders, Schizophrenia, Mood disorders Very often these individuals are able to carry on a near normal social & occupational life without arousing suspicion regarding the delusional disorder

ACUTE & TRANSIENT PSYCHOTIC DISORDERS

These disorders neither follow the course of schizophrenia nor resemble mood disorders in clinical picture & usually have a better prognosis than schizophrenia The onset is abrupt or acute, associated with identifiable acute stress A complete recovery usually occurs within 2 – 3 months

CLINICAL FEATURES

- Several types of hallucinations, delusions, changing in both type & intensity from day to day or within the same day
- Marked emotional turmoil, which ranges from intense feelings of happiness & ecstasy to anxiety & irritability
- Do not fulfill the criteria for Schizophrenia

INDUCED DELUSIONAL DISORDERS

This is an uncommon Delusional disorder characterized by, Sharing of delusions between usually 2 or occasionally more persons, who usually have a closely knit emotional bond. Only one has the 'Genuine' Delusions due to an underlying psychiatric disorder on separation of the 2, while the dependent individual may give up his delusions, The patient with the 'genuine' Delusions Should then be treated appropriately.

SCHIZOAFFECTIVE DISORDER

In this disorder, the symptoms of schizophrenia & mood disorders are prominently present within the same episode. Types: Schizoaffective disorder – Depressed type schizoaffective disorder – Manic type Schizoaffective Mixed type

CAPGRAS SYNDROME (Delusion of Double)

It is characterized by delusional conviction that the other person in the environment is not their real selves but is their own doubles. It is one of the delusional misidentification syndromes

Treatment:

- Antipsychotics
- Mood stabilizers
- Antidepressants
- ECT
- Supportive Psychotherapy

GERIATRIC CONSIDERATIONS

- Schizophrenia, a severe & persistent mental illness with an onset in early adulthood, is not usually associated with older adults
- Prevalence was thought to decline with aging as a result of early mortality, Decreased symptom severity & recovery
- Late – onset schizophrenia (after 45years), More Prevalent in women than in Men Characterized by Paranoid delusions. It has Varying in degree of Impairment, but the Psychopathology decreases with age
- Psychotic Symptoms that appear in late life are usually associated with depression or dementia, not schizophrenia
- Patients may respond to supportive therapy and low doses of Atypical Antipsychotic Drugs.

PSYCHO EDUCATION

- ❖ Explain the patient & family that schizophrenia is a chronic disorder with symptoms that affect the person's thought process, mood, emotions & Social functions throughout the person's life time
- ❖ Teach the patient & Family About the importance of medication compliance and the therapeutic / Non – therapeutic effects of antipsychotic medications
- ❖ Instruct the patient & Family to recognize impending symptom exacerbation and to notify physician when the patient poses a threat / danger to self or others& requires hospitalization
- ❖ Teach the patient & family to identify Psychosocial / family stressors that may exacerbate symptoms of the disorder & methods to prevent them

REHABILITATION

The focus of psychiatric rehabilitation is strengthening self-care & promoting& improving quality of life through relapse prevention It has improved outcomes by, Providing Community, Family Support Services to decrease hospital Readmission rates & increase Community Integration
Social skills training
Vocational Rehabilitation
Half-Way Homes
Long-term Homes
Closer Supervision
Day Hospitals, etc.

MANIA

Introduction

Mania is a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required).

Meaning of Mania ′The word is derived from the Greek word (mania) meaning "madness, frenzy"

Definition

Mania is an alteration in mood that is characterized by extreme happiness, extreme irritability, hyperactivity, little need for sleep and /or racing thoughts which my lead to rapid, speech.

ETIOLOGY

1. Biological theories genetics first degree relatives' Monozygotic twins' Biochemical influences Excess of nor-epinephrine and dopamine Low serotonin Physiological Right sided lesions in limbic system, temporoorbital areas, basal ganglia, and thalamus. Enlarged ventricles and subcortical white matter
2. Psychosocial theories Both biological and psychosocial factors (such as environmental stressors) may cause mania.
3. The transactional model bipolar disorders mostly results from genetic, biological and psychosocial determinants. The cycle may be directly linked to external stressors. The transactional models consider these stressors as well as past experiences, existing condition and individual's perception of the event.

Classification

According to the symptoms Mania can be classify into 3; these are.

1. Hypomania
2. Acute mania
3. Delirious mania

HYPOMANIA- At this stage the disturbance is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization Mood: ′cheerful and expensive ′Unfulfilled desires will bring irritability ′Nature is volatile and fluctuating.
Cognition and Perception: ′Ideas of great worth and ability ′Flight of ideas ′Easily distracted ′Goal directed activities are difficult Activity and behavior: ′Increases motor activity ′Extroverted and sociable ′Talk and laugh too much, usually very loudly and often inappropriately ′Increased libido ′Anorexia and weight loss in some cases
ACUTE MANIA- Most individual experience marked impairment in functioning and require hospitalization Mood: ′Euphoria and elation ′Mood is variant easily changing to irritability and anger or even sadness and crying
Cognition and Perception: ′Fragmented and often psychotic cognition and perception ′Flight of ideas ′Accelerated pressured speech which abruptly changes from topic to topic ′Speech is disorganized and coherent ′Hallucinations and delusions (usually paranoid and grandiose) ′Attention can be diverted even by small stimuli.
Activity and behavior: ′Excessive psychomotor activity ′Increased sexual interest ′Poor impulse control manipulate others to carry out their wishes, and if things go wrong very skillfully project responsibility for the failure onto others ′Need for sleep is diminished ′Extremely energetic.
′May go for many days without sleep and still don't feel tired ′Neglected hygiene and grooming ′Dress may be disorganized, flamboyant or bizarre ′Excessive makeup or jewelry.

DELIRIOUS MANIA- Severe form of mania with clouding of consciousness and intensification of the symptoms associated with acute mania Mood: ′Labile ′May show Feelings of despair, quickly converting to unrestrained merriment and ecstasy ′Irritable or indifferent to the environment ′Panic anxiety may be evident
Cognition and perception: ′Clouding of consciousness ′Confusion, disorientation and sometimes stupor ′Religiosity ′delusions of grandeur or persecution ′Auditory or visual hallucinations ′Extremely distractible and incoherent.

Activity and Behaviour: ′Psychomotor activity is frenzied and characterized by agitated, purposeless movements ′Safety of these individuals is at stake unless this activity is curtailed ′Exhaustion, injury to self or others and eventually death could occur without intervention

DIGNOSTIC EVALUTIONS

1. Psychological tests such as young mania rating scale
2. ICD 10 diagnostic criteria

Signs and symptoms

1. Elevated expansive or irritable mood Stages of elevated mood ′
   Euphoria (stage l) : increased sense of psychological wellbeing and happiness ′ Elation(stage ll) : moderate elevation of mood with increased psychomotor activity ′
   Exaltation (stage lll) : intense elevation of mood with delusion of Grandeur ′ Ecstasy(stage lV) : severe elevation of mood. Intense sense of blissfulness.
2. Psychomotor activities: ′ Increased psychomotor activity ranging from over activeness to manic excitement
3. Speech and Thought: ′ Flight of ideas ′ Pressure of speech ′ Delusion of Grandeur ′ Delusion of Persecution ′ Distractibility 19

Other Features:

- Increased sociability
- Poor judgement
- High risk activities
- Decreased need for sleep(<3hrs)
- Decreased food intake
- Decreased attention
- Poor judgement
- Absent insight

Treatment modalities -There are basically 3 types treatment modalities; ′

Pharmacological treatment
Psycho - social Treatments
ECT

PHARMACOLOGICAL TREATMENT

- Mood stabilizers (anti-manic drugs)
- lithium (900-2100mg/day)-drug of choice
- carbamazepine (200-1600mg/day)
- Sodium valproate (600-2600mg/day)
- Anticonvulsants: Clonazepam (0.5-20mg/day)
- Calcium channel blockers: Verapamil(80-320mg)
- Antipsychotics: Olanzapine(10-20mg)
- Chlorpromazine(75-400mg)

Psycho-Social Treatment

1. Family Therapy
2. Cognitive Therapy
3. Individual Psychotherapy
4. Group Therapy

Electro-Convulsive Therapy ′ ECT can also be used for acute manic excitement , if not adequately responding to antipsychotics and Lithium

NURSING ASSESSMENT

1. NURSING DIGNOSIS

1. Risk for injury related to extreme hyperactivity and impulsive behaviour, as evidenced by lack of control over purposeless and potentially injurious movements
2. Impaired social interaction related to short attention span, high level of distractibility and labile mood, as evidenced by insufficient or excessive quantity or ineffective quality of social exchange
3. Ineffective coping skills related to poor impulse control evidenced by acting out behaviour
4. Disturbed thought process related to disorientation and decreased concentration as evidenced by disruption in activities
5. Altered family process related to euphoric mood and grandiose ideas, manipulative behaviour as evidenced by changes in family relationships.

2. Nursing intervention

- Develop a relationship with the person based on empathy and trust.
- Ensure that the person remains free from injury.
- Assist the person to decrease their agitation and hyperactivity.
- Promote positive health behaviors, including medication compliance and healthy lifestyle
- 'Promote the person's engagement with their social and support network. 'Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self-care activities for families and cares of the person with mania.

DEPRESSION

INTRODUCTION

- Depression is an affective disorder.
- Affective disorders: mental illnesses characterized by pathological changes in mood.
- Depression: pathologically depressed mood.

DEFINITION

- DEPRESSION (By WHO): Common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self- worth, disturbed sleep or appetite, low energy, and poor concentration.

EPIDEMIOLOGY

- Globally more than 350 million people of all ages suffer from depression. (WHO)
- For the age group 15-44 major depression is the leading cause of disability in the U.S.
- Women are nearly twice as likely to suffer from a major depressive disorder than men are.
- With age the symptoms of depression become even more severe.
- About thirty percent of people with depressive illnesses attempt suicide.

ETIOLOGY

- Genetic cause
- Environmental factors
- Biochemical factors: Biochemical theory of depression postulates a deficiency of neurotransmitters in certain areas of the brain (noradrenaline, serotonin, and dopamine).
- Dopaminergic activity: reduced in case of depression, over activity in mania.
- Endocrine factors - hypothyroidism, Cushing's syndrome etc.

- Abuse of Drugs or Alcohol
- Hormone Level Changes
- Physical illness and side effects of medications DRUGS
- Analgesics
- Antidepressants
- Antihypertensives
- Anticonvulsants
- Benzodiazepine withdrawal
- Antipsychotics

PHYSICAL ILLNESS

- Viral illness
- Carcinoma
- Neurological disorders
- Thyroid disease
- Multiple sclerosis
- Pernicious anemia
- Diabetes
- Systemic lupus erythematosus
- Addison's disease

CLINICAL MANIFESTATIONS

- Thinking is pessimistic and, in some cases, suicidal.
- In severe cases psychotic symptoms such as hallucinations or delusions may be present.
- Insomnia or hypersomnia, libido, weight loss, loss of appetite.
- Intellectual or cognitive symptoms include a decreased ability to concentrate, slowed thinking, & a poor memory for recent events.

DIAGNOSIS

- ICD 10 Diagnostic criteria for a depressive episode {who} USUAL SYMPTOMS
- Depressed mood.
- Loss of interest and enjoyment.
- Reduced energy leading to increased fatiguability and diminished activity.

COMMON SYMPTOMS

- Reduced concentration and attention.
- Reduced self-esteem and self-confidence.
- Ideas of guilt and unworthiness.
- Bleak and pessimistic views of future.
- Ideas or acts of self-harm or suicide.
- Disturbed sleep.
- Diminished appetite.

MILD DEPRESSIVE EPISODE

- For at least 2 weeks, at least two of the usual symptoms of a depressive episode plus at least two common symptoms.

MODERATE DEPRESSIVE EPISODE

- For at least 2 weeks, at least two or three of the usual symptoms of a depressive episode plus at least three of the common symptoms.

SEVERE DEPRESSIVE EPISODE

- For at least 2 weeks all three of the usual symptoms of a depressive episode plus at least 4 of the common symptoms some of which should be of severe intensity.

INVESTIGATIONS

- RATING SCALES-Beck depression inventory o Hamilton depression rating scale
- DEXAMETHASONE SUPPRESSION TEST

TREATMENT ANTIDEPRESSANTS

1. MAO inhibitors:
- Irreversible: Isocarboxazid, Iproniazid, Phenelzine and Tranylcypromine.
- Reversible: Moclobemide and Clorgyline.
2. Tricyclic antidepressants (TCAs)
- NA and 5 HT reuptake inhibitors: Imipramine, Amitryptiline, Doxepin, Dothiepin and Clomipramine.
- NA reuptake inhibitors: Desimipramine, Nortryptyline, Amoxapine.
3. Selective Serotonin reuptake inhibitors:
- Fluoxetine, Fluvoxamine, Sertraline and Citalopram
4. Atypical antidepressants:
- Trazodone, Mianserin, Mirtazapine, Venlafaxine, Duloxetine, Bupropion and Tianeptine
5. MAO Inhibitors
- Drugs act by increasing the local availability of NA or 5 HT.
- MAO is a Mitochondrial Enzyme involved in Oxidative deamination of these amines.
- MAO-A: Peripheral nerve endings, Intestine and Placenta (5-HT and NA).
- MAO-B: Brain and in Platelets (Dopamine).
- Selective MAO-A inhibitors (RIMA) have antidepressant property (e.g.: Moclobemide).
- Side effects: postural hypotension, weight gain, atropine like effects and CNS stimulation.
- Severe hypertensive response to tyramine containing foods-cheese reaction
- Drug interaction: Ephedrine, Reserpine.
- Moclobemide (Rimarex): 150 mg BDS-TDS Max: 600 mg/day
- Less ADR as compared to irreversible MAOI

6. TCAs • NA, 5 HT and Dopamine are present in Nerve endings
- Normally, there are reuptake mechanism and termination of action.
- TCAs inhibit reuptake and make more monoamines available for action.
- In most TCA, other receptors (incl. those outside the CNS) are also affected: blockade of H1-receptor, Alpha-receptors, M-receptors.
- Imipramine (depsonil) : 50- 200 mg/day - antidepressant action starts after few weeks, whereas blockade starts immediately
- Amitryptyline (tryptomer) : 50- 200 mg/day
7. SSRIs • First line drug in depression.
- Relatively safe and better patient acceptability.
- Some patients not responding to TCAs may respond with SSRIs.
- SSRIs inhibit the reuptake mechanism and make more 5 HT available for action.
8. Relative advantages:
- No sedation, so no cognitive or psychomotor function interference
- No anicholinergic effects
- No alpha-blocking action, so no postural hypotension and suits for elderly
- No seizure induction
- No arrhythmia λ Drawbacks
- Nausea is common
- Interfere with ejaculation
- Insomnia, dyskinesia, headache and diarrhea
- Impairment of platelet function – epistaxis
9. SSRIs – Pharmacokinetic comparison
10. Atypical antidepressants

NON – PHARMACOLOGIC THERAPY

- LIFESTYLE CHANGES

- o Stress reduction
- o social support
- o Sleep
- PSYCHOTHERAPY
- o Cognitive behavioral therapy
- o Interpersonal therapy
- o Psychodynamic therapy
- ELECTROCONVULSIVE THERAPY
- o Safe & effective disorder for all subtypes of major depressive disorder.
- o ADR: Cognitive dysfunction, cardiovascular dysfunction, prolonged apnea etc.

Bipolar Affective Disorder

Bipolar disorder Bipolar disorder (BD) : >(also called Manic Depression or Manic- Depressive Disorder), an unstable emotional condition characterized by cycles of abnormal, persistent high mood (mania) and low mood (depression),at least of two episodes.

1. Age of onset: First episode at any age from child hood to old age.
2. Duration: Maniac episode lasts for 2weeks to 4 months and depression: 6months rarely for one year.
3. Mania- Mania, is a state of abnormally elevated arousal, affect, and energy level, or "a state of heightened overall activation with enhanced affective expression together with lability of affect. υThe symptoms are heightened mood (either euphoric or irritable); flight of ideas and pressure of speech; and increased energy, decreased need for sleep, and hyperactivity.
4. Hypomania- Hypomania (literally "under mania" or "less than mania") is a mood state characterized by persistent disinhibition and elevation (euphoria). Hypomania is distinct from mania in that there is no significant functional impairment.
5. Bipolar I: Bipolar I is distinguished by the presence or history of one or more manic episodes or mixed episodes with or without major depressive episodes.
6. Bipolar II: Bipolar II consisting of recurrent intermittent hypomanic and depressive episodes or mixed episodes.
7. Bipolar Disorder Not Otherwise Specified (BD-NOS)- Bipolar Disorder Not Otherwise Specified (BD-NOS), sometimes called "sub-threshold" bipolar, indicates that the patient suffers from some symptoms in the bipolar spectrum (e.g., manic and depressive symptoms) but does not fully qualify for any of the three formal bipolar mentioned above.
8. Management-
   - Pharmacotherapy
- Electroconvulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS): Focal stimulation of brain in patients who are awake.
- Deep brain stimulation: it is an invasive technique implanting electrode in brain followed by the stimulation of particular area.
- Neurofeedback: Self-regulation technique.
- Bright light therapy: used for depressive disorder.
- Psychotherapy: CBT, IPT, Family therapy
- Behavioural activation therapy
- Relapse prevention strategies

Organic Brain Syndrome

Definition

Organic Mental Disorders are a group of disorders caused by "demonstrable" organic pathological conditions affecting the brain.

These conditions may affect the brain directly (e.g., trauma, infection, tumor or degeneration) or they may be secondary to systemic diseases (e.g., metabolic, endocrine or toxic.

THERE ARE TWO MAJOR CATEGORIES OF O.M.D.:

A. Cognitive disorders: 1 - Delirium 2- Dementia 3- Amnestic disorders

B. Mental disorders secondary to general medical conditions: 1-Organic hallucinosis, 2-Organic mood disorders, 3-Organic anxiety disorder, 4-Organic delusional disorder, 5-Organic personality and behavioral disorders,

ETIOLOGY OF ORGANIC MENTAL DISORDERS A wide range of organic pathological conditions can produce Organic Mental Disorders, including:

1- Head trauma
2- Brain infections, tumors, cerebrovascular or degenerative diseases
3- Metabolic disorders
4- Nutritional deficiencies
5- Toxins
6- Substance-related disorders

DELIRIUM

Definition- Delirium is an acute reversible state of global cortical dysfunction characterized by disturbance of consciousness. It is associated with global impairment of cognitive functions as well as other mood and behavioral changes.

CLINICAL FEATURES OF DELIRIUM

1. Disturbance of consciousness
2. Global disturbance of cognitive functions including: a. Attention b. Memory c. Perception d. Orientation
3. Other manifestations: a. Emotional disturbances b. Psychomotor behavior c. Sleep-wake cycle

ONSET, COURSE AND PROGNOSIS OF DELIRIUM Onset is acute or rapid (over hours or days). Course shows typical diurnal fluctuations of symptoms with nocturnal worsening. Prognosis: It is a transient condition that resolves within days to few weeks if the cause is treated.
EPIDEMIOLOGY OF DELIRIUM 10% of hospitalized surgical or medical patients. 30% of ICU patients. Elderly and young children more susceptible. Equal prevalence in males and females

ETIOLOGY

1. Head trauma
2. Metabolic and endocrine disorders
3. Substance related
4. Medication induced
5. Toxins
6. Severe anemia and vitamin deficiency
7. Postsurgical conditions
8. Infections
9. Cerebrovascular strokes
10. Epilepsy
11. Multifactorial

MANAGEMENT OF DELIRIUM

1- Treatment of the cause
2- Supportive measures
3- Providing optimum sensory environment
4- Symptomatic treatment for anxiety, agitation or psychotic symptoms

DEMENTIA

Definition- A syndrome characterized by multiple cognitive defects including disturbance of memory, without disturbance of consciousness. The syndrome results from organic diseases of the brain that are usually of a chronic and progressive nature.

CLINICAL FEATURES OF DEMENTIA

1. Multiple cognitive defects: a. Memory impairment: b. Other cognitive disturbances: Aphasia, Apraxia, Agnosia Disturbance of executive functions Disturbed attention, perception and orientation
2. Associated deterioration of other functions: a. Impaired emotional control b. Depression and anxiety c. Impairment of judgment d. Psychotic symptoms 3. Associated neurological manifestations: a. Usually late b. Various sensory and motor manifestations c. incontinence and bedridden.

ONSET, COURSE AND PROGNOSIS OF DEMENTIA- Onset is usually insidious, over months or years. Course is usually chronic and progressive (over years) ending in death. Prognosis: irreversible. Some types may be reversible (15%), if the cause is treatable (e.g., endocrine or metabolic causes).

EPIDEMIOLOGY OF DEMENTIA- 5% of elderly over 65 years. 20% of elderly over 80 years. 15% are reversible if the cause is treatable

ETIOLOGY OF DEMENTIA

1. Degenerative diseases: a. Alzheimer's disease b. Pick's disease c. Parkinson's disease d. Wilson's disease
2. Hereditary Dementia, e.g., Huntington's disease
3. Demyelinating disease, e.g., multiple sclerosis
4. Cerebrovascular disease
5. Chronic Infections
6. Trauma to brain
7. Tumor
8. Metabolic disorders,
9. Drugs & toxins (chronic exposure)

MANAGEMENT OF DEMENTIA- Treatment of the cause in reversible types. treatment for irreversible types. Some medications (anticholine-esterase inhibitors) may help delay memory and cognitive decline. Supportive measures Symptomatic treatment for agitation, insomnia, psychotic

COMMON TYPES OF DEMENTIA ® Alzheimer disease (50-60% of all dementias) ® Vascular dementia(15-30% of all dementias)

1. ALZHEIMER DISEASE Onset, Course & Prognosis: Onset: may be late (after age 65) or early (before 65). Gradual onset, progressive course and death within 2- 8 years from onset
   Clinical Features: gradual memory impairment followed by deterioration of other cognitive aspects. Same symptoms of dementia.

ETIOLOGY OF ALZHEIMER DISEASE Genetic factors plays a major role:

- Familial in 40% of cases
  Significantly more in monozygotic than dizygotic twins
  Related to Down syndrome

2. VASCULAR DEMENTIA

- More common in males
- Onset earlier than Alzheimer's disease
- Course: * Onset may be acute. *Course usually "stepwise" as it reflects recurrent infarcts.

Clinical Features:

* Focal neurological manifestations
* Patchy cognitive impairment
* Pathology: Cerebral infarction and multiple areas of neuronal loss

Etiology: Risk factors include:

* Cardiovascular disease (hypertension, heart disease)
* Cerebrovascular disease (atherosclerosis, embolic or thrombotic occlusion, hemorrhage)

Management: same like dementia

3. AMNESTIC DISORDERS - They are isolated disturbances of memory. They involve recent memory and remote memory which lead to inability to learn new information or recall previously learned information. Immediate recall remains intact.

ETIOLOGY OF AMNESTIC DISORDERS- They are due to pathological conditions causing damage of certain diencephalic (thalamic) and mid temporal structures, (e.g., hippocampus, mamillary bodies and fornix).

COMMON CAUSES OF AMNESTIC DISORDERS

1. Korsakoff's syndrome
2. Head trauma
3. Cerebrovascular disease
4. Brain tumor
5. Brain surgery
6. Systemic conditions: e.g., hypoxia (CO poisoning) and hypoglycemia
7. Substance related

Personality Disorders

PERSONALITY- The totality of emotional and behavioral characteristics that are particular to a specific person and that remain somewhat stable and predictable over time PERSONALITY TRAITS…enduring patterns of perceiving, relating and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. (APA, 2000)

PERSONALITY DISORDERS- Personality disorders are diagnosed when personality traits become inflexible and maladaptive and significantly interfere with how a person function in society or cause the person emotional distress.

Cluster A: People whose behavior appears odd or eccentric

- Paranoid personality disorder.
- Schizoid personality disorder.
- Schizotypal personality disorder.

Cluster B: People who appear dramatic, emotional, or erratic

- Antisocial personality disorder.
- Borderline personality disorder.
- Histrionic personality disorder.
- Narcissistic personality disorder.

Cluster C: People who appear anxious or fearful

- Avoidant personality disorder.
- Dependent personality disorder.
- Obsessive-compulsive personality disorder.

1. Cluster A

(1) Paranoid Personality Disorder

It is having "Schizophrenic-continuum According to ICD-10, the diagnostic guide lines for paranoid personality disorder include the following features:

(a) Over sensitivity
(b) Tendency to bear grudges
(c) Suspiciousness: Without justification, regarding sexual fidelity of the spouse and sexual partner
(d) Secretive
(e) Withholding
(f) Jealous
(g) Harming

Diagnosis

Paranoid personality disorder is found morbidly in some patients of paranoid schizophrenia.

Differential Diagnosis

■ Delusional (paranoid).

Treatment

(a) Individual psychotherapy
(b) Supportive psychotherapy

The response of treatment is very poor. Drug treatment has a limited role,

(ii) Schizoid Disorder

According to the ICD-10, the diagnostic guidelines for schizoid personality disorder include the following features:

(a) Emotional coldness (anhedonia)
(b) Reserve
(c) Little experience with others (sexual experience). (e) Lack of close and confiding relationship.
(e) Few, if any, activities and provide pleasure.
(f) Detachment or flattened affectivity.
(g) Limited capacity to express either warm, tender feelings or anger towards the others.
(h) Apparent indifference to either praise or criticism.
(i) Marked insensitivity to prevailing social norms and conventions.

Treatment

(a) Individual psychotherapy.
(b) Psychoanalysis.
(c) Gradual involvement in group psychotherapy.

The patients often do not seek treatment on their own. Their response to their treatment is usually not good. Drug treatment has a very Acc limited role.

(iii) Schizotypal Disorder

According to the ICD-10, this disorder is not classified under specific personality disorders but instead along with schizophrenia. The clinical features are as follows:

(a) Inappropriate or constricted affect (the individual: appears cold and aloof),
(b) Behaviour or appearance that is odd. eccentric or peculiar.
(c) Poor rapport with others and tendency to social withdrawal.
(d) Difficulty in feeling understood and accepted.

Cluster B (dramatic, emotional, erratic)

antisocial personality disorder.

Antisocial personality disorder is characterized by chronic antisocial behavior that violates other rights or social norms which predisposes the affected person to the criminal behavior

The person is unable to maintain the consistent, responsible functioning at work, school or as a parent.

SIGN AND SYMPTOMS

- Failure to sustain the relationship.
- Impulsive actions.
- Low tolerance to frustration.
- Tendency to cause violence.
- Lack of guilt
- Inability to maintain close personal or sexual relationship

Histrionic personality disorder.

- Patient with this disorder is characteristically have a pervasive pattern of excessive emotionality and attention seeking behavior and are drawn to momentary excitement and fleeting adventure.
- This disorder is most common in female.
- People with this disorder need to be the center of attention at all time

SIGN AND SYMPTOMS

- Dramatic emotionality (emotional blackmail, angry scenes, demonstrative suicide attempts.)
- Attention seeking behavior.
- Lack of considerations for other
- Self-dramatization.

Narcissistic personality disorder.

- Patient with Narcissistic personality disorder is self-centered, self-absorbed and lacking in empathy for others.
    - He typically takes advantages of people to achieve his own ends, and uses them without regards to their feelings.

SIGN AND SYMPTOMS:

- Attention seeking
- Dramatic behavior
- Unable to face criticism.
- Lack of empathy.
- Arrogances.
- Exploitative behavior

Borderline personality disorder

- Borderline personality disorder is marked by a pattern of instability in interpersonal relationship, mood, behavior, and self-image.

The 4 main categories of SIGN AND SYMPTOMS are,

- Unstable relationship.
- Unstable self-image
- Unstable emotions
- Impulsivity.

Other S/S includes,

- Lack of control of anger.
- Recurrent suicidal threats or behavior.
- Uncertainty about personal identity.
- Chronic feeling of emptiness

Cluster C (anxious and fearful)

Avoidant personality disorder

- People with this disorder have low self-esteem, and self-confident, they will be negative and have a difficulty in viewing situation and interactions objectives.

SIGNS AND SYMPTOMS

- Fear of disapproval or rejection.
- Unwillingness to become involved with people.
- Shyness.
- Insecurity.
- The persons having this disorder also have other psychiatric disorder like – social phobia, anxiety disorder, OCD, depressive disorder, somatoform disorder, etc.

Dependent personality disorder

- This disorder is characterized by an extreme need to be taken care of, which leads to submissive and fear of separation or rejection. • People with this disorder, let other make important discussion for them and have a strong need for constant reassurance and support

SIGN AND SYMPTOMS:

- Feeling uncomfortable and helplessness.
- Inability to make decisions.
- Low self-esteem and lack of self-confidence.
- Hypersensitivity.

Obsessive compulsive personality disorder:

- The individual places a great deal of pressure on himself and other not to make a mistake.
- Believes his way of doing something is the only correct way, may force himself and others to follow right moral principles.

SIGN AND SYMPTOMS

- Feeling of excessive doubt and caution.
- Perfectionism.
- High standards

TREATMENT

ANXIOLYTIC DRUGS:

- To treat severe stress, - Alprazolam - Ativan - Librium
- Diazepam, etc.

NEUROLEPTIC DRUGS: ANTIPSYCHOTIC

- It can be useful in case of paranoid and schizotypal personality disorder. - Olanzapine - Haloperidol – Droperidol

PSYCHODYNAMIC TREATMENT: • It's also known as the insight-oriented therapy, focuses on unconscious processes as they are manifested in a person's present behavior.

- The goal of psychodynamic therapy is a client's self-awareness and understanding of the influence of the past on present behavior

COGNITIVE AND BEHAVIOUR TEHRAPY

- Most cognitive behavioral approaches address specific aspects of thought, feelings, behavior, or attitude and do not claim to treat the entire personality disorder of the person.

CHILDHOOD DISORDERS

Classification

F70-F79: Mental retardation

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Severe mental retardation

F73 Profound mental retardation

F80-F89: Disorders of psychological development

F80 Specific developmental disorders of speech and language

F81: Specific developmental disorders of scholastic skills

F82: Specific developmental disorder of motor function
F83 Mixed specific developmental disorders
F84 Pervasive developmental disorders

F90-F98 Behavioral and emotional dis orders with onset usually occur ring in childhood and adolescence
F90: Hyperkinetic disorders
P91 Conduct disorders
F93 Emotional disorders with onset specific to childhood
F94: Disorders of social functioning with onset specific to childhood and adolescence
F95 Tic disorders
F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

DEVELOPMENTAL DISORDER

- Developmental disorders are a group of psychiatric conditions originating in childhood that involve serious impairment in different areas

Causes

- Environment
- Genetics
- Stress in early childhood

Types

- Learning disabilities
- Communication disorder
- Autism spectrum disorders
- Attention deficit hyperactivity disorder (ADHD)
- Developmental coordination disorder

Learning Disabilities

- Learning disabilities are disorders that affect one's ability to understand or use spoken or written language, do mathematical calculations, coordinate movements or direct attention.
- Not all learning problems fall into the category of learning disabilities. Many children are simply slower in developing certain skills

Kinds of Learning Disabilities

- Dyslexia is a reading and language-based learning disability, With this problem, a child may not understand letters, groups of letters, sentences or paragraphs.
- Dysgraphia is a term for problems with writing. An older child may not form letters correctly, and there is difficulty writing within a certain space.
- Dyscalculia is a term for problems concerning math.
- Information-processing disorders are learning disorders related to a person's ability to use the information that they take in through their senses - seeing, hearing, tasting, smelling, and touching.

Communication Disorder

- Communication disorders include problems related to speech, language and auditory processing.
- Some causes of communication disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, emotional or psychiatric disorders, and developmental disorders. Frequently, however, the cause is unknown

Autism Spectrum Disorder

- Autism spectrum disorder (ASD) is a lifelong development disability characterized by difficulties in social interaction, communication, restricted and repetitive interests and behaviors, and sensory sensitivities.
- Core problems –

1) Difficulty with socialization and communication;
2) Odd interests and behavior; and finally,
3) Problems with attention and self-regulation

.

Causes

- Genes
- Environmental triggers
- Other health conditions
- muscular dystrophy – a group of inherited genetic conditions that gradually cause the muscles to weaken
- Down's syndrome – a genetic condition that typically causes a learning disability and a range of physical features
- cerebral palsy – conditions that affect the brain and nervous system, causing problems with movement and co-ordination
- infantile spasms – a type of epilepsy that develops while a child is still very young (usually before they're one year old)
- neurofibromatosis – a number of genetic conditions that cause tumors to grow along the nerves (the main types are neurofibromatosis type 1 and neurofibromatosis type 2)
- the rare genetic conditions fragile X syndrome, tuberous sclerosis and Rett syndrome

Attention Deficit Hyperactive Disorder (ADHD)

- ADHD, or attention-deficit hyperactivity disorder, is a behavioral condition that makes focusing on everyday requests and routines challenging.
- People with ADHD typically have trouble getting organized, staying focused, making realistic plans and thinking before acting. They may be fidgety, noisy and unable to adapt to changing situations.
- Children with ADHD can be defiant, socially inept or aggressive.

Developmental Coordination Disorder

- also known as developmental dyspraxia is a chronic neurological disorder beginning in childhood that can affect planning of movements and co-ordination as a result of brain messages not being accurately transmitted to the body

Symptoms

- have difficulty moderating the amount of sensory information that their body is constantly sending them.
- Poor memory
- Poor sense of direction
- Poor motor control

Treatment for developmental disorder

- treatment approaches
- Clinical therapies
- Complementary therapies
- Biomedical treatments
- Family support
- Service delivery models

Pervasive Developmental Disorders

- characterized by deficits and delays
- In social and communicative development, which are associated with restricted patterns of interest and behaviour.

Pervasive Developmental Disorders

- Autistic disorder (childhood autism);
- Rhett’s disorder;
- Childhood disintegrative disorder;

- Asperger's syndrome;
- pervasive developmental disorder not otherwise specified (PDD-NOS, atypical autism)

Childhood Autism
- Classical autism is characterized by difficulties in 3 areas
- "triad of impairment"
- Social deficit
- Communication deficit
- Restricted/ repetitive interests and behavior

Social deficits
- Babies who don't like being held
- Reduced eye contact
- Unusual facial expressions
- Lack of gesture
- Poor understanding of other's feelings
- Lack of empathy
- Few peers relationships
- Child does not respond to affection

Communicate deficits
- May be completely absent speech
- Merely show unusual or asocial qualities
- Echolalia
- Odd prosody (unusual pitch/ stress/ rhythm/ intonation)
- Pronoun reversal (referring themselves as he or she)
- They have problems in 2-way conversations

Restricted/ repetitive interest & behaviours
- Show a deep interest in things others regard as very mundane
- Washing machines / license plates
- Reject other toys
- Stereotypies
- Repetitive movements often triggered by stress
- Hand flapping / head rolling
- Self harming is not uncommon
- Includes biting and hitting

Clinical features
- Must be present by 3 years in older to diagnose

Epidemiology Diagnosis Prevelance Gender Ratio (male: female)
Overall pervasive developmental disorders 2 per 1000 4:1
Autism 13 per 10 000 4:1
Asperger's syndrome 1 per 2000 4-20 :1
Rett's syndrome 1 per 12-15000 Females only
Childhood disintegrative disorder 1 per 12 000 Unknown but males predominate

ICD 10 Childhood autism
- A type of pervasive developmental disorder that is defined by: a. the presence of abnormal or impaired development that is manifest before the age of 3 years; b. the characteristic type of abnormal functioning in all the three areas of psychopathology: reciprocal social interaction, communication, and restricted, stereotyped, repetitive behaviour.

- In addition to these specific diagnostic features, a range of other non-specific problems are common, such as
- Phobias,
- sleeping and eating disturbances,
- temper tantrums, and (self-directed) aggression.

Differential Diagnosis
- Asperger's syndrome
- Deafness
- Specific developmental language disorder
- Learning disability

etiology
- Multifactorial with a strong polygenic genetic component
- Genetic factors
- Twins – 90% heritability
- If a sibling has autism – 2-20% change of other getting the disease
- Organic brain disorders
- Seizures +
- Cognitive abnormalities
- Symbolic thinking and language
- Inability to judge correctly what other people are thinking
- Abnormal parenting has not been shown to be a case

Asperger's syndrome
- Characteristic impairment in social interaction, &
- Repetitive behaviors or restricted interests
- But has normal speech & intellectual abilities

Characteristics
- Developmentally appropriate speech & language
- Unusual use of language (prosody, abnormal rate/rhythm/volume, novel works)
- Motor clumsiness
- Unusually deep interest in one particular topic
- rigid behaviour and stereotypes
- Social awkwardness
- Difficulty in making close friends
- Often shows high level performance in one interested topic
- Does not become obvious until around 4-8 years
- Autism can diagnose before this age

Co-morbidities
- Mood disorders
- Anxiety disorders
- Associate with
- Tics
- Tourette's syndrome
- ADHD
- OCD
- Bipolar disorder

Course & prognosis
- Majority can go to normal schools
- Some extra classroom support may need

- In interested areas
- Can show outstanding performance

Rett's syndrome

- Rare developmental disorder of females
- Resembles neurodegenerative disorder
- Thought to be caused by a mutation in genes on X-chromosome
- They usually develop normally until 6-8 months
- Then start to regress developmentally
- They loss speech
- Purposeful hand movements
- Motor skills
- Head growth – stops
- Stereotypies starts to develop
- Handwashing
- Bruxism
- flapping
- Breathing problems are common
- Hyperventilation
- Breath holding
- Sighing
- Help in distinguish between autism
- Physical problems are abundant
- Epilepsy (80%)
- Constipation
- Poor growth
- Scoliosis
- Cardiac & motor problems
- Average life expectancy -30 years

Childhood disintegrative disorder

- Entirely normal development for the 1st 2 years
- Followed by marked regression &
- Loss of skills in multiple areas of development over a few months
- Develops deficits in
- Social skills
- Communication skills
- Repetitive/restrictive interests & behaviour

Management of PDD

- PDD/ASDs will never be curative
- General measures
- Psychoeducation
- Finding an appropriate educational setting
- Treating psychiatric and physical co-morbidities
- Parental training

Biological treatment

- Atypical antipsychotics (risperidone)
- Effective in reducing
- Aggression, tantrums
- Stereotypies & self-injuries
- Stimulants or atomoxetine
- Effective in child co-morbid ADHD
- SSRI

- Decrease repetitive or obsessive behaviour

Biological treatment
- Melatonin
- In affecting sleep cycle

Psychological treatment
- Speech and language therapy
- Social skill training
- Behaviour modification programs

Conduct Disorder
- Conduct disorder is a serious behavioural and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules.

Types of Conduct Disorder
1. Childhood onset occurs when the signs of conduct disorder appear before age 10.
2. Unspecified onset means the age at which conduct disorder first occurs is unknown
3 Conduct disorder are categorized according to the age at which symptoms of the disorder first occur:
4. Adolescent onset occurs when the signs of conduct disorder appear during the teenage years.

Symptoms of Conduct Disorder Aggressive Conduct
- intimidating or bullying others
- physically harming people or animals on purpose
- committing rape
- using a weapon
- Deceitful behavior may include:
- lying
- breaking and entering
- stealing
- forgery
- Destructive Behavior
- Destructive conduct may include arson and other intentional destruction of property
- Violation of rules may include:
- skipping school
- running away from home
- drug and alcohol use
- sexual behavior at a very young age

Causes
- Genetic Factors
- Organic factors - brain damage
- Biochemical factors
- Psychosocial Factors
- child abuse
- a dysfunctional family
- parents who abuse drugs or alcohol
- Poverty
- Parental rejection

Risk for Conduct Disorder
- Being male
- Living in an urban environment or poverty

- Having A family history of conduct disorder or mental illness
- Having other psychiatric disorders
- Drugs abuse or alcohol
- Dysfunctional home environment
- Having a history of experiencing traumatic events
- Being abused or neglected

Diagnosis
- Complete history
- Educational history (to determine cognitive deficit , learning disabilities or problems in intellectual functioning)
- Neurological examination

Treatment Modalities
Drugs may include –
- anticonvulsants
- Lithium
- Antipsychotics
- Psychotherapy
- Guidance and counseling
- Social skill training
- Role playing
- Modelling
- Shaping of behaviour

Nursing Management
- Allot sufficient staff and provide close supervision to the child.
- Observe the child for anger cues, encouraging activities and aggressive behaviour.
- Set limit on manipulative behaviour and identify the consequences of manipulative behaviour.
- Provide immediate feedback for positive behaviour.
- Encourage the child to maintain the activity log book and make daily entry of activities in his own way. Later on, analyses the activity which provide insight to the child about activity and responses.

Tic Disorder

Tics are defined as sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations

Motor and vocal tics are divided into:
1] Simple motor tics:
2] Simple vocal tics
3] Complex motor tics
4] Complex vocal tics

DSM-IV-TR TIC DISORDERS:
1] Gilles de la Tourette syndrome
2] chronic motor or vocal tic disorder,
3] transient tic disorder, &
4] tic disorder not otherwise specified

DSM-IV-TR Diagnostic Criteria for Tourette's Disorder:
1] Multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
2] The tics occur many times a day, nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months (2 months in ICD-10)

3] The onset is before age 18 years.
4] The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).

- Prevalence: 4 to 5 per 10,000
- Onset of the motor component of the disorder:7 years; Vocal tics: 11 years
- Boys > Girls

ETIOLOGY
1] Genetic Factors
2] Neurochemical and Neuroanatomical Factors
3] Immunological Factors

A] GENETIC FACTORS:
1) Twin studies.
2) Bilinear mode of familial transmission:
3) Rare sequence variant in SLITRK1 on chr.13q31 4)
50% Tourette's patients have ADHD 5)40% Tourette's patients have OCD 6)First degree relatives at risk of tics and OCD

B] NEUROCHEMICAL & NEUROANATOMICAL FACTORS
1] Dopamine system: --Anti Dopaminergic agents [Haloperidol, Pimozide, Fluphenazine] -----tic suppressors. --Central Dopaminergic activators [methylphenidate, amphetamines, cocaine] --------tic exacerbators. --However, no concrete evidence
2] choline and n-acetyl aspartate: --Reduction of the above in left putamen and frontal cortex. --This leads to reduced density of neurons
3] Endogenous opioids: pharmacological agents that antagonize endogenous opiates for e.g.naltrexone reduce tics.
4] Noradrenergic system: Clonidine decreases NA and causes reduced Dopaminergic activity & hence reduces tics.
5] Structural abnormalities Basal Ganglia lesions are known in movement disorders

C] IMMUNOLOGICAL FACTORS autoimmune process that is secondary to streptococcal infections is a potential mechanism for Tourette's disorder.

CLINICAL FEATURES:
- Initial tics are in the face and neck and then they progress downwards
- The most commonly described tics are those affecting the face & head, arms & hands, lower extremities, RS & GIT.
- The most frequent initial symptom is an eye-blink tic, followed by a head tic or a facial grimace. The complex tics appear many years later [coprolalia-1/3rd]
- Prodromal symptoms- irritability, attention difficulties, poor frustration tolerance……diagnosed as ADHD for which stimulants are started……25% end up with Tourette's
- Attention difficulties often precede the onset of tics, whereas obsessive-compulsive symptoms often occur after their onset.

COURSE AND PROGNOSIS:
1] Most often there is reduction in severity and frequency with age.
2] Co-morbid MDD, OCD and ADHD worsen the prognosis and cause exacerbation.
3] Imaging has revealed presence of smaller caudate nucleus in patients and has predictive value in prognosis.
4] Mild forms need not require treatment if they are socially functional.

TREATMENT:
1] Not to mis interprets tic as behavioral problem

2] Family psychoeducation
3] Mild cases: no treatment required
4] Severe cases: pharmacotherapy & behavioral therapy

PHARMACOTHERAPY

1] Haloperidol and Pimozide most widely researched and used. Haloperidol initial daily dose for adolescents is 0.25 and 0.5 mg. not approved in children < 3 years age. Pimozide- 1mg-2mg----increase alt. days up to 10-20 mg
2] Risperidone and Olanzapine have also showed beneficial results.
3] Clonidine and guanfacine: Although presently not approved by US FDA, several studies reported that clonidine and guanfacine were efficacious in reducing tics.
4] For associated OCD, SSRIs used alone or with APD's. 5] For co-existing ADHD the decision depends on severity and if required Atomoxetine or methylphenidate might have to be started.

BEHAVIORAL THERAPY:

- Habit reversal technique, stopping premonitory urge, relaxation therapy (it may reduce the stress that often exacerbates Tourette's disorder).
- Premonitory urge: older children, adolescents, and adults often report tics to be preceded by an unpleasant sensation denoted as a —premonitory urge‖.
- Premonitory Urge for Tics Scale (PUTS) : This is a 10 item scale, & 9 items pertaining to intensity of premonitory urge is graded on a scale of 1 to 4. Total maximum score is 36, while minimum score is 9.

CHRONIC MOTOR OR VOCAL TIC DISORDER DSM-IV-TR Diagnostic Criteria:

- Single or multiple motor or vocal tics but not both, have been present at some time during the illness.
- The tics occur many times a day nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months (2 months in ICD-10)
- The onset is before age 18 years.
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition
- Criteria have never been met for Tourette's disorder.
- Prevalence is 100-1000 times more than Tourette's
- Similar hereditary factors as Tourette's.
- Motor tics >> vocal tics [not as loud … mainly grunting due to diaphragm, thoracic or abdominal muscles]
- Prognosis- onset between 6-8years, facial tics—good prognosis
- Management- psychotherapy & behavior therapy

TRANSIENT TIC DISORDER DSM-IV-TR Diagnostic Criteria for Transient Tic Disorder

- Single or multiple motor and/or vocal tics
- The tics occur many times a day, nearly every day for at least 4 weeks, but for no longer than 12 consecutive months.
- The onset is before age 18 years.
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition
- Criteria have never been met for Tourette's Disorder or Chronic Motor or Vocal Tic Disorder.
- Specify if: Single episode or Recurrent
- 5-24% of school children
- Organic origin, may progress to Tourette's or chronic motor or vocal tic disorder
- Exacerbated by stress and anxiety.
- Good prognosis
- Self-limiting mostly

TIC DISORDER NOT OTHERWISE SPECIFIED • DSM-IV-TR Diagnostic Criteria

- This category is for disorders characterized by tics that do not meet criteria for a specific tic disorder.

UNIT- 5
SUBSTANCE USE DISORDERS

Substance abuse Disorders due to Psychoactive substance use refer to conditions arising from the abuse of Alcohol, Psychoactive drugs & Other Chemicals such as Volatile Solvents.

TERMINOLOGIES

Substance refers to any Drugs, Medication, or Toxins that shares the potential of abuse. Addiction is a Physiological & Psychological dependence on Alcohol or other drugs of Abuse that affects the Central Nervous System in such a way that withdrawal symptoms are experienced when the substance is Discontinued.

Abuse refers to Maladaptive pattern of Substance use that impairs health in a board sense.

Dependence refers to certain Physiological & Psychological phenomena induced by the repeated taking of a Substance.

Tolerance is a state in which after repeated administration, a drug produced a decreased effect, or increasing doses are required to produce the same effect. Withdrawal State is a group of signs & symptoms recurring when a drug is reduced in amount or withdrawn, which last for a limited time.

ICD – 10 CLASSIFICATIONS

- F10 – F19 Mental & Behavior Disorders due to Psychoactive Substance Use.
- F10 - Mental & Behavior Disorders due to use of Alcohol.
- F11 - Mental & Behavior Disorders due to use of Opioids.
- F12 - Mental & Behavior Disorders due to use of Cannabinoids.
- F13 - Mental & Behavior Disorders due to use of Sedatives & Hypnotics.
- F14 - Mental & Behavior Disorders due to use of Cocaine.
- F16 - Mental & Behavior Disorders due to use of Hallucinogens.

COMMONLY USED PSYCHOTROPIC SUBSTANCE

- Alcohol
- Opioids
- Cannabis
- Cocaine
- Amphetamines & other sympathomimetics
- Sedatives & Hypnotics (E.g.: Barbiturates)
- Inhalants (e.g.: Volatile Solvents)
- Nicotine
- Other Stimulants (e.g.: Caffeine)

ETIOLOGY BIOLOGICAL FACTORS

Genetic Vulnerability:

Family History Of Substance use Disorders Biochemical Factors : Role of Dopamine & Nor-epinephrine have been implicated in Cocaine, Ethanol, & Opioid Dependence. Abnormalities in Alcohol dehydrogenase or in the Neurotransmitter mechanisms are thought to play a role in Alcohol Dependence.

Neurobiological theories: ¬Drug addict may have an inborn deficiency of Endorphins. Enzymes produced by a given gene might influence hormones & Neurotransmitters, contributing to the development of a personality that is more sensitive to the peer pressure. Withdrawal & Reinforcing effects of drugs. Co-morbid medical Disorder (Eg: To Control Chronic Pain)

BEHAVIORAL THEORIES-Drug abuse as the result of Conditioning / Cumulative reinforcement from drug use. Drug use causes euphoric experience perceived as rewarding, thereby motivating user to keep taking the drug. Stimuli & Setting associated with drug use may themselves become reinforcing or may trigger drug craving that can lead to relapse.

PSYCHOLOGICAL FACTORS - General Rebelliousness, Sense of Inferiority, Poor Impulse Control, Low Self-Esteem, Inability to cope up with the pressures of living & society (Poor Stress Management Skills), Loneliness, Unmet needs, Desire to escape from reality, Desire to experiment, a sense of Adventure, Pleasure Seeking, Machoism, Sexual Immaturity.
SOCIAL FACTORS- Religious Reasons, Peer Pressure, Urbanization, Extended Period of Education, Unemployment, Overcrowding, Poor Social Support, Effects of Television & Other Mass Media, Occupation: Substance use is more common in chefs, Barmen, Executives, Salesman, Actors, Entertainers, Army, Personnel, Journalists, Medical personnel, etc.,
EASY AVAILABILITY OF DRUGS ¬Taking Drugs Prescribed by the Doctors (Eg: Benzodiazepine Dependence) ¬Taking drugs that can be bought legally without Prescription (Eg: Nicotine, Opioids) ¬Taking Drugs that can be Obtained from illicit Sources (Eg: Street Drugs)
PSYCHIATRIC DISORDERS Substance Use Disorders are more Common in Depression, Anxiety Disorders (Social Phobia), Personality Disorders (Especially Anti-Social Personality), & Occasionally in Organic Brain Disorders & Schizophrenia.

ALCOHOL DEPENDENCE SYNDROME

Alcohol Means Essence, anciently it called as Magnus Hass which is derived from Arabic Word. Alcoholism refers to the uses of alcoholic Beverages to the Point of Causing Damage to the Individual, Society, Or Both. (Or) Chronic Dependence of Alcohol Characterized by Excessive & Compulsive Drinking that produce Disturbances in mental Or Cognitive level of functioning which interferes with social & Economic Levels.

PROPERTIES OF ALCOHOL

Alcohol is a Clear Colored Liquid with a Strong Burning Taste. The Rate of Absorption of alcohol into the Blood stream is more Rapid than its Elimination. Absorption of Alcohol into the Bloodstream is Slower when food is Present in the Stomach. A Small amount is Excreted through Urine & a Small Amount is Exhaled.

EPIDEMIOLOGY

Incidence of Alcohol Dependence is 2% in India. 20 – 30 % of Subjects Aged Above 15years are Current Users Of Alcohol, & Nearly 10% of them are Regular Or Excessive Users. 15 – 30 % Of Patients are Developing Alcohol – Related Problems & Seeking admission in Psychiatric Hospitals.

CAUSES OF ALCOHOLISM

Hard physical Labour, (Occupations – Bar mates, Medical Professionals, Journalists & Actors). A Sudden loss of Properties or Closed ones. Ignorance Suddenly a person Become a Rich / Poor. Disorders Like Depression, Anxiety, Phobia, & Panic Disorders. Biochemical Factors (Alterations in Dopamine & Epinephrine) Psychological factors (Low self Esteem, Poor Impulse, Escape From reality, Pleasure Seeking). Sexual Immaturity Social Factors (Over Crowding, Peer Pleasure, Urbanizations, Religious Reason, Unemployment, Poor Social Support, Isolation).

PROCESS OF ALCOHOLISM

- Experimental Stage
- Recreational Stage
- Relaxation Stage
- Compulsion Stage

STAGES OF ALCOHOLISM

- Progressive Phase
- Crucial Phase
- Chronic Phase
- Rehabilitative Phase

- Road For Recovery

CLINICAL FEATURES OF ALCOHOL DEPENDENCE

- Minor Complaints: (Malaise, Dyspepsia, Mood Swings Or Depression, Increased Incidence of Infection)
- Poor Personal Hygiene.
- Untreated Injuries (Cigarette Burns, Fractures, Bruises that cannot be fully Explained).
- Unusually High tolerance for Sedatives & Opioids.
- Nutritional Deficiency (Vitamins & minerals).
- Secretive Behavior (may Attempt to Hide disorder or Alcohol supply) consumption Of Alcohol-Containing products (Mouthwash, After-Shave lotion, Hair Spray, Lighter Fluid, Body Spray, Shampoos).
- Denial of Problem.
- Tendency to Blame others & Rationalize Problems (Problems Displacing Anger, Guilt, Or Inadequacy onto Others to Avoid Confronting Illness).

ICD-10 CRITERIA FOR ALCOHOL DEPENDENCE

- A Strong Desire to take the Substance
- Difficulty in Controlling Substance Taking Behavior
- A Physiological Withdrawal State.
- Progressive neglect of Alternative pleasures or Interests.
- Persisting with Substance Use Despite Clear Evidence of Harmful Consequences

PSYCHIATRIC DISORDERS DUE TO ALCOHOL DEPENDENCE

- Acute Intoxication
- Withdrawal Syndrome
- Alcohol-Induced Amnestic Disorders
- Alcohol-Induced psychiatric Disorders

ACUTE INTOXICATION

- It Develops During Or Shortly After Alcohol Ingestion. It is Characterized by,
- Clinically Significant Maladaptive Behavior or Psychological Changes (Eg's: Inappropriate Sexual or Aggressive Behavior).
- Mood Lability
- Impaired Judgment
- Slurred Speech
- Inco-ordination
- Unsteady gait
- Nystagmus
- Impaired Attention & Memory
- Finally Resulting in Stupor or Coma.

WITHDRAWAL SYNDROME

Person Who Has been Drinking Heavily Over a Prolonged period of time, Any Rapid Decrease in the amount of Alcohol in the Body is likely to Produce Withdrawal Symptoms.
These are: Simple Withdrawal Symptoms, Delirium Tremens

SIMPLE WITHDRAWAL SYNDROME:

It is Characterized by,

- Mild tremors
- Nausea
- Vomiting Weakness
- Irritability
- Insomnia Anxiety

DELIRIUM TREMENS

It Occurs Usually within 2- 4days of Complete or Significant Abstinence From Heavy drinking. The course is Very Short, with Recovery Occurring within 3-7days.

It is Characterized by,

- A Dramatic & Rapidly Changing Picture of Disordered Mental Activity, with Clouding Of Consciousness & Disorientation in Time & Place.
- Poor Attention Span.
- Vivid Hallucinations which are Usually Visual, Tactile Hallucinations Can also Occur.
- Severe Psychomotor Agitation
- Shouting & Evident Fear
- Grossly Tremulous Hands which Sometimes Pick-Up Imaginary Objects; Truncal ataxia.
- Autonomic Disturbances Such as Sweating, Fever, Tachycardia, Raised Blood pressure, Pupillary dilation.
- Dehydration with Electrolyte Imbalances.
- Reversal of Sleep-Wake Pattern or Insomnia
- Blood tests to Reveal Leukocytosis & LFT
- Death may Occur due to Cardiovascular Collapse, Infection, Hyperthermia, Or Self-Inflicted Injury.

ALCOHOL-INDUCED AMNESTIC DISORDERS

Chronic Alcohol Abuse associated with Thiamine Deficiency (Vitamin B) is the most frequent Cause of Amnestic Disorders.

This Condition is Divided into: Wernicke's Syndrome, Korsakoff's Syndrome

WERNICKE'S SYNDROME is Characterized by,

- Prominent Cerebellar Ataxia
- Palsy of the 6th Cranial Nerve
- Peripheral Neuropathy
- Mental Confusion

KORSAKOFF'S SYNDROME

The Prominent Symptoms in this Syndrome is Gross Memory disturbance.

Other Symptoms Include:

- Disorientation
- Confusion
- Confabulation
- Poor Attention Span & Distractibility
- Impairment of Insight

DIAGNOSTIC EVALUATION

- History collection.
- Mental Status Examination.
- Physical Examination.
- Neurologic Examination.
- CAGE Questionnaires.
- Michigan Alcohol Screening Tests (MAST).
- Alcohol Use Disorders Identification Tests (AUDIT).
- Paddington Alcohol Test (PAT).
- Blood Alcohol Level to indicate Intoxication (200mg/dl).
- Urine Toxicology to reveal use of Other Drugs.
- Serum Electrolytes Analysis Revealing Electrolyte Abnormalities associated with Alcohol Use.
- Liver function Studies demonstrating alcohol related Liver Damage.
- Hematologic Workup Possibly revealing Anemia, Thrombocytopenia.
- Echocardiography & Electrocardiography demonstrating Cardiac Problems.
- Based on ICD10 Criteria.

TREATMENT MODALITIES

- Symptomatic Treatment.
- Fluid Replacement Therapy.
- IV Glucose to Prevent Hypoglycemia.
- Correction of Hypothermia / Acidosis. ¬Emergency Measures for Trauma, Infection or GI Bleeding.

TREATMENT FOR WITHDRAWAL SYMPTOMS DETOXIFICATION:

The Drugs of Choice are Benzodiazepines. Eg: Chlordiazepoxide 80-200 mg/day Diazepam 40-80 mg/day, in divided doses.

OTHERS:

- Vitamin B – 100mg of Thiamine Parenterally, Bd 3 to 5 days, Followed by Oral Administration for Atleast 6 months.
- Anticonvulsants ¬ Maintaining Fluid & electrolyte Balance
- Strict Monitoring of Vitals, Level of Consciousness & Orientation.
- Close Observation is Essential

ALCOHOL DETERRENT THERAPY

Deterrent agents are given to desensitize the individual to the effects of alcohol & Abstinence. The Most commonly Used Drug is Disulfiram or Tetraethyl thiuram disulfide or Antabuse.

DISULFIRAM

Disulfiram is used to ensure Abstinence in the Treatment of Alcohol Dependence. Its Main effect is to Produce a rapid & Violently Unpleasant Reaction in a Person who ingests even a small amount of alcohol While Taking Disulfiram.

DOSAGE: Initial Dose is 500mg/day orally for the 1st 2weeks, followed by a maintenance dosage of 250mg/day. The Dosage should not exceed 500mg/day.

INDICATIONS: Disulfiram use is as an Aversive Conditioning Treatment for Alcohol Dependence.

CONTRAINDICATIONS: ¬Pulmonary & Cardiovascular Disease ¬Disulfiram Should be used with caution in patients with Nephritis, Brain Damage, Hypothyroidism, Diabetes, Hepatic Disease, Seizures, Poly-drug Dependence or an Abnormal EEG. ¬High Risk for Alcohol Ingestion.

ACTION: It is an Aldehyde Dehydrogenase inhibitor that interferes with the metabolism of alcohol & produces a marked increase in blood acetaldehyde levels. Accumulation of acetaldehyde (more than 10 times which occurs in the normal metabolism of alcohol) produces a wide array of Unpleasant reactions Called DISULFIRAM-ETHANOL REACTION (DER). Characterized by Nausea, Throbbing headache, Hypotension, Sweating, thirst, Chest Pain, tachycardia, Vertigo, blurred Vision associated with Severe Anxiety.

ADVERSE EFFECTS: Fatigue, Dermatitis, Impotence, Optic Neuritis, Mental Changes, Acute Polyneuropathy, Hepatic Damage, Convulsions, Respiratory Depression, cardiovascular Collapse, Myocardial Infarction, Death.

NURSING RESPONSIBILITY:

- An informed Consent should be taken before Starting treatment.
- Ensure that at least 12hours have elapsed since the last ingestion of Alcohol before Administering the Drug.
- Patient should be warned against Ingestion of any alcohol- containing preparations such as Cough Syrups, Sauces, Aftershave Lotions, Etc.,
- Caution patient against taking CNS Depressants & Over-the- Counter (OTC) Medications during disulfiram therapy.
- Instruct The Patient to avoid driving or other activities requiring alertness.
- Patients should be warned that the Disulfiram-alcohol Reaction may continue for as long as 1or 2 weeks after the last dose of disulfiram.
- Patients should carry identification cards describing Disulfiram- alcohol reaction & listing the name & phone number of the physician to be called.

- Emphasize the Importance of Follow-Up visits to the physician to monitor progress in long-term therapy.

PSYCHOLOGICAL THERAPY:

- Motivational Interviewing
- Group Therapy
- Aversive Conditioning / Therapy
- Cognitive Therapy
- Relapse Prevention Technique: This technique helps the patient to identify high-risk relapse factors & develop strategies to deal with them.
- Cue Exposure Technique: The technique aims through repeated exposure to desensitize drug abusers to drug effects, & thus improve their ability to Remain Abstinent.
- Assertive Training
- Behavior Counseling
- Supportive Psychotherapy
- Individual Psychotherapy

AGENCIES CONCERNED WITH ALCOHOL-RELATED PROBLEMS

- This is a self-Help organization founded in the USA by 2 Alcoholic men Dr. Bob Smith & Dr. Bill Wilson On 10th june,1985.
- Alcoholic Anonymous considers Alcoholism as a Physical, Mental, Spiritual disease, a Progressive one, which can be Arrested but not Cured.
- Members attend Group meetings usually twice a week on a long – term basis.
- Each member is assigned a support person from whom he may seek help when the temptation to drink occurs.
- In Crisis he can obtain immediate help by telephone.
- Once Sobriety is achieved, he is Expected to help others.
- The Organization works on the firm belief that Abstinence must be Complete. ⌈The only Requirement for membership is a Desire to stop drinking.
- There is no authority, but only a fellowship of imperfect alcoholics whose strength is formed out of weakness.
- Their primary purpose is to help each other stay sober and help each other alcoholics to achieve sobriety.
- Al-Anon This is a Group Started by Mrs. Annie, Wife of Dr. Bob to support the Spouses of Alcoholics.
- Al-Teen Provides Support to their Teenage Children. Hostels These are intended mainly for those rendered homeless due to alcohol-related problems. They Provide Rehabilitation & Counseling. Usually, abstinence is a Condition of Residence.

NURSING MANAGEMENT

Nursing Assessment:

Recognition of Alcohol Abuse using CAGE Questionnaire

C – Have you ever felt you ought to CUT down on your drinking?
A – Have People ANNOYED you by criticizing your drinking?
G – Have you ever felt GUILTY about your drinking?
E – Have you ever had a drink first thing in the morning (An EYE – OPENER) to steady your nerves or get rid of a Hangover?

1. Be suspicious about 'At Risk' Factors:
2. problems in the Marriage & Family, At Work, With Finances or with the Law ¬ At risk occupations ¬ Withdrawal Symptoms after Admission ¬ Alcohol – related physical Disorders ¬ Repeated Accidents ¬ Deliberate Self Harm
3. If at – risk Factors raise Suspicion, the next step is to ask Tactful but Persistent Questions to confirm the diagnosis.
4. Certain clinical Signs lead to the suspicion that drugs are being injected: Needle Tracks & Thrombosed Veins, wearing Garments with long Sleeves, etc., IV use should be suspected in any patient who presents with Subcutaneous Abscesses or Hepatitis.
5. Behavioral Changes: Absence from School or work, Negligence of Appearance, Minor Criminal Offences, Isolation from Former Friends& Adoption of new Friends in a Drug Culture.
6. Laboratory Tests: Raised Gamma – Glutamyl Transpeptidase (GGT), Raised Mean Corpuscular Volume (MCV), Blood Alcohol Concentration, most drugs can be detected in urine except Lysergic Acid Diethylamide (LSD).
7. Gastrointestinal: Nausea/Vomiting, Changes in Weight/Appetite, Signs of Malnutrition, Color & Consistency of Stool.
8. Nervous System: Orientation, Level of Consciousness, Co-ordination, Gait, Long term & Short-term Memory, Signs of Depression & Anxiety, Tremors or Increased Reflexes, Pupils (Constricted/Dilated)
9. Cardiovascular & Respiratory: Vital Signs, Peripheral Pulses, Dyspnea on Exertion, Abnormal Breath Sounds, Arrhythmias, Fatigue, Peripheral Edema.
10. Integumentary: Skin lesions, Needle tracks on Scaring on arms, legs, fingers, toes, under the tongue, or between gums & lips.
11. Emotional Behavior: ¬ Affect, Rate of Speech, Suspiciousness, anger, agitation, Hallucinations, Blackouts, Violent Episodes, Support Systems ¬ Denial & Rationalization are the feelings of fear, Insecurity, Low Self Esteem.
12. Identify the type of Substance the person has been using, the amount, frequency, method of administration & the length of time the substance has been abused.
13. Note of any Suicidal ideation or interest, with drained Symptoms.
14. Assess for level of motivation for treatment.
15. Identify reason for Admission.
16. A Baseline Physical & Emotional Nursing assessment is done to determine Admission status & Provide baseline from which to determine progress towards an expected Outcome.

NURSING DIAGNOSIS

- Risk for injury related to Hallucinosis, acute Intoxication evidenced by Confusion, Disorientation, inability to identify potentially Harmful Situations.
- Altered Health Maintenance related to inability to identify, manage or seek out help to maintain health, evidenced by various physical symptoms, Exhaustion, Sleep Disturbances, etc.,
- Ineffective Denial Related to weak, under-developed ego, evidenced by Lack of Insight, Rationalization of problems, Blaming Others, Failure to Accept responsibility for his Behavior.
- Ineffective individual coping related to impairment of adaptive behavior & Problem
- Solving abilities, evidenced by use of substances as Coping Mechanisms.

OTHER SUUBSTANCE USE DISORDERS DRUG ADDICTION IN INDIA

40 lakhs Registered Drug addicts in South Asia, among this 1.25 lakhs are in India.

DISTRIBUTION:

- Alcohol – 42 %
- Opioids – 20%
- Heroin – 13%
- Cannabis – 6.2%
- Others – 1.8%
- Majority of Drug Addicts Aged Between 16 – 30 Years

- These drug Abusers are mostly Unmarried, Under low Socio-Economic status
- Among this Drug users 33% were Engaged in Anti – Social Activities.

CANNABIS USE DISORDER
- Its derived from hemp plant cannabis sativa.
- The dried leaves and flowering tops are often referred to as GANJA or MARIJUANA.
- The resin of the plant is referred to as HASHISH.
- Bhang is a drink made from cannabis.
- Cannabis is either smoked or taken in liquid form.

ACUTE INTOXICATION MILD INTOXICATION
It is characterized by
- Mild impairment of consciousness and orientation.
- Tachycardia
- A sense of floating in the air
- Euphoria
- Dream Like States
- Tremors
- Photophobia
- Dry Mouth
- Lacrimation
- Increased Appetite
- Alteration In the Psychomotor Activity

SEVERE INTOXICATION
It Causes Perceptual Disturbances Like
- Depersonalization
- Derealization
- Illusion
- Hallucination
- Somatic Passivity

WITHDRAWAL SYMPTOMS
- Increased Salivation
- Hyperthermia
- Insomnia Decreased Appetite
- Loss Of Weight

COMPLICATIONS
- Memory Impairment
- A motivational Syndrome
- Transient Or Short-Lasting Psychiatric Disorders Such as Acute Anxiety, Paranoid Psychosis, Hysterical Fugue Like States, Hypomania, Schizophrenia.

- TREATMENT Supportive and Symptomatic Treatment

NICOTINE ABUSE DISORDER
- It is Obtained from “NICOTIANA TABACUM”.
- It is one of the most Highly Addictive & Heavily Used Drug.

NICOTINE DEPENDENCE SYMPTOMS
- Impaired Attention, Learning, Reaction Time, Problem Solving Abilities.

- Lifts One's Mood
- Decreases Tension
- Depressive Feeling
- Decreased Cerebral Blood Blow
- Relaxes the Skeletal Muscles.

ADVERSE EFFECTS OF NICOTINE
- Respiratory paralysis
- Salivation
- Pallor
- Weakness
- Abdominal Pain
- Diahorrea
- Increased Blood Pressure
- Tachycardia Tremor

NICOTINE TOXICITY
- Inability to Concentrate
- Confusion
- Sensory Disturbances
- Decreases the Rapid Eye Movement while Sleep During Pregnancy,
- Increased Incidence of Low-Birth-Weight Babies
- Increased Incidence of Newborns with Persistent Pulmonary Hypertension.

TREATMENT PSYCHOPHARMACOLOGICAL THERAPY
- Nicotine Replacement therapy
- Nicotine Polacrilex Gum (Nicorette)
- Nicotine Lozenges (Commit)
- Nicotine Patches (Nicotrol, Nicoderm)
- Nicotine Nasal Spray (Nicotrol)
- Nicotine Inhaler Non-Nicotine Medications: ¬ Bupiropian (Zyban) – Started with 150mg, Bd For 3 Days; After that Increase the dose to 300mg, Bd.

THERAPIES
- Smoking Cessation
- Behavior Therapy
- Aversive Therapy
- Hypnosis

OPIOID USE DISORDERS
- The most Important Dependence Producing Derivatives are Morphine & Heroin.
- The commonly Abused Opioids (Narcotics) in our Country are Heroin (Brown Sugar, Smack) And the Synthetic Preparations Like Pethidine, Fortwin & Tidigesic.
- More Opiate Users had begun with Chasing Heroin (Inhaling the Smoke / Chasing the Dragon), they Gradually Shifted to Needle use.
- Injecting Drug users have become a high Risk Group for HIV Infection.

ACUTE INTOXICATION
It is characterized by,
- Apathy,
- Bradycardia,
- Hypotension,
- Respiratory Depression,

- Subnormal Temperature,
- Pinpoint Pupils. In Later Stage,
- Delayed reflexes,
- Thready Pulse,
- Coma.

WITHDRAWAL SYNDROME

It Rarely Produce a Life – Threatening Situation. Common Symptoms Includes, Withdrawal Symptoms Begin Within 12 Hours of the Last Dose, Peak in 24 -36 hours, Disappear in 5 – 6 Days. Watery Eyes, Running Nose, Yawning, Loss of Appetite, Irritability, Tremors, Anxiety. Sweating, Cramps, Nausea, Diahorrea, Insomnia, Raised Body Temperature, Piloerection

COMPLICATIONS ¬Illicit Drug Use: Parkinsonism, Peripheral Neuropathy, Transverse Myelitis. ¬Intravenous Use: Skin Infections, thrombophlebitis, Pulmonary embolism, Endocarditis, Septicemia, AIDS, Viral Hepatitis, tetanus. ¬Involve in criminal Activities.

TREATMENT Opioid Overdose: Treated with Narcotic Antagonists [Egs: Naloxone, Naltrexone] Detoxification: Withdrawal symptoms can be managed By Methadone, Clonidine, Naltrexone, Buprenorphine, etc. Maintenance Therapy: After the Detoxification Phase, the patient is maintained on one of the following Regimens: - Methadone Maintenance - Opioids Antagonists - Psychological methods like Individual Psychotherapy, Behavior Therapy, Group Therapy, Family Therapy.

COCAINE USE DISORDER

- Cocaine is an Alkaloid derived from the Shrub “ERYTHOXYLON COCA”
- Common street name is “CRACK”
- In 1880 it is used as a Local Anesthesia. ¬It can be administered orally, intra-nasally by smoking or parenterally.

ACUTE INTOXICATION Characterized by pupillary dilatation, tachycardia, hypertension, sweating and nausea & hypo manic picture.

WITHDRAWAL SYNDROME

- Agitation
- Depression
- Anorexia
- Fatigue
- Sleepiness

COMPLICATIONS

- Acute Anxiety reaction.

Uncontrolled compulsive behavior.

Seizures
Respiratory depression
Cardiac Arrhythmias

TREATMENT MANAGEMENT OF INTOXICATION:

- Amyl Nitrite is an antidote.
- Diazepam / Propanolol (withdrawal syndrome)
- Anti - Depressants (Imipramine or Amitriptyline).
- Psychotherapy.

AMPHETAMINE USED DISORDER

- Powerful CNS stimulants with peripheral sympathomimetic effect.

- Commonly used are Pemoline and Methyl Phenidate.

ACUTE INTOXICATION
Characterized by,
- Tachycardia
- Hypertension
- Cardiac failure
- Seizure
- Hyperpyrexia
- Pupillary dilation
- Panic
- Insomnia
- Restlessness
- Irritability
- Paranoid hallucinatory syndrome
- Amphetamine induced psychosis

WITHDRAWAL SYNDROME
Characterized by
- Depression
- Apathy
- Fatigue
- Hypersomnia / Insomnia
- Agitation
- Hyperphagia

COMPLICATIONS
- Seizure
- Delirium
- Arrhythmias
- Aggressive behavior
- Coma

LSD USE DISORDER (LYSERGIC ACID DIETHYLAMIDE)
- A powerful Hallucinogen
- First synthesized in 1938.
- Produces its effect by acting on 5-Hydroxy Tryptamine (serotonin) levels in brain.
- A common pattern of LSD used in TRIP (followed by long period of abstinence)

INTOXICATION
Characterized by Perceptual changes occurring in clear consciousness
- Depersonalization
- Derealization
- Illusions
- Synesthesia's (colors are heard, sounds are felt)
- Automatic hyperactivity
- Marked anxiety
- Judgment impaired.
- Paranoid ideation

WITHDRAWAL SYMPTOMS
Flashbacks (a brief experiences of the hallucinogenic state)

COMPLICATIONS
- Anxiety
- Depression
- psychosis / visual Hallucinosis

TREATMENT
- Symptomatic Treatment with
- Anti-Anxiety,
- Anti-Depressants or
- Anti-Psychotic medications.

BARBITURATE USE DISORDER
The Commonly Abused Barbiturates are seco - barbital, pento - barbital, amo - barbital.

INTOXICATION
- Acute intoxication characterized
- Lability of mood
- Disinhibited behavior
- Slurring of speech
- Inco-ordination
- Attention and memory impairment

COMPLICATIONS
- Intravenous use can lead to skin abscess
- Cellulitis
- Infection
- Embolism
- Hypersensitivity reaction

WITHDRAWAL SYNDROME
- Restlessness
- Tremors
- Seizure in severe cases resembling delirium tremens

TREATMENT
- If the patient is conscious, induction of vomiting and use of Activated Charcoal can reduce the absorption.
- Treatment is symptomatic.

INHALANTS / VOLATILE USE DISORDER

The Commonly used Volatile Solvents include
- Petrol
- Aerosols
- Thinners
- Varnish remover
- Industrial solvents

INTOXICATION
- Inhalation of a volatile solvent leads to Euphoria
- Excitement
- Belligerence
- Slurring of speech

- Apathy
- Impaired Judgment
- Neurological signs

WITHDRAWAL SYMPTOMS
- Anxiety
- Depression

COMPLICATIONS
- Irreversible damage to the liver and kidneys
- Peripheral neuropathy
- Perceptual disturbances
- Brain damage

TREATMENT
- Reassurance
- Diazepam for intoxication.

NURSING INTERVENTIONS

Acute Intoxication
- Care for a Substance Abuse patient starts with an Assessment
- To determine which substance he is abusing, Assess the Signs and symptoms vary with the substance and dosage.
- During the Acute phase of drug Intoxication and Detoxification - Maintaining the patient's vital functions, ensuring his safety, and easing discomfort.
- During Rehabilitation, caregiver help the patient acknowledge his substance abuse problem and find alternative ways to cope with stress & help the patient to achieve recovery and stay drug-free.

Acute Episodes
- Continuously monitor the Patient's Vital Signs and Urine Output.
- Watch for Complications of Overdose & Withdrawal.
- Maintain a safe and quiet environment.
- Take appropriate measures to prevent suicide attempts and assaults.
- Remove harmful objects from the room, and use restrains only if you suspect the patient might harm himself or others.
- Approach the patient in a non - threatening way; limit sustained eye contact, which he may perceive as threatening.
- Institute seizure precautions.
- Administer IV fluids to Increase Circulatory Volume.
- Give medications as Ordered.
- Monitor & Record the Patients effectiveness.

Withdrawal State
- Administer Medications as ordered, to Decrease Withdrawal Symptoms, Monitor & Record their Effectiveness.
- Maintain a Quiet & Safe Environment, because Excessive Noise may Agitate the Patient.

PREVENTION PRIMARY PREVENTION

- Reduction of Prescribing by Doctors (Anxiolytics Especially Benzodiazepines)
- Identification & Treatment of Family Members who may be Contributing to the Drug Abuse.

- Introduction of social changes by - Putting Up the Price of Alcohol & Its Beverages. - Controlling / Abolishing the Advertising of Alcoholic drinks.
- Controls On sales by Limiting Hours or Banning sales in Super-Markets.
- Restricting Availability & Lessening Social Deprivation (Governmental Measures).
- Strengthen the Individual's Personal & Social Skills to Increase Self Esteem & Resistance to Peer Pressure.
- Health Education to College Students & the Youth about the Dangers of Drug Abuse.
- Overall Improvement in the Socio – Economic Condition of the Population.

SECONDARY PREVENTION

- Early Detection & Counseling.
- Brief Intervention in Primary Care (Simple Advices from Practitioner & Educational Leaflet).
- Motivational Interviewing.
- A Full Assessment Which Includes, Appraisal of Current Medical, Psychological & Social Problems.
- Detoxification with Benzodiazepines.

TERITARY PREVENTION

- Alcohol Deterrent Therapy
- Other Therapies include Assertive Training, Teaching Coping Skills, Behavior Counseling, Supportive & Individual Psychotherapy.
- Agencies concerned with Alcohol – Related Problems (Alcoholic Anonymous, Al – Anon, Al – Teen, etc.).
- Motivation Enhancement including Education about Health consequences of Alcohol use.
- Identifying High Risk Situations & Developing Strategies to Deal with them (Eg: Craving Management).
- Drink Refusal Skills (Assertiveness Training)
- Dealing with Faulty Cognitions.
- Handling Negative mood States.
- Time Management.
- Anger Control.
- Financial Management.
- Developing the Work Habit.
- Stress management.
- Sleep hygiene.
- Recreation & Spirituality.
- Family Counseling – To Reduce Interpersonal Conflicts, Which may Otherwise Trigger RELAPSE.

REHABILITATION

- The Aim of Rehabilitation of an Individual De -addicted from the Effects of Alcohol/Drugs.
- To Enable him to Leave the Drug Sub – Culture.
- To Develop New Social Contacts, in this Patients First Engage in Work & Social Activities in Sheltered Surroundings & then take Greater Responsibilities for Themselves in Conditions Increasingly like those of Everyday Life.
- Continuing Social Support is Usually Required when the Person makes the Transition to Normal Work & Living.

PSYCHOEDUCATION (FOR PATIENTS & FAMILY)

- Teach about the Physical, Psychological & Social Complication of Drug & Alcohol Use.
- Inform the Concern that Psychoactive Substance may alter a person's Mood, Perceptions, Consciousness or Behavior.

- Explain to the Family that the Patient may Use Lies, Denial or Manipulation to continue Drug of Alcohol Use and to avoid Treatment.
- Teach the Patient/Family that Drug Overdose or Withdrawal can result in a Medical Emergency & even Death, Give the Family Emergency resources for Help.
- Caution the Patient that Sharing Dirty or Used Needle can Result in a Life-Threatening Disease such as AIDS, Hepatitis – B.
- Teach the Family to Establish Trust with the Patient and to Use Firm limit Setting, when necessary to help the Patient Confront Drug Abuse Issues.
- Provide the Patient with a Full Range of Treatment during Hospitalization such as Medication, Individual Therapy, Group therapy, 12 step program (AA) & Behavior Modification to Strengthen the Recovery Process.
- Teach how to Recognize Psychosocial Stressors that may Exacerbate Substance Abuse Problem & how to Avoid or Prevent them.
- Emphasize the Importance of Changing Lifestyle, Friendships & Habits that Promote Drug Use to Remain Sober.
- Teach about the Availability of Local Self – Help Programs (AA, Al – Anon, Al - Teen) to Strengthen the Patient's Recovery & Support the Family's Assistance.
-

Unit- 6
Management of mental sub-normality

Definition

"Mental retardation refers to significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior & manifested during the developmental period" (American Association on MentalDeficiency,1983).

Significant subaverage is defined as an Intelligence Quotient (IQ) of 70 or below on standardized measures of intelligence. The upper limit is intended as a guideline & could be extended to 75 or more, depending on the reliability of the intelligence test used.

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

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

- During infancy & childhood
- Sensory & motor skill development
- Communication skill (including speech & language)
- Self-help skills
- During childhood & adolescence
- Application of basic academic skill to daily life activities
- Application of appropriate reasoning & judgment in the mastery of the environment
- Social skills during late adolescence
- Vocational & social responsibilities & performance⎪Developmental periods is defined as the period of time between conception & the 18th birthday.

Epidemiology

- About 3% of the world population is estimated to be mentally retarded.
- In India, 5 out of 1000 children are mentally retarded (The Indian Express, 13th March2001).
- Mental retardation is more common in boys than girls.

- With severe & profound mental retardation mortality is high due to associated physical disease.

Etiology Genetic Factors

Chromosomal abnormalities

- Down's syndromes
- Fragile X syndrome
- Trisomy X syndrome
- Turner's syndrome
- Cat-cry syndrome
- Prader-willi syndrome
- Metabolic disorders
- Phenylketonuria
- Wilson's disease
- Galactosemia
- Cranial malformation
- Hydrocephaly
- Microcephaly
- Gross disease of brain
- Tuberous scleroses
- Neurofibromatosis
- Epilepsy

Prenatal Factors

Infection

- Rubella
- Cytomegalovirus
- Syphilis
- Toxoplasmosis,
- herpes simplex
- Endocrine disorders
- Hypothyroidism
- Hypoparathyroidism
- Diabetes mellitus

Physical damage &disorders

- Injury
- Hypoxia
- Radiation
- Hypertension
- Anemia
- Emphysema

Intoxication

- Lead & certain drug
- Substance abuse

Placental dysfunction

- Toxemia of pregnancy
- Placenta previa
- Cord prolapses

Classification:

- Mild Retardation (IQ 50-70) This is commonest type of mental retardation accounting for 85-90% of all cases. These individuals have minimum retardation in sensory-motor areas.

- Moderate Retardation (IQ 35-50) About 10% of mentally retarded come under this group.
- Severe Retardation (IQ 20-35) Severe mental retardation is often recognized early in life with poor motor development & absent or markedly delayed speech & communication skills.
- Profound Retardation (IQ below 20) This group accounts for 1-2% of all mentally retarded. The achievement of developmental milestones is markedly delayed. They require constant nursing care & supervision.

SIGN AND SYMPTOMS

- Failure to achieve developmental milestones
- Deficiency in cognitive functioning such as inability to follow commands or directions
- Failure to achieve intellectual developmental markers
- Reduced ability to learn or to meet academic demands
- Expressive or receptive
- Psychomotor skill deficits
- Difficulty performing self-esteem
- Irritability when frustrated or upset
- Depression or labile moods
- Acting-out behavior
- Persistence of infantile behavior

DIAGNOSIS

- History collection from parents & caretakers
- Physical examination
- Neurological examination
- Assessing milestones development
- Investigations– Urine & blood examination for metabolic disorders– Culture for cytogenic & biochemical studies– Amniocentesis in infant chromosomal disorders– chorionic villi sampling– Hearing & speech evaluation
- EEG, especially if seizure is present
- CT scan or MRI brain, for example, in tuberous sclerosis
- Thyroid function tests when cretinism is suspected
- Psychological tests like Stanford Binet Intelligence Scale & Wechsler Intelligence Scale for Children's (WISC), for categorizing the child's level of disability.

PROGNOSIS

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

TREATMENT MODALITIES

- Behavior management
- Environmental supervision
- Monitoring the child's development needs & problems.
- Programs that maximize speech, language, cognitive, psychomotor, social, self-care, & occupational skills.
- Ongoing evaluation for overlapping psychiatric disorders, such as depression, bipolar disorder, & ADHD.
- Family therapy to help parents develop coping skills & deal with guilt or anger.
- Early intervention programs for children younger than 3 with mental retardation Provide day schools to train the child in basic skills, such as bathing & feeding. Vocational training.

NURSING INTERVENTION

- Determine the child's strengths & abilities &develop a plan of care to maintain & enhance capabilities.
- Monitor the child's developmental levels & initiate supportive interventions, such as speech, language, or occupational skills as needed.
- Teach him about natural & normal feelings &emotions.
- Provide for his safety needs.
- Prevent self-injury. Be prepared to intervene itself-injury occurs.
- Monitor the child for physical or emotional distress.
- Modify his behavior by having him redirect his energy
- Teach the child adaptive skills, such as eating, dressing, grooming & toileting.
- Demonstrate & help him practice self-care skills.
- Work to increase his compliance with conventional social norms & behaviors.
- Maintain a consistent & supervised environment.
- Maintain adequate environmental stimulation.
- Set supportive limits on activities.
- Work to maintain & enhance his positive feelings about self & daily accomplishments.

Post Basic BSc Nursing
Mental Health Nursing
Unit- 7
Psychiatric Emergencies

An emergency is defined as an unforeseen combination of circumstances which calls for an immediate action.

A medical emergency is defined as a medical condition which endangers life and/or causes great suffering to the individual.

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

Conditions in which there is alteration in behaviors, emotion or thought, presenting in an acute form, in need of immediate attention and care.

Characteristics-

- Any condition/ situation making the patient & relatives to seek immediate treatment.
- Disharmony between subject and environment.
- Sudden disorganization in personality which affects the socio-occupational functioning.

Objectives-

- To safeguard the life of patient.
- To bring down the anxiety of family members.
- To enhance emotional security of others in the environment.

Types-

- Suicide or deliberate self harm
- Violence or excitement
- Stupor
- Panic
- Withdrawal symptoms of drug dependence.
- Alcohol or drug overdose
- Delirium
- Epilepsy or status epileptics

- Severe depression (suicidal or homicidal tendencies, agitation or stupor)
- Iatrogenic emergencies

a. Side effects of psychotropic drugs
b. Psychiatric complications of drugs used in medicine (eg: INH, steroids, etc.)

- Abnormal responses to stressful situations.

General Guidelines for manage Psychiatric Emergencies-

- Handle with the utmost of tact and speech so that well being of other patients is not affected.
- Act in a calm and coordinate manner to prevent other clients from getting anxious.
- Shift the client as early as possible to a room where they can be safe guarded against injury.
- Ensure that all other clients are reassured and the routine activities proceed normally.
- Psych. emergencies overlap medical emergencies and staff should be familiar with the management of both.

SUICIDE (Deliberate Self Harm)

One of the commonest psychiatric emergency. Commonest cause of death among psychiatric patients. Suicide is defined as the intentional taking of one's life in a culturally non-endorsed manner. Attempted suicide is an unsuccessful suicidal act with a nonfatal outcome.

Epidemiology-

- One among the top 10 causes of death.
- Suicide rate in India – 10.8 per 1 lakh population
- Male to female ratio – 64 : 36
- Highest in the age group 15-29 yrs

Methods used

- Ingestion of poison (34.8%)
- Hanging (32.2%)
- Burning (8.8%)
- Drowning (6.7%)
- Jumping in front of train or vehicle (3%)

Etiology

- Psychiatric disorders
  Major depression
  Schizophrenia
  Drug or alcohol abuse
  Dementia
  Delirium
  Personality disorder
- Physical disorders
  Chronic or incurable physical disorders like cancer, AIDS
- Psychosocial factors
  Failure in examination
  Dowry harassment
  Marital problems
  Loss of loved object
  Isolation and alienation from social groups
  Financial and occupational difficulties

Risk Factors-

- Age > 40 years
- Male gender
- Staying single

- Previous suicidal attempts
- Depression
  Presence of guilt, nihilistic ideation, worthlessness..
  Higher risk after response to treatment
  Higher risk in the week after discharge
- Suicidal preoccupation
- Alcohol or drug dependence
- Chronic illness
- Recent serious loss or major stressful life event
- Social isolation
- Higher degree of impulsivity

Warning Sign for Suicide-

- Appearing depressed or sad most of the time.
- Feeling hopeless, expressing hopelessness
- Withdrawing from family and friends,
- Sleeping too much or too little ϒ Making overt statements like “I can’t take it anymore”; “I wish I were dead”;
- Making covert statements like “it’s okay now, everything will be fine”; “I wont be a problem for much longer”
- Loosing interest in most activities
- Giving away prized possessions
- Making out a will
- Being preoccupied with death or dying
- Neglecting personal hygiene.

Common Misconception of Suicide

- People who talk about suicide do not complete suicide
- People who attempt suicide really want to die.
- Suicide happens without any warning
- Once people decide to die by suicide, there is nothing you can do to stop them.
- All suicidal individuals are mentally ill.
- Once a person is suicidal, he is suicidal forever.

Management

- Be aware of the warning signs
- Monitor the patient’s safety needs
- Take all suicidal threats or attempts seriously.
- Search for toxic agents such as drugs/ alcohol.
- Do not leave the drug tray within reach of the patient
- Make sure that daily medication is swallowed.
- Remove sharp instruments from the environment.
- Remove straps and clothing such as belts.
- Do not allow the patient to bolt the door from inside.
- Somebody should accompany to the bathroom.
- Patient should never be left alone
- Spent time with patient; allow ventilation of emotions.
- Encourage to talk about his suicidal plans/ methods
- In case of severe suicidal tendency – sedation
- A ‘ no suicide’ agreement may be signed
- Enhance self esteem by focusing on his strengths.

- Acute psychiatric emergency interview
- Counselling and guidance
- To deal with the desire to attempt suicide
- To deal with ongoing life stressors and teaching new coping skills.
- Treatment of psychiatric disorders

VIOLENCE / EXCITEMENT / AGGRESSIVE BEHAVIOR

Physical aggression by one person on another. During this stage, patient will be irrational, uncooperative, delusional and assaultive.

Etiology-

- Organic psychiatric disorders
  Delirium
  Dementia
  Wernicke-Korsakoff's psychosis
- Other psychiatric disorders
  Schizophrenia
  Mania
  Agitated depression
  Withdrawal from alcohol and drugs
  Epilepsy
  Acute stress reaction
  Panic disorder
- Personality disorder

Do's

- Protect yourself
- Unarm the patient
- Keep the doors open
- Keep others near you
- Do restrain if necessary
- Assert authority
- Show concern, establish rapport and assure the patient

Don't

- Do not keep potential weapon near the patient
- Do not sit with back to patient
- Do not wear neck tie or jewellery
- Do not keep any provocative family member in the room
- Do not confront
- Do not sit close to the patient

Management

- Untie the patient, if tied up
- Reassurance
- Talk to the patient softly
- Firm and kind approach is essential

- Ask direct and concise questions
- Avoid yes or no questions
- Assist the patient in defining the problem
- Sedation
- Diazepam 5-10 mg slow IV
- Haloperidol 2-10 mg IM/IV
- Chlorpromazine 50-100 mg IM
- Collect detailed history and explore the cause
- Carry out complete physical examination
- Check hydration status; if severe dehydration– IV fluids
- Have less furniture in the room, remove all sharp instruments
- Keep environmental stimuli to the minimum
- Stay with the patient to reduce anxiety
- Redirect violent behavior with physical outlets such as exercise, outdoor activities
- Encourage the patient to 'talk out' the aggressive feelings rather than acting them out

Physical Restraints

- Used as a last resort
- Should be done in a humane way
- Take written consent from care givers (preferable)
- Get a second opinion if possible

GUIDELINES

- Approach patient from front
- Never see a potentially violent patient alone
- Have a 4 member team to hold each extremity
- Keep talking while restraining
- Do not leave the unattended after restraining
- Observe every 15 minutes for any numbness, tingling or cyanosis in the extremities.
- Ensure that nutritional and elimination needs are met.

Guidelines for self protection while handling aggressive client-

- Never see the patient alone
- Keep a comfortable distance away from patient
- Be prepared to move
- Maintain a clear exit route
- Be sure that the patient has no weapons with him
- If patient is having a weapon, ask him to keep it down rather than fighting with him.
- Keep something (pillow, mattress, blanket) between you and weapon.
- Distract the patient to remove the weapon (eg; throwing water on the face)
- Give prescribed antipsychotics

STUPOR & CATATONIC SYNDROME

Stupor is a clinical syndrome of akinesis and mutism but with relative preservation of conscious awareness. Often associated with catatonic signs and symptoms
Catatonic syndrome -- any disorder which presents with atleast two catatonic signs.
Catatonia– either excited or withdrawn
Catatonic signs-- negativism, mutism, stupor, ambitendency, echolalia, echopraxia, catalepsy, stereotypes, verbigeration, excitement and impulsiveness.

Management

- STUPOROUS PATIENT

- Ensure patent airway
- Maintain hydration (Ryle's tube feeding or IV fluids)
- Check vital signs
- History and physical examination
- Draw blood for investigation before starting any treatment
- Identify the specific cause and treat
- Provide care for an unconscious patient
- Care of skin, nutrition, elimination and personal hygiene is required
- Give ventillatory support if needed.

Panic Episodes

Episodes of acute anxiety and panic – occur as a part of psychotic or neurotic illness

MANIFESTATIONS
- Palpitations
- Sweating
- Tremors
- Feelings of choking
- Chest pain
- Nausea
- Abdominal distress
- Fear of dying
- Paresthesia
- Hot flushes

Management
- Give reassurance
- Search for causes
- Inj. Diazepam 10 mg or Lorazepam 2 mg
- Counsel the patient and relatives
- Use behavior modification techniques

Victim Of Disaster

- People who have survived a sudden, unexpected, overwhelming stress

Features
- Anger
- Frustration
- Guilt
- Numbness
- Confusion
- Flashbacks
- Depression

Management
- Treatment of the life threatening physical problem

Intervention
- Listen attentively
- Do not interrupt
- Acknowledge understanding of the pain & distress

- Look into their eyes
- Console them – patting on the shoulders / touching / holding their hands
- Use silence
- Do not ask them to stop crying
- Provide accurate and responsible information
- Group therapy
- Benzodiazepines to reduce anxiety
- Referral to mental health service, if required.
- Educate about the available resources
- Teach them that these reactions are normal to these type of situations.
- Teach coping strategies to avoid the development of crisis.

Unit-8
Therapeutic Modalities

Psychotherapy

A process which attempts to help the patient relieve symptoms, resolve problems or seek personal growth through a structured relation (i.e. specified goals and methods) with a trained professional therapist. The therapist may be a psychiatrist, a psychologist, a nurse, etc...

Types of Psychotherapy

A. According to Format:

1- Individual therapy.
2- Group therapy.
3- Family therapy.
4- Marital therapy.
5- Community or Milieu therapy.

B. According to content (the applied personality theory)

1 - Supportive.
2- Expressive (dynamic or insight oriented).
3- Behavioural.
4- Biofeedback
5- Cognitive-Behavioural
6- Experiential (Humanistic approach).
7- Rehabilitation and activity therapies.

Supportive Psychotherapy-

Definition and Aims

It is the form of therapy that deals with conscious conflicts and current problems. It aims at supporting the patient and helping him to:

1- Relieve symptoms and resolve problems.
2- Regain equilibrium and maintain stability.
3- Achieve better adaptation, coping and functioning.

Indications

1 - Crisis, acute distress or acute adjustment disorders.
2- Chronic or handicapped patients (e.g., chronic Schizophrenia, mood or personality disorders).
3- Patients who do not need (not motivated) or not fit (lacking ego strength or intellectual ability) for deeper expressive therapy

Techniques of supportive psychotherapy

- Establishing an emphatic understanding relation (therapeutic alliance).

- Active listening (empathic).
- Reassurance and encouragement.
- Suggestion, advice and persuasion.
- Clarification and explanation (education), e.g., as regards symptoms, interpersonal problems and ways of coping.
- Strengthening useful defenses.
- Suppression of unwanted conflicts.
- Improving ego strength and functioning (e.g., reality testing, autonomy, etc...).
- Environmental manipulation and modification.

Psychodynamic (Expressive) Therapy

A group of deep therapies that aim at symptom resolution as well as producing positive fundamental changes in the patient's character or personality.
This is achieved through:

- Uncovering unconscious conflicts and shift them to the conscious awareness of the patient.
- Help the patient resolve the conflicts and correct deficits through understanding and insight
- Induce change motivated by insight.
- Corrective relational and emotional experiences with the therapist.

Types of psychodynamic therapy

Psychodynamic psychotherapy includes a variety) of models, e.g..
classical psychoanalysis (of limited use now)
psychoanalytic oriented models,
short-term models,
object relation and self-psychologv models
The short-term techniques are characterized by being:

1- Time-limited. i.e.. weekly sessions for 3-6 months.
2- Problem-focused. i.e.. focused on limited key aspects of the patient's psychopathology

Behavioral Therapies

Behavioral therapy is based on the theory that symptoms are persistent maladaptive behaviors acquired by conditioning or learning. Therapy consists of "deconditioning" or "unlearning" of such behavioral habits and "relearning" of new adaptive behaviors. e.g., phobia.

Cognitive Behaviour Therapy (CBT):

CBT is aimed to change patterns of thinking or behaviour that are behind people's difficulties, and so change the way they feel. The client and therapist work together to understand the problem and develop new strategies for tackling them. CBT is helpful in OCD, panic disorder, post-traumatic disorder, phobias, eating disorder, insomnia and alcohol abuse.

Systematic Desensitization:

Systematic desensitization also known as graduate exposure therapy. It was developed Joseph Wolpe. This occur in three steps. The first step is the identification of an anxiety inducing stimulus hierarchy. The second step is learning of relaxation or coping strategies. When the individual has been taught these skills, he or she use them in third step to react towards and overcome situations in the established hierarchy. It is useful in phobias and anxiety disorders.

Flooding:

Instead of working up a hierarchy of anxiety producing stimuli in systematic desensitization in flooding technique the individual is flooded with continuous presentation of phobic stimulus until if no longer produces anxiety. It is helpful in phobia cases.

Shaping:

Reinforcements are given to the individual related to desired response to produce behaviour of another person eg Watching favourite or desired person's films and coping their behaviour. It is helpful in behavioural problems.

Modeling:

It is learning of new behaviour of role models who have qualities or skills which the individual wants to be. Often children's role models are parents, teacher and friends Adult role models are their favourite heroes. Sometime it may lead to maladaptive behaviour too

Token Economy:

In this therapy tokens are given when desired behaviour or goals are achieved There may be a verbal or written consent between therapist and patient. The tokens may be given for allowing to visit outside the hospital, providing books, allowing to watch movies The patient earn token for each activity by performing desired behaviour.

Aversion Therapy:

Aversion therapy is used to modify the desired behaviour by giving painful stimulus like electric shocks, bad odours, pintching etc, when the person perform undesired behaviour. It is helpful in sexual disorder and alcohol abuse.

Assertive Training:

Assertive training is teaching or encouragement of not being afraid toward an unappropriate response and negative comments etc. Assertiveness help patient to feel better about themselves by encouraging them to stand up for their own. It increases self esteem and ability to satisfying interpersonal relationship. The patient develop assertiveness through role modeling and positive or negative reinforcements.

Time Out:

It is removal of patient from the environment where the unacceptable behaviour is being exhibited. It work on based on aversive stimulus and punishment principles.

INTERPERSONAL/GROUP PSYCHOTHERAPY

Group therapy is a form of interpersonal psychotherapy in which a number of patient meet together under the guidance of therapist for the purpose of sharing of ideas, gaining of personal insight and improving interpersonal, communication and coping strategies.

Technique:

A group of maximum of 15 members seat together possibly in circled manner for 45 minutes to 1 hour duration for specified interval. The therapist introduce group about desired outcome and act as a facilitator. The members of group share their thoughs and ideas or perform activities. The therapiest provide positive reassurance, laughter, role playing in between of therapy.

Psychodrama:

It is the role playing a situation usually on problem or struggles of patient. The actors are selected among the patient's group on voluntary basis to play role under the guidance of director (i.e. therapist) on an artificial stage. In this role, the client is able to express true feelings toward individuals (represented by group members) with whom he or she has conflict or problem. When the drama completed the group members discuss situation along with audience. This offers feedback, express their feelings and share similar experiences.

Family Therapy:

Family therapy also known as marital or couple therapy. It focus on family as a unit principle. The problems of patient or family are discussed among members and guidance provided by the therapist.

Sexual Relationship Therapy:

It is also known as sex therapy. It is a strategy for the improvement of sexual function and treatment of sexual dysfunction. These are helpful in premature ejaculation, delayed ejaculation, erectile

dysfunction, vaginismus, paraphilias etc. The sex therapist assist those experiencing problems in overcoming them. The aims of therapy to understand the biological, psychological, pathological and pharmacological relations context of sexual problems. The techniques like Master and Johnson's and squzee technique are used for premature ejaculation.

MILIEU THERAPY

Definition:

The milieu therapy also termed as "therapeutic community" or "therapeutic environment". According B. F. Skinner milieu therapy is a scientific structuring of the environment in order to effect behavioural changes and to improve the psychological health and functioning of the individual. It is very helpful in schizophrenia and personality disorder.

Goal:

- Manipulate the environment so that all aspects of client hospital experiences. considered therapeutic.
- Client is expected to learn adaptive coping, interaction and relationship skill that can be generalized to other aspects of his or her life.
- Achieving client autonomy.

Characteristics:

The concept of milieu therapy developed from a desire to counteract the negative, regressive effects of institutionalization, reduce ability to think and act independently, an adoption of institutional values and attitudes and loss of commitments in the outside world. In order to counteract the negative effects following strategies is used –

1. Distribution of power and responsibility of health team members.
2. In therapeutic milieu confidentiality is replaced by mutual trust, honesty and open communication.
3. Staff members approach the client in a structured or consistent manner, thereby shortening the treatment time.
4. The client work activities are geared towards developing skills that will be useful for client future job.
5. The client are kept in their usual environment day care centre and half way home,where the family isolation is minimized and interaction is promoted.
6. Adaptation of the environment to meet the developmental needs of client.

Programme within milieu :

1. Client environment
- Structured meeting.
- Client input in all activities.
- Decision making for others.
- Discussion on everyday's problems.
- Meeting frequently.

2. Work related activities.
- Work therapy.
- Monetary reward.
- Works based on client's choice.
- Variety of activities.

Nurses Role:

A nurse participating in the design or renovation of the setting can greatly affect the therapeutic physical environment. A nurse input concerning the number of activities and interactions that occur in a dayroom can determine if the design is functional. Shower,curtains, lockers for personal items, bulletin board to display personal art work and picture and bed side lamp can be added with a little costs.

OCCUPATIONAL THERAPY

Occupational therapy is use of assessment and intervention to develop recover, or maintain the meaningful activities, or occupation, of individual, groups or communities. It is an allied health profession performed by occupational therapist. They posses bachelor or master degree in occupational therapy. Occupational therapy work with other professional in physical therapy, speech therapy, audiology, nursing, social work, clinical psychology and medicine.

Activities under occupational therapy:

1. Activities of daily living-Bathing, toileting, dressing, feeding, gromming etc.
2. Instrumental activities of daily living; Care of others like children, pets, driving, financial management, safety etc. Rest and sleep, Education formal or informal Work based on like and likes of patient e.g. crafts, gardening, sweeping etc. Job as a manager, supervisor, cow worker, painter, production, latherworketc. Play activities, Social work Participation in social, religious activities

Indications:

Occupational therapy is used to prevent disability due to mental illness. It is useful in following
Schizophrenia and other psychotic disorder
Depressive disorder
Anxiety disorder
Eating disorder
Post traumatic stress disorder
Obsessive compulsive disorder.

Role of Nurse:

- Ensure that clients basic needs are fulfilled.
- Assess physical and psychological status of client to perform activities and plan accordingly.
- Help the client to develop trustful relationship with others.
- Encourage client about his ability to perform activities or job and become productive member of his/her family and society.
- Educate about stress management.
- Provide positive reinforcement after each successful achievement.
- Understand patient likes and dislikes and help to choose his/her activity.
- Encourage/assist client in group activities and help in allievating anxiety during group activity.
- Promote self worthiness in client.

The mental health nurse play an important role as a member of mental health team administering psychotherapies. The role of nurse may vary according to therapy. A general role of nurse in psychotherapy are as follows -

- Prepare the require set up, articles and environment needed for therapy.
- Encourage and explain about therapy to the patient and family members or nominated representative to enhance their cooperation in therapy.
- Coordinate members of mental health team as needed for therapy
- Administer or assist the psychiatrist, clinical psychologist or any other therapist in administration of therapy.
- Closely observe the effectiveness of therapy and document it.
- Maintain the records of therapy. Encourage the patient to attend all sessions of therapy completely and actively.
- Convey respect, warmth, empathy and genuineness during therapy.
- The nurse should never de motivate or criticize or insult or laugh on patient behaviour and activities during therapy.
- Patient ego should not be hurt specially during group therapy

- Encourage client to participate in group activities during psycho drama, family therapy, sexual relationship therapy and group psychotherapy.
- A patient anxiety and anger should be delt carefully during the therapy.
- Children and elderly people must be taken care with more attention.
- If possible, at the end of therapy inform the client about further session of psychotherapy.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) has been demonstrated to be an effective and safe treatment for many psychiatric disorders. The use of ECT still generates significant controversy and viewed as harmful by the general public, psychiatric patient and health professional too The ECT have been negatively portrayed by media and movies thus create stigma towards ECT.

Definition:

Electroconvulsive therapy is a somatic treatment where by the artificial induction of a grandmal seizure through the application of electrical current to the brain.

History:

There has been use of various substances or drugs to produce seizures like camphor, insulin and pentylenetetrazol. In 1938, Italian psychiatrist Lucio Bini and neurologist Ugo Cerletti performed the first electrical induction of a series of seizures on a catatonic patient and produced a successful treatment response. In 1950, Max Fink used succinylcholine (a muscle relaxant) with ECT

Mechanism of Action:

The mechanism of action of ECT is not fully known. ECT affect multiple central nervous system components including hormones, neuropeptides, neurotrophic factors and neurotransmitter. Nearly every neurotransmitter system is affected by ECT, including GABA, beta-adrenergic, serotonin, muscarinic, cholinergic and dopamine system.

Indications:

- Major depressive disorder
- Bipolar disorder Schizophrenia
- Scizoaffective disorder
- Obsessive compulsive disorder
- Depression due to parkinson disease, pain, delirium and acute confusion psychosis
- Suicidal tendency due to depression

Contraindication:

- Increased Intracranial: Pressure (due to brain tumor, stroke or any lesion).
- Myocardial Infarction, Anneurysm, congestive
- Complicated pregnancy
- Chronic pulmonary disorders
- Minors (Banned by law also)

Adverse Effects:

- Drowsiness, confusion and temporary memory loss are common.
- Anxiety and difficulty in concentration, attention and orientation.
- Headache is common.
- Poor body control.
- Rarely permanent memory loss, brain damage and death.

Types:

(1) Direct ECT - ECT given without anesthesia and muscle relaxants. This have been banned by law.

(2) Modified ECT ECT is given with muscle relaxant and anesthesia.

Frequency and numbers of ECT

- 2-3 times per week
- Total numbers varies from 6-12 ECTS.

Amount of current

- The dose of electric current depends upon desired seizure response.
- Amount of current: 90-150 volts
- Duration: 0.1-1.0 seconds

Seizure Activity

The therapeutic adequacy of ECT is determined by occurance of generalized tonic clonic seizure for minimum 15 seconds in motor area. It is monitored by following

Methods:

- Cuff procedure.
- EEG recording during ECT.
- Observing planter extension and eyelid contraction during ECT.

Placement of Electrodes :

(1) Bilateral ECT (Bifrontotemporal): Each electrode is placed 1 inch above the midpoint of an imaginary line from tragus of ear to lateral canthus of the eye.
(2) Right unilateral: One electrode placed over the non dominant fronto temporal area and the other on the non dominant centro parital scalp, just lateral to the midline vertex. As the left hemisphere is dominant in most of people, unilateral electrode is usually placed over the right hemisphere.
(3) Bifrontal The electrode placed on each side of the head is more frontal than is standard bifrontotemporal placement.

Procedure and Nursing Interventions

1. Preprocedure Assessment:

- A through history of following-
- History of response to ECT and other treatment.
- History and examination of cardiovascular, musculo-skeletal, dental problems,pulmonary, neurological,
- Anesthesia history: Allergy, reaction and response.
- Investigations Complete blood count, serum chemistry, renal function, urinalysis and chest x-ray.
- Informed consent to be obtained from patient and/or family members.
- Explain procedure to patient and family member to allivete anxiety.
- Assess vital sign especially blood pressure.
- Patient stomach should be emptied 4-6 hours before ECT
- Provide shooping of hair and advice to avoid oil.
- Empty bowel and bladder just before ECT.
- Remove any metallic objects, ornaments, dentures from patient body and clothings.
- Administer anticholinergics to reduce bradyarrhythmias, oral and respiratory secretions like Atropine 0.6 mg IM /IV or SC 30 minutes before ECT just before ECT.

Procedure:

- Place the patient in supine position.
- Assist physician in general anesthesia Inj. Thiopentone 2-5 mg/kg LV. Or Inj. Propofol 0.75-2.5 mg/kg IV.

- Administer muscle relaxant like Inj Succinylcholine 0.5-1.5 mg/kg body weight.
- Administer oxygen.
- Place the mouth gag between teeth to prevent tongue bite during seizures.
- Apply electrodes moistened with saline or 25% bicarbonate solution or apply gel.
- Put side rails of bed to prevent fall and injury. Hold patient thigh and shoulder tightly.
- The physician apply ECT and monitor seizure activity for therapeutic adequacy.
- Remove mouth gag and do suctioning of oral cavity after Administer oxygen till consciousness regained.
- After procedure care Shift the patient to ward.
- Place the patient in lateral position to prevent aspiration. Put side rails of bed.
- Monitor vital sign and possible side effects of ECT.
- Record and report the procedure.

Unit- 9
Community Mental Health Nursing

Community mental health services began as an effort for whom were considered "mad" or "lunatic" and usually thought to be unmanageable. As the development of psychiatric it shifted towards the treatment of the mentally ill and development of psychiatric institution. In the beginning it was "asylums" and later as "mental hospitals" to treat person with mental illness. This formed the ground work for development of current community mental health services.

Definition:

Community mental health is a pattern of decentralised mental health, mental health care, or other services for people with mental illness. The community based cares are designed to supplement and decrease the need for more costly inpatient mental health care delivered in hospital.

History of Community Mental Health :

In ancient India the mental illnesses to be cause of devine curse and treatment usually took place in religious centres. Similar thoughts were present in western world also. The mentally ill people thought to be untreatable and unmanagable. They were thought to be violent and danger for the society resulting in isolation, prisoning or chained in asylums.

Phillip Pinel (1793) removed the chains from mentally ill patient confined in a hospital outside Peris, thus bringing about the first revolution in community psychiatry.

Dorothea Dix (1841) began a personal crusade across the land on behalf of institutionlized mentally ill client. The effort of this "self-appointed inspector" resulted in more humane treatment of person with mental illness and establishment of number of mental hospital.

The Indian Lunatic Act (1912) was passed by British ruled India to enact to govern reception, detention and care of lunatics and their property.

The Bhore committee (1946) presented the situation with regards to mental health services in India. Based on its recommendations many mental hospitals were setup across the country.

The National Mental Health Programme (1981) focused on community based mental health care and community psychiatry centres were setup to experiment with primary mental health care approach. This also recommended the formation of "District Mental Health Team" in order to decentralized the mental health care services at district level.

The Mental Health Act (1987) became an strong asset in order to protect the rights of mentally ill persons.

The District Mental Health Programme (1996) was a great developmental platforms for community mental health.

After Erwadi tragedy (2007) government initiated lincencing mental hospitals and upliftment of standards of mental health services around the country.

India has travelled a long journey to reach current mental health services at community level. Apart of government, several voluntary agencies, NGOs, halfway homes, crisis intervention centres and rehabilitation centres are working in periphery regions.

The field of community mental health is facing a great shortage of trained manpower. The WHO Mental atlases (2014) shows deficiency of psychiatric beds (0.08 per 10,000 population), psychiatrist (0.03 per 10,000 population); psychologist (0.004 per 10,000 population); and psychiatric nurses (0.016 per 10,000 population). These inadequate infrastructure and the scarcity of health care professionals in India contribute to wide treatment gaps in mental health care.

Importance of Community Mental Health :

The provision of mental health facilities are important in following ways -

1. Reduce pressure of mental hospitals.
2. Early diagnosis and treatment of patient within community itself.
3. Reduce traveling distance to approach mental health services.
4 Community participation in mental health development and community based mental health programme. Thus remove stigma and misconception about mental illness.
5. Provision of accessible rehabilitation services.
6. Treatment of patient in milieu environment and familial integration.
7. To reduce treatment gaps as lies common with institionalized mental health services.
8. Opportunity for mental hygiene, mental health and mental illness topics through mass media
9, Accessible facilities for physically handicapped, mental retarded and other deficient client.

Role of Nurse in Community Mental Health:

The field of community mental health provide a wide range of scope and opportunity for the nurses. The nurse working in the community health plays many role as follows –

1. Educator

The nurse understand the mental health and illness concepts, which she can easily transmit to the public. She/he can educate public about causes, symptom, diagnosis and management of mental illness. She/he can also helps in reducing stigma and misconception related to mental illnesses. Coordinating health teaching with community people will facilitate in obtaining objectives of community and national health.

2. Coordinator:

The nurse work as coordinator among multidisciplinary mental health team member. The nurse play vital role in case finding, screening, crisis intervention, home visit, referrel and follow-up to evaluate the breakdown and deficit.

3.Rehabilitator:

The key elements of rehabilitation psychiatry are reduction of impairement, remediation of disabilities through skill training and supportive interventions and remediation of handicaps. The community mental health nurse provide therapeutic intervention at various community settings like home, residential home and foster homes etc.

4.Practioner:

The nurse practioner provide direct or indirect nursing care to the individual, family and community. She/he may provide door to door care during home visit. The home visit provide excellent opportunity to community mental health nurse to educate people about mental health and early diagnosis and management of mental illnesses.

5. Advocate:

The rights of mentally ill people often violeted in the community. The nurse advocate of patient's rights in relation to their care. She/he may advocate for rights of food and shelter, right of treatment and rights of freedom of patient. Sometime she may have to negotiate for rights of mentally ill people.

6. Advisor:

The nurse may advice the people about preventive promotive, curative and rehabilitative services available for mental health and illness.

7.Leader:

The nurse being educated is respected by the general public. The people often listen the talk of nurses. Thus she may lead the group to provide targated services in thecommunity.

PREVENTIVE PSYCHIATRY NURSING

Preventive psychiatry consist of measures taken for prevention of mental disorder as opposed to disease treatment.

- The model of prevention was advocated by Leavell and Clark in 1975, has influenced both public health practice and ambulatory care delivery worldwide.
- This model suggests that the natural history of any disease, exist on a continnum, with health at one end and advanced disease at other hand.
- The model delineates application of preventive measures that can be used to promote health and arrest the disease process at different points along the continnum.
- The goal is to maintain a healthy state and to prevent disease or injury.

Levels of Prevention

The model define following levels of prevention as follows

1. Premordial Prevention :

It is prevention of emergence of risk factors in population in which they have not yet appeared. e.g. discouraging children from adopting harmful lifestyle. In case of psychiatry, mental hygiene play a primordial prevention toward psychiatric disorders.

2.Primary Prevention

It is an action taken prior to the onset of disease, which removes the possibility that disease will ever occur. It includes avoiding toxic drug during antenatal period, safe labour, nutritional diet, screening for genetic factors associated with mental disorders, proper psychosexual and other development etc.

3. Secondary Prevention :

The action which halts the progress of a disease at its incipient stage and prevents complications. It includes early diagnosis and treatment of disease, early screening and referral etc.

4.Tertiary Prevention :

All measures available to reduce or limit impairement and disabilities, minimizing sufferings caused by existing disorders. It includes involvement of family in therapeutic process, recreational and occupational activities and follow up care. The mental illness can be prevented by taking preventive measures in age and gender specific like in children, adolescent, adulthood, old age and women.

CHILDREN AND ADOLESCENT

Identification of mental disorders in children can be tricky for health care providers Children differs from adult in that they experience and cope with, adapt and relate to other and the world around them. There are several different mental disorders that can affect children including

- Anxiety disorders
- Attention deficit hyperactivity disorder
- Developmental disorder: Pervasive

- Eating disorders
- Substance abuse
- Elimination disorder
- Antisocial activity
- Learning and communication disorder
- Mood disorder depression, bipolar
- Tic disorder
- Mental retardation
- Suicide

Contributing Factors :

The factors like poor developmental environment, childhood or birth trauma (physical or psychological), abuse maltreatment, family history of above disorders, poverty, parental saperation etc. may be a contributing factors for childhood mental illnesses.

Prevention:

Most mental disorder are caused by a combination of factors and cannot be prevented. However the following preventive measures may be helpful ---

- Early recognition of symptoms and proper treatment.
- Parent education about psychological developmental milestone, use of defense mechanism, proper use of discipline, awareness towards (Positive Parenting)
- Eradication of poverty & Counselling
- Screening of risk cases in early period (Perinatal period)
- Adequate nutrition
- Marital counselling to reduce saperation and divorce.
- Adequate supervision and inforcement of legislation to prevent physical, psychological abuse and substance abuse. Education related to prevention of STD/HIV etc.
- Early identification of conflicts and suicidal behaviour.

ADULTHOOD

Contributing Factors:

- Stress and conflicts.
- Environmental and intra familial violence, domestic violence,
- Physical disorders.
- Disability.
- Poor sexual functioning
- Substance abuse especially alcohol and injectable drugs.
- Poor nutritional supports

Preventive measures:

- Early detection and treatment
- Eradication of poverty.
- Good nutritional supports
- Education about prevention of STD and HIV.
- Marital counselling for sexual malfunctioning
- Job security and good working environment development
- Financial security.
- Strengthening of women's proction law and rights.
- Management of physical disorders.
- Social supports

- Adequate supervision and inforcement of legislation related to domestic violence and substances abuse etc.
- Adaption of healthy aging activities and habits. and minority group
- Social securities for low economic, ethnic

OLD AGE

The older adult or elderly goes to rapid change in physical and mental functioning related to aging. This leads to sensory deficit, deficit activity of daily living, social deprivation and isolation, sexual dysfunctioning. The disorder associated with elderly have been discussed in previous chapters in detail (eq. Alzaeimer's disease dementia etc).

Contributing Factors :
- Inability to perceive and adapt role change.
- Loss of loving one i.e. spause, family members and friends.
- Lonelyness due to loss of job or retirement.
- Presence of physical disorders mainly musculosketetal, cardio-vascular, respiratory, nervous system and cancer etc.
- Presence of brain disorders like alzeheimess disease, dementia and stroke.
- Poor nutritional supports
- Elderly neglect

.
Preventive Measures:
- Adaption of healthy aging activities.
- Proper nutritional support
- Balanced physical activity.
- Involvement in routine activities at home.
- Good family environment.
- Social support groups.
- Involvement in religious activities
- Prevention Gender of abuse and violence of elderly by inforcing legislation strictly

WOMEN

Gender a critical determinants of mental health and illness. The patterns of psychological distress and psychiatric disorders among women are different from those in men. Women have a higher chance disorders which commonly occur in women are
- Depressive disorder
- Anxiety disorder
- Obsessive compulsive disorder
- Hypochondriasis
- Eating disorders
- Post traumatic stress Suicidal tendency

Contributing Factors :
- Stressful life may be due to home and work environment and role, domestic abuse, and reproductive activities.
- Marital conflicts and family conflict.
- Poor socioeconomic status.
- Less recreational opportunity.
- Broken family i.e. saperated, divorce and widow.
- Sexual abuse. Poor reproductive health.
- Social evils: Dowery, Pardah, girl child marriage, girl child discriminations.
- Physical disorders especially nutritional deficiency, reproductive endocrine disorders.

- Social insecurity.

Preventive Measures:
- Adequate provisions of nutritional support.
- Autonomy in financial activities and decision making.
- Good opportunity for recreation.
- Family and marital counselling.
- Pleasurable family and work environment.
- Community support group for under previlaged women.
- Strict adherence to law for prevention of women's abuse and upliftment of women's rights.

Role of nurse in metal health programme

The National Mental Health Programme (NMHP) was launched in 1982 The major eves of the programme was to ensure availability and accessibility of minimum health care for all in the foreseeable future, particularly to the most vulnerable and under privileged sections of population, encourage application of mental health ledge in general health care and social development, and to promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.
Under NMHP the District Mental Health Programme (DMHP) was launched in to provide sustainable and to integrate these services with other health services; detection and treatment of patients within the community itself, and to that pt and their relatives do not have to travel long distance to go to hospitals and among home in the cities.

Role of Nurse:

(1) National Level :
- The nurse helps in formulation and plan strategies of programme
- Identify the needs on current mental health nursing and plan accordingly at national level.
- Adequate opportunity of training and higher education in nursing to meet the shortage of staff in mental health nursing.
- Provide adequate opportunity of development of field of mental health nursing by promotion of research.
- Facilitate adequate budget for development of mental health nursing like starting new programmes and higher education, enhancing seats for PG Nursing, training of inservice and research etc.

The opportunity to play a active role at national level have been enhance as a member of National Mental Health Authority under Mental Healthcare Act 2017.

2. State Level:

As like member of National Health Authority, the nurse member also appointed as a member of state Mental Health Authority. This provide a great opportunity for mental health nurse to strengthen the mental health nursing at state level by playing following role
- Participate in state level planning strategies of NMHP
- Identify the proper needs of the state based on data available.
- Facilitate development of state mental health nursing area like training of UG and PG courses, inservice education, research and maintainance of register of Mental Health Nurse by state council.
- Forward the needs of budget and solutions of problems to state authority.
- Pull the budget for nursing area and plan and supervise proper utilization of budget
- Motivate for active participation by nurses in "World Mental Health Day"and Alzheimer's Day etc.
- Coordinate between state and national level.

Role at Regional or Mental Hospital :
- Actively participate in all activities under NMHP

- Properly utilize the budget provided.
- Training of UG and PG nurses in field of mental health nursing.
- Become an asset with self readiness for being utilized for activities of NMHP
- Celebration of varies mental health related days at clinical or institutional area
- Education of general public through provided IEC material.

District Level:

- Actively participate as district level mental health team member.
- Organization of DMHP and NMHP activities,
- Participate in training and short-term courses for professional development.
- Coordinate between district level with national and peripheral staff
- Participate in diagnosis and treatment of mental health problems.
- Reduce stigma and misconception and create awareness towards mental illness through awareness among general public.
- Participate in research activities.
- Provide rehabilitation, referral and follow up programme,
- Provide services in out reach programme.

  The district level activities are performed at psychiatric unit at district hospital, government and psychiatric hospital and voluntary agencies. These activities may also be conducted under DMHP.

Community Level:

The community level activities are performed by CHCS PHCs and Subcentres. The role of nurse are as follows:

- Participate in examination, diagnosis and management of mental health needs of the mentally ill patient.
- Provide nursing care in inpatient patient.
- Participate in out reach activity/plan and psychiatry clinic in PHC/CHCs and other site periodically.
- Participate and impart training to the health personnel of CHCs and PHCs as per guideline issue by National Mental Health Cell general public.
- Create awareness through IEC and other strategies among Organization and participation in mental health awareness related celebrations
- Assist in referral and follow up care.
- Participate in training programme.