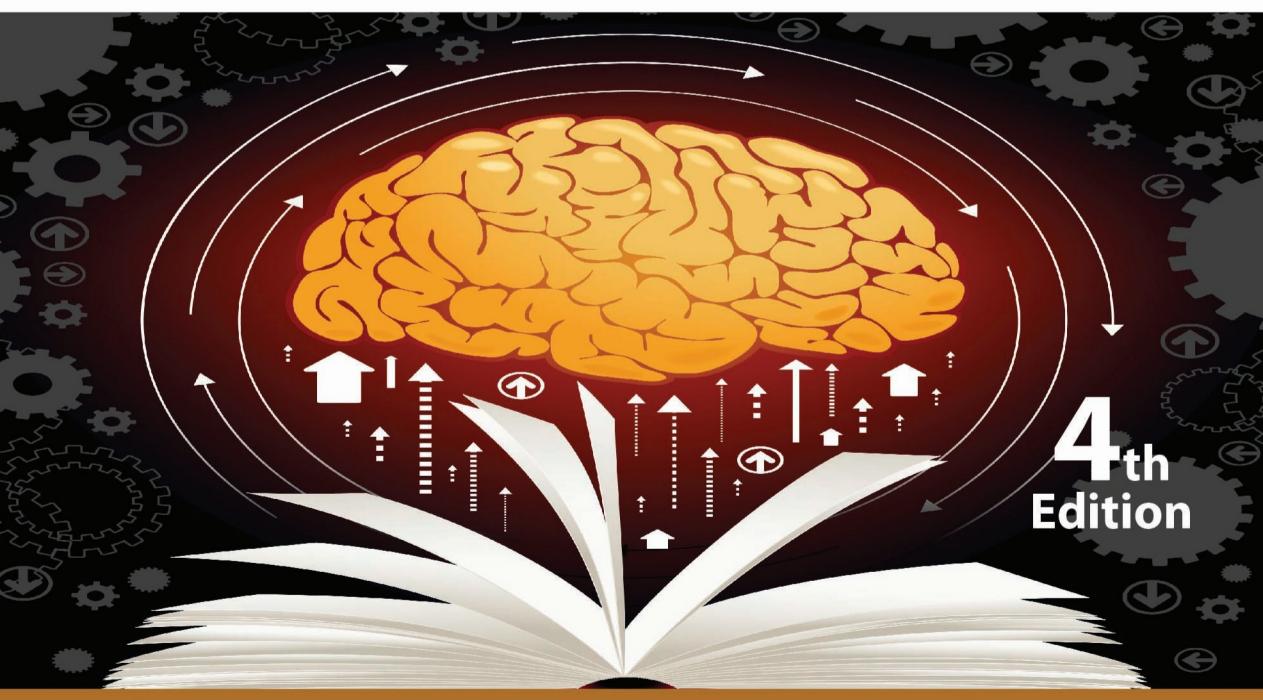




A GUIDE TO MENTAL HEALTH & PSYCHIATRIC NURSING



4th
Edition

R Sreevani

Foreword
K Reddemma



A Guide to
**MENTAL HEALTH AND
PSYCHIATRIC NURSING**

A Guide to MENTAL HEALTH AND PSYCHIATRIC NURSING

Fourth Edition

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Foreword

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The Health Sciences Publisher

New Delhi | London | Panama



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A Guide to Mental Health and Psychiatric Nursing

First Edition: 2004
Second Edition: 2007
Reprint: 2008
Third Edition: 2010
Fourth Edition: 2016
Revised Reprint: 2018

ISBN 978-93-5250-047-5

Dedicated to

My Husband

Foreword

With an increase in awareness regarding the various roles a nurse can play, it has been widely accepted that she would strategically be placed for performing the functions of a psychiatric nurse. This has led to an unprecedented and a rapid change in the responsibility shouldered by her. To equip her for this commendable task, an urgent need was felt in molding the curriculum at various levels. Every change in the syllabus should be well supported by good publications in the market that add to the knowledge and information.

The revised fourth edition of *A Guide to Mental Health and Psychiatric Nursing* by Dr R Sreevani is a concrete step toward this end. This book is well written and structured so that it is straightforward for the reader to make sense of the complex but essential aspects of psychiatric nursing.

Having read this textbook in its entirety, I would recommend it to both student nurses and qualified nurses alike. The breadth and depth of information presented is ample and well expressed thus encouraging a practical approach to psychiatric nursing. The author has successfully maintained easy-to-read style throughout, interspersing the text with the use of well-annotated diagrams and clear illustrations that not only brings the subject of psychiatric nursing to life but also ensures that the book is enjoyable and interesting to read. The inclusion of tabulated information contributes effectively to the comprehension of the text thus making the subject matter more accessible to the student.

For student nurses, pursuing their basic qualification, it provides a key handbook and would be a welcome addition to their bookshelves. Qualified nurses longing to expand their psychiatric nursing knowledge whilst studying for advanced psychiatric nursing course, but as yet unfamiliar with the approach or for others who simply want to improve their nursing skills, this book would undoubtedly be an essential acquisition. It encourages nurses to assess patients more thoroughly and have a more productive and informed input into patient care.

I am confident, this textbook would appeal to a wide audience within the nursing profession and is to be recommended in any nurses' library portfolio.



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Preface to the Fourth Edition

It gave me immense pleasure when the publishers called for the fourth edition of the textbook. It was a great opportunity for me to update the text with special reference to current trends and make a few revisions where necessary, though the syllabus did not undergo any change.

As a panel member for setting exam papers in various universities, I observed that a few questions are being posed in the form of multiple choice questions (MCQs), and also they are extensively asked in PG and PhD entrance examinations. Though the student nurse has read through the text systematically and understood the various concepts, the distracters can pose a real challenge in tackling the MCQs. Accordingly, MCQs covering the whole topic have been included at the end of each chapter.

The drug guide which was introduced in the third edition has been made up-to-date with the inclusion of newer drugs. A list of abbreviations that one would come across in the text have been segregated and presented at the end of the book for ready reference.

Various topics in chapter 1, such as Evolution of Mental Health Services and Treatment, Development of Modern Psychiatric Nursing, Prevalence and Incidence of Mental Health Problems and Disorders have been revised and updated so as to keep the student nurse abreast of the latest happenings. New topics, such as Mental Health Care Act, 2013, National Bill, Mental Health Policy 2014, Diagnostic and Statistical Manual of Mental Disorder (DSM-5), Developments in National Mental Health Program and District Mental Health Program have been introduced.

The contents in some of the chapters such as Therapeutic Communication and Nurse-Patient Relationship, Nursing Management of Patient with Substance Use Disorder, Psychiatric Emergencies and Crisis Intervention, Legal Issues in Mental Health Nursing and Community Mental Health Nursing have been reorganized for better comprehension. The other chapters were left untouched as they are well suited with the requirements of the readers.

I hope this edition will make a good reading.

R Sreevani

Preface to the First Edition

The well-being of a human being has two facets *viz.*, physical and mental health. However, the physical health of an individual has donned greater prominence over the mental health aspect. One need not go very far to seek an answer. Mental ailments have been considered a taboo in the society from time immemorial, resulting in their restriction to the various households than becoming public knowledge. Ignorance of mental health concepts and related ailments has also led to lower awareness levels among the masses. It is only in the recent past that due emphasis has been laid on mental health needs and practices. Commendable progress has been made in the related areas, which includes revision and upgradation of syllabi at various levels of education, identifying qualified people and appointing them in appropriate places for better monitoring of mental healthcare needs, and providing inputs to healthcare teams by conducting seminars and workshops.

The idea to come out with a guide on mental health and psychiatric nursing was conceived during my teaching experience when I found that the students of BSc Nursing did not have a concise text covering their entire syllabus and were left wanting for adequate information on certain topics. An earnest effort has been made to include all such information in this publication. This guide has been compiled in line with the syllabus formulated by the Rajiv Gandhi University of Health Sciences for BSc Nursing Course.

TEXT ORGANIZATION

The guide consists of 16 chapters. The highlights are as under:

Chapter 1 deals with the concept of mental health and mental illness. The chapter ends with various etiological factors and classification of mental disorders.

Chapter 2 covers the development of psychiatry and psychiatric nursing and also includes history taking and mental status examination formats.

Chapters 5, 7 and 9 include a very detailed description of the nursing management of functional psychiatric disorders, neurotic disorders and psychoactive substance use, which is in accordance with the nursing process, making the contents more suitable and practical.

Chapter 11 has been devoted to child psychiatric nursing, in which an array of details has been provided, ranging from mental retardation, its rehabilitation, complete care, steps in teaching skills to mentally retarded children, thus accommodating nursing students interested in obtaining an in-depth knowledge on the subject.

Chapter 12 deals with therapeutic modalities in psychiatry. The role of a nurse in administering various psychotropic drugs to patients, care of a patient undergoing ECT has been highlighted in this chapter. It also includes psychological therapies, therapeutic milieu and activity therapy. Suggested activities for psychiatric patients with various psychiatric disorders have also been included.

Chapter 14 covers the various statutes in legal psychiatry and their provisions affecting the role of a nurse, and also a variety of roles that she has to play in different legal situations.

Chapter 15 gives an account of the role of a nurse in the community, and also in prevention of mental disorders and rehabilitation.

Psychiatric emergencies, though not included in the prescribed syllabus, have been covered in chapter 16 with appropriate references to previous chapters for details on management.

The book has for the most part employed the ICD system (International Classification of Diseases and Related Health Problems-10) in describing various psychiatric disorders. Theoretical aspects have been well complemented by practical aspects where necessary, enabling the students to equip themselves better for their future endeavors.

The book also includes an exhaustive glossary of various terms used in describing common psychiatric disorders, which is a must for gaining a broad understanding of the subject. Each chapter is followed by certain important questions culled out from the previous examinations allowing the students to get an idea of what is expected of them. A list of references has been furnished at the end of the guide for further reading.

The matter has been presented in simple language, and the guide being comprehensive, caters to the needs of an average student at the graduate level. However, students of General nursing, MSc nursing and other mental health professionals interested in getting an overview may also find it useful.

After going through the book, the students should be able to not only manage their exams on psychiatric nursing, but also meet the mental healthcare needs of patients more effectively.

All constructive suggestions from the readers in making this guide more valuable and helpful will be earnestly solicited.

R Sreevani

Acknowledgments

I thank the Lord Almighty, who has given me the privilege and strength to write this book in the field of my specialization.

I would like to go on record to express my deep gratitude to Shri Jitendar P Vij (Group Chairman) and Mr Ankit Vij (Group President) of M/s Jaypee Brothers Medical Publishers (P) Ltd, New Delhi, India, for being instrumental in translating an idea mooted long ago into print, and also provide nursing students with a book on Mental Health and Psychiatric Nursing in line with their syllabus.

I thank:

Dr K Reddemma (*Formerly*, Dean, Behavioural Sciences and Professor, Department of Nursing, NIMHANS, Bengaluru) for her valuable suggestions and guidance, and for accepting to write the foreword for this book.

My husband, Mr Giridhar A, for the constant encouragement and motivation, which strengthened my resolve to come out with this publication.

Dr Prasanthi N, PhD (Nursing), my colleague and friend, for her moral support and guidance.

My grandparents, parents, in-laws, Mrs Seethamma and all my family members for their extensive help.

My acquaintances Mr Sidaveerappa B Tuppad, Vice-Principal, National Institute of Nursing, Sangrur, Punjab, and Mrs J Jeayareka, Assistant Professor (N), AIIMS, Raipur, Chhattisgarh, for their suggestions and inputs.

The student community and the faculty alike for sending their suggestions and critical comments, which helped in making this textbook a better one.

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Chapter 1

Perspectives of Mental Health and Mental Health Nursing

MENTAL HEALTH

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease. Hence, mental health is an integral and essential component of health. It is the foundation for individual well-being and the effective functioning in a community. Mental health is also related to promotion of mental well-being, prevention of mental disorders and treatment, rehabilitation of people affected by mental disorders.

It is a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between the realities of the self and that of other people and the environment.

DEFINITIONS

The World Health Organization (WHO) defines mental health as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Karl Menninger (1947) defines mental health as, "An adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness."

The American Psychiatric Association (APA 1980) defines mental health as, "Simultaneous success at working, loving and creating with

the capacity for mature and flexible resolution of conflicts between instincts, conscience, important other people and reality."

Thus, mental health would include not only the absence of diagnostic labels such as schizophrenia and obsessive compulsive disorder, but also the ability to cope with the stressors of daily living, freedom from anxieties and generally a positive outlook towards life's vicissitudes and to cope with those.

Components of Mental Health

The components of mental health include:

- **The ability to accept self:** A mentally healthy individual feels comfortable about himself. He feels reasonably secure and adequately accepts his shortcomings. In other words, he has self-respect.
- **The capacity to feel right towards others:** An individual who enjoys good mental health is able to be sincerely interested in other's welfare. He has friendships that are satisfying and lasting. He is able to feel a part of a group without being submerged by it. He takes responsibility for his neighbors and his fellow members.
- **The ability to fulfill life's tasks:** A mentally healthy person is able to think for himself, set reasonable goals and take his own decision. He does something about the problems as they arise. He shoulders his daily responsibilities, and is not bowled

Box 1.1: Criteria for mental health

- » Adequate contact with reality
- » Control of thoughts and imagination
- » Efficiency in work and play
- » Social acceptance
- » Positive self-concept
- » A healthy emotional life

over by his own emotions of fear, anger, love or guilt (Box 1.1).

Indicators of Mental Health

Jahoda (1958) has identified six indicators of mental health which include:

1. **A positive attitude towards self:** This includes an objective view of self, including knowledge and acceptance of strengths and limitations. The individual feels a strong sense of personal identity and security within the environment.
2. **Growth, development and the ability for self actualization:** This indicator correlates with whether the individual successfully achieves the tasks associated with each level of development.
3. **Integration:** Integration includes the ability to adaptively respond to the environment and the development of a philosophy of life, both of which help the individual maintain anxiety at a manageable level in response to stressful situations.
4. **Autonomy:** It refers to the individual's ability to perform in an independent self-directed manner; the individual makes choices and accepts responsibility for the outcomes.
5. **Perception of reality:** This includes perception of the environment without distortion, as well as the capacity for empathy and social sensitivity—a respect and concern for the wants and needs of others.
6. **Environmental mastery:** This indicator suggests that the individual has achieved a satisfactory role within the group, society or

environment. He is able to love and accept the love of others.

Seven signs of mental health

1. Happiness
2. Control over behavior
3. Appraisal of reality
4. Effectiveness in work
5. Healthy self-concept
6. Satisfying relationships
7. Effective coping strategies

Characteristics of a Mentally Healthy Person

- He has an ability to make adjustments.
- He has a sense of personal worth, feels worthwhile and important.
- He solves his problems largely by his own effort and makes his own decisions.
- He has a sense of personal security and feels secure in a group, shows understanding of other people's problems and motives.
- He has a sense of responsibility.
- He can give and accept love.
- He lives in a world of reality rather than fantasy.
- He shows emotional maturity in his behavior, and develops a capacity to tolerate frustration and disappointments in his daily life.
- He has developed a philosophy of life that gives meaning and purpose to his daily activities.
- He has a variety of interests and generally lives a well-balanced life of work, rest and recreation.

MENTAL ILLNESS

Mental illness is maladjustment in living. It produces a disharmony in the person's ability to meet human needs comfortably or effectively and function within a culture.

A mentally ill person loses his ability to respond according to the expectations he has for himself and the demands that society has for him.

In general, an individual may be considered to be mentally ill if:

- The person's behavior is causing distress and suffering to self and/or others.
- The person's behavior is causing disturbance in his day-to-day activities, job and interpersonal relationships.

DEFINITION

Mental and behavioral disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behavior associated with personal distress and/or impaired functioning (WHO, 2001).

Characteristics of Mental Illness

- Changes in one's thinking, memory, perception, feeling and judgment resulting in changes in talk and behavior which appear to be deviant from previous personality or from the norms of community.
- These changes in behavior cause distress and suffering to the individual or others or both.
- Changes and the consequent distress cause disturbance in day-to-day activities, work and relationship with important others (social and vocational dysfunction).

EVOLUTION OF MENTAL HEALTH SERVICES AND TREATMENT

Historically, mental illness was viewed as a demonic possession, the influence of ancestral spirits, the result of violating a taboo or neglecting a cultural ritual and spiritual condemnation. As a result, the mentally ill were often starved, beaten, burnt, amputated and tortured in order to make the body an unsuitable place for the demon. Gradually, man began the quest for scientific knowledge and truth, which can be traced as follows:

- Pythagoras (580–510 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 (427–347 BC) identified the relationship between mind and body.
- Asciphiades, who is referred to as the Father of Psychiatry, made use of simple hygienic measures, diet, bath, massage in place of mechanical restraints.
- The Greeks were the first to study mental illness scientifically and separate the study of mind from religion. Aristotle, a Greek philosopher, emphasized on the release of repressed emotions for the effective treatment of mental illness. He suggested catharsis and music therapy for patients with melancholia.
- During the middle ages, the mentally ill were not considered as outcasts, but as people to be helped. One of the great figures during this time was St. Augustine, who believed that although God acted directly in human affairs, people were responsible for their own actions.
- Renaissance in Europe (1300–1600 AD): This period represented the saddest chapter in the history of psychiatry when it was believed that demons were the cause of hallucinations, delusions and sexual activity, and the treatment was torture and even death.

Some Important Milestones

- 1773** The first mental hospital in the US was built in Williamsburg, Virginia.
- 1793** Philippe Pinel removed the chains from mentally ill patients confined in Bicetre, a hospital outside Paris, thus bringing about the first revolution in psychiatry.
- 1812** The first American textbook in psychiatry was written by Benjamin

- Rush, who is referred to as the Father of American Psychiatry.
- 1908** Clifford Beers, an ex-patient of a mental hospital, wrote the book, 'The Mind That Found Itself' based on his bitter experiences in the hospital. He founded the American Mental Health Association, which made a major contribution towards the improvement of conditions in mental hospitals.
- 1912** Eugen Bleuler, a Swiss psychiatrist coined the term 'schizophrenia'.
- 1912** The Indian Lunacy Act was passed.
- 1927** Insulin shock treatment was introduced for schizophrenia.
- 1936** Frontal lobotomy was advocated for the management of psychiatric disorders.
- 1938** Electroconvulsive therapy (ECT) was used for the treatment of psychoses.
- 1939** Development of psychoanalytical theory by Sigmund Freud led to new concepts in the treatment of mental illness.
- 1946** The Bhore Committee presented the situation with regard to mental health services. Based on its recommendations, five mental hospitals were set up at Amritsar (1947), Hyderabad (1953), Srinagar (1958), Jamnagar (1960) and Delhi (1966). An All India Institute of Mental Health was also set up at Bengaluru (currently known as National Institute of Mental Health and Neurosciences or NIMHANS).
- 1949** Lithium was first used for the treatment of mania.
- 1952** Chlorpromazine was introduced which brought about a revolution in psychopharmacology and changed the whole picture of mental health care.
- 1963** The 'Community Mental Health Centres' Act was passed.
- 1970s** Slow and steady reduction of beds in custodial institutions, growth in General Hospital Psychiatric Units and out-patient services was seen.
- 1978** The Alma-Ata declaration of "Health for All by 2000 AD" posed a major challenge to Indian mental health professionals. In order to achieve mental health for all (as a part of the achievement of Health for All by 2000 AD), in 1980 the Government of India called for experts in the field for assessing the mental health needs of the people and recommended steps for providing mental health care.
- 1981** Community psychiatric centers were set up to experiment with primary mental health care approach at Raipur Rani, Chandigarh and Sakalwara, Bengaluru.
- 1982** The focus shifted to community based care, which became the basis for the National Mental Health Program.
- 1982** The Central Council of Health, India's highest health policy making body accepted the National Mental Health Policy and brought out the National Mental Health Program in India.
- 1987** The Indian Mental Health Act was passed. The Government of India passed two Acts, Mental Health Act 1987, and Person with Disability Act 1995 to protect the rights of persons with mental illness, mainstreaming of these people into the society. As per the Mental Health Act, 1987, there is a provision for constitution of Central Mental Health Authority (CMHA) at Central level and State Mental Health Authority (SMHA) at State level. These statutory bodies are delegated with the task of development, regulation and coordination of mental health services in the State.
- 1990** The Government of India formed an Action Group at Delhi to pool the opinions of mental health experts about the National Mental Health Program (NMHP). National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, took the leadership in orienting health care professionals about the mental health programs of

our country. A number of innovative approaches for the treatment and rehabilitation of mental illness initiated, and the most important ones are:

- Integration of mental health care with general health care.
- School mental health programs.
- Promotion of child mental health through the involvement of Anganwadis [Integrated Child Development Services (ICDS) program].
- Crisis intervention for suicide prevention.
- Halfway homes for mentally ill individuals for social skills training, vocational training.
- Education and involvement of the general public through the activities of non-governmental organizations.
- Media materials for public education.
- Training for non-professionals to work with mentally ill individuals.

1997 National Human Rights Commission prepared a Plan of Action for improving the conditions in mental hospitals in the country and enhancing awareness of the rights of those with mental disability.

2001 Current situation analysis (CSA) was done to evolve a comprehensive plan of action to energize the NMHP.

Advanced Center for Ayurveda in Mental Health and Neurosciences at the National Institute of Mental Health and Neurosciences (NIMHANS), initiated research studies in areas like epilepsy, mental retardation, schizophrenia, etc.

The Advanced Center for Yoga Therapy and Research at NIMHANS started intervening in psychiatric disorders through yogic approach: a few nurses are involved in teaching basic yogic exercises to the mentally ill patients.

The National Human Rights Commission of India is mandated under section

12 of the protection of Human Rights Act 1993 to visit Government run mental hospitals to study the living conditions of inmates and make recommendations thereon. In 1997 project, quality assurance in Mental Health Institutions was initiated to analyze the conditions generally prevailing in 37 Government run mental hospitals and departments. The findings of this study confirm that mental hospitals in India are still being managed and administered on a custodial mode of care. Characters sized by prison-like structure with high walls, watch towers, fenced wards and locked cells. Mental hospitals are like detention centers where persons with mental illness are kept caged in order to protect society from the danger their existence poses.

2001 On Aug 6th, 27 more mentally ill people died as they were tied to their beds when fire engulfed the thatched roof of the Moideen Badusha Mental Home at Erwadi, Tamil Nadu State. Following this tragedy, the National Human Rights Commission of India (NHRC) advised all the chief ministers to submit a certificate stating no person with mental illness are kept chained in either Government or private institutions. The incident of Erwadi has opened up the eyes of the Government which in turn took lots of affirmative actions to improve mental health sector in the country, like district wise survey of all registered and unregistered bodies purporting to offer mental health care and license to be granted on standards are maintained. Government has implemented the District Mental Health Program which incorporates the WHO community mental health care model. It focuses on treatment availability at primary level, community awareness and renovation and construction of hospital

- for mental health in the State. It also covers training components for human resource development in the field of mental health.
- 2002** National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Ministry of Health and Family Welfare.
- 2007** Under the Eleventh five year plan, Centers of Excellence in the field of mental health were established to upgrade and strengthen identified existing mental health hospitals for addressing acute manpower gap and provision of state of the art mental health care facilities in the long run. During this period, 11 mental health institutes were funded for developing as Centers of Excellence in Mental Health.
- 2008** WHO Mental Health Gap Action Program was launched which aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle income.
- 2013** World Health Organization launched the Mental Health Action Plan 2013-2020 on 7 October, 2013. The action plan identifies the important role of mental health in achieving health for all people. It stresses prevention of mental illness and aims to achieve equity through universal health coverage.
- 2013** Under the Twelfth five year plan the Government of India integrated different components of National Mental Health Program with the components of National Rural Health Mission, namely school health, reproductive child health and adolescent friendly clinics to reach out to the community in a more effective manner.
- 2013** The Mental Health Care Bill was introduced in the Rajya Sabha on 19 August, 2013. The Bill abolishes the Mental Health Act, 1987.
- 2013** Under central sector, the Ministry of Social Justice and Empowerment launched Deendayal Disabled Rehabilitation Scheme (DDRS) and provided financial assistance to Non-Governmental Organizations (NGOs), for providing various services to persons with disabilities and mental retardation including special schools, half way homes, etc. The National Trust for the Welfare of Persons with autism, cerebral palsy, mental retardation and multiple disabilities implements various other schemes for the rehabilitation of such individuals.
- 2014** In April 2011, the Government of India Constituted a policy group to recommend a mental health policy for the country. After due deliberations and intense discussions, the group has submitted recommended policy. The suggested Mental Health Policy has been duly considered by the Minister of Health and Family Welfare, Government of India. This National Mental Health Policy 2014 is in accordance with the intent of World Health Assembly resolution. This policy incorporates an integrated, participatory rights and evidence based approach.
- World Mental Health Day is observed on 10th October every year, with the overall objective of raising awareness of mental health issues around the world and mobilizing efforts in support of mental health.

Indian Psychiatric Association

Indian Psychiatric Association is a professional body of psychiatry in India; it is the largest association of Indian psychiatrists. Berkeley Hill of Ranchi founded the Indian Association for Mental Hygiene in 1929. In 1935, the Indian division of the Royal Medico Psychological Association was formed with the efforts of Banarsi Das. In 1946, the Indian Psychiatric Society was inaugurated.

The main aims of this association are promotion of mental health and mental health education, promote and advance the subject of psychiatry, formulation and advise on the standards of education and training in psychiatry, promote research in the field of psychiatry, deal with matters relating to mental health concerning the country and promote ethics in practice of psychiatry in India. Indian Psychiatric Society is publishing its own journal, Indian Journal of Psychiatry.

DEVELOPMENT OF MODERN PSYCHIATRIC NURSING

Psychiatric nursing in general arose from the need for hospitals to provide socially acceptable levels of care for patients.

Some Important Milestones

- 1840s** Florence Nightingale made an attempt to meet the needs of psychiatric patients with proper hygiene, better food, light and ventilation and use of drugs to chemically restrain violent and aggressive patients.
- 1872** First training school for nurses, based on the Nightingale system was established by the New England Hospital for Women and Children, USA. Linda Richards, the first nurse to graduate from the one-year course, developed 12 training schools in the USA.
- 1882** First school to prepare nurses to care for the mentally ill was opened at McLean Hospital in Waverly. A two-year program was started but few psychological skills were addressed and much importance was given to custodial care such as personal hygiene, medication, nutrition, etc.
- 1913** Johns Hopkins became the first school of nursing to include a fully developed course for psychiatric nursing in the curriculum.
- 1921** Short training courses of 3 to 6 months were conducted in Ranchi.
- 1943** Psychiatric nursing course was started for male nurses. The Chennai Government organized a three-month psychiatric nursing course for male nursing students.
- 1946** Health Survey Committee's report recommended preparation of nursing personnel in psychiatric nursing also. Commencement of training in existing institutions like mental hospitals of Bengaluru and Ranchi.
- 1948–50** Four nurses were sent to UK by the Government of India, for training in 'mental nurses' diploma.
- 1952** Dr Hildegard Peplau defined the therapeutic roles that nurses might play in the mental health setting. She described the skills and roles of the psychiatric nurse in her book 'Interpersonal Relations in Nursing'. It was the first systematic theoretical framework developed for psychiatric nursing.
- 1953** Maxwell Jones introduced therapeutic community.

The important factor in the development of psychiatric nursing was the emergence of various somatic therapies like, insulin shock therapy (1927), psychosurgery (1936), and ECT (1938). These therapies required the medical surgical skills of the nurses and increased the demand for improved psychological treatment for patients who did not respond well. As the nurses collaborated with the doctors in carrying out these therapies, they struggled to define their role as psychiatric nurses.

Major growth in psychiatric nursing occurred after World War II because of the emergence of services related to psychiatric problems. The content of psychiatric nursing became an integral part of general nursing curriculum.

- 1953-54** The urgent need for nurses trained in psychiatric care was felt by the Government of India.
- 1954** Nur Manzil Mental Health Centre, Lucknow, started psychiatric nursing orientation courses of 4–6 weeks duration.
- 1956** One year post-certificate course in psychiatric nursing was started at NIMHANS, Bengaluru.
- 1958** All the wards at the Agra Mental Hospital were ordered to be kept open and all ward locks were removed from the charge of the ward attendant. Nurses took an active role in patient care and handled their newer responsibilities with great consciousness and devotion. It was observed that nursing staff have better opportunities to judge the behavior of the patient and there are more interpersonal contacts between patients and staff.
- 1960** The focus began to shift to primary prevention and implementing care and consultation in the community. The name ‘psychiatric nursing’ was changed to ‘psychiatric and mental health nursing,’ and a second change was made in the 1970s when it was known as ‘psychosocial nursing’.
- 1963** Journal of Psychiatric Nursing and Mental Health Services was published. Mysore Government started a nine-month course in psychiatric nursing for male nursing students, in lieu of midwifery.
- 1964** Mudaliar committee felt the need for preparing a large number of psychiatric nurses and recommended inclusion of psychiatry in the nursing curriculum (as per International Council of Nursing).
- 1965** The Indian Nursing Council included psychiatric nursing as a compulsory course in the BSc Nursing program.
- 1967** The Trained Nurses Association of India (TNAI), formed a separate committee for psychiatric nursing to improve the perception of psychiatric nursing as well as to set guidelines for nursing teachers to conduct theory classes and clinical training in psychiatric nursing.
- 1973** Standards of Psychiatric and Mental Health Nursing practice were enunciated to provide a means of improving the quality of care.
- 1975** Psychiatric Nursing was offered as an elective subject in MSc Nursing at the Rajkumari Amrit Kaur College of Nursing, New Delhi. Now various colleges offer psychiatric nursing as an elective subject in MSc Nursing. Some of them include SNDT College of Nursing, Mumbai; NIMHANS, Bengaluru; College of Nursing, Ludhiana; College of Nursing, CMC, Vellore; Father Müller’s College of Nursing, Mangalore; College of Nursing, Thiruvananthapuram; MAHE, Manipal; MV Shetty Institute of Health Sciences, Mangalore, Sri Devaraj Urs College of Nursing, Kolar, etc.
- 1980** Scientific advances in the area of psychobiology, brain imaging techniques, knowledge about neurotransmitters and neuronal receptors, molecular genetics related to psychiatry, etc. emerged. These contributed to the shift from psychodynamic models to more balanced psychobiological models of psychiatric care.
- 1986** The Indian Nursing Council (INC) made psychiatric nursing a component of General Nursing and Midwifery course. American Psychiatric Nurses Association was established.
- 1990** During these years integration of neurosciences into holistic biopsychosocial practice of psychiatric nursing occurred. Advances in understanding the inter-relationships of brain, behavior, emotions and cognition offered many new opportunities for psychiatric nurses. International Council of Nurses declared 1990 as the year of mental health nursing.

- 1991** Indian Society of Psychiatric Nurses formed at NIMHANS, Bengaluru.
- 1994** The above mentioned changes led to the revision of Standards of Psychiatric and Mental Health Nursing.
- 1995** Journal of American Psychiatric Nurses Association was established.
- 2000** The scope and standards of psychiatric mental health clinical nursing was published by American Nurses Association.
- 2003** American Nurses Association began certifying psychiatric mental health practitioners.
- 2010** ISPN published journal titled Indian Journal of Psychiatric Nurses.

Over the years, the professional psychiatric nursing role has grown in complexity. In contemporary psychiatric nursing practice, the role includes the parameters of clinical competence, patient advocacy, fiscal responsibility, professional collaboration, social accountability, legal and ethical obligations.

Indian Society of Psychiatric Nurses

Indian Society of Psychiatric Nurses (ISPN) was started in 1991 at NIMHANS, Bengaluru, under the guidance of Dr K Reddemma, with the motive of enhancing the advanced knowledge and skills in the field of psychiatric nursing, to provide a platform for discussion and deliberation on evidence based practice, to create awareness and translate the research findings to practice. ISPN is publishing its own journal called the Indian Journal of Psychiatric Nurses. First national conference of ISPN was held at NIMHANS on the theme 'Child Psychiatric Nursing' in 2002. The first international conference of ISPN was held in 2005 on the theme 'Adolescent Mental Health issues' at NIMHANS, Bengaluru. In 2005, ISPN became a member of Indian Confederation of Health Accreditation.

Current Issues, Future Prospects and Challenges—India

- There is a lack of clearly enunciated definition of the roles of professional psychiatric nurses.
- Greater emphasis should be given to encourage a master's degree in psychiatric nursing, so that nurses become pioneers in teaching non-professionals and play active role in specialized treatment modalities like behavior therapy, family therapy and individual and group counseling.
- To offer Diploma in psychiatric nursing course in more colleges so that trained psychiatric nurses will be available for psychiatric units in general and district hospitals.
- To maintain the minimum standards of psychiatric nursing care in mental hospitals, the recommended psychiatric nurse:patient ratio as per the INC is 1:5 in non-teaching and 1:3 in teaching hospitals. High priority needs to be given to increase psychiatric nursing manpower at the diploma, masters and doctorate levels.
- There is a crucial need to create proper jobs at par with other professionals, particularly in the community. High priority must be given to fill vacant positions in educational institutions. This will facilitate adequate manpower development in psychiatric nursing.
- An integrated and coordinated role, both in service and training is essential in maintaining the quality and standard of psychiatric nursing.
- Unfortunately, most psychiatric centers do not have qualified psychiatric nurses, even today. High priority should be given to place qualified psychiatric nurses in counseling centers, community mental health and school mental health programs.
- The National Mental Health Program for India (1982) recommended the formation of a District Mental Health Team (DMHT) in order to decentralize mental health

- care at the district level, with two qualified psychiatric nurses and one psychiatrist.
- The role of the psychiatric nurse in the district mental health program is to provide care to the inpatients. The qualified psychiatric nurses will actively participate in decentralized training to professionals and non-professionals working at taluk and Primary Health Centers (PHCs). They will also supervise the task of multipurpose workers in mental health care delivery. They will assist the psychiatrist in research activities and in monitoring mental health care at district and PHC levels. Nurse's active participation in mental health education to the public will go a long way in creating public awareness in the care of individuals with various mental disorders.
 - In the present scenario most of the nursing institutions and hospitals are working in independent environment and rendering services not in tandem with each other. While hospital staff nurses are working only in hospitals, the teaching faculty is teaching only in schools and colleges. As a result, the nurses who are working in the hospital are unable to update their know-how as regards the new trends and practices, while the teaching staff fail to upgrade their practical skills. Such a system breeds a wider gap between theory and practice which is not healthy for the system as a whole. As the gap between education and practice has widened, there are now significant differences between what is taught in the classroom and what is practiced in the service setting.

Among the various mental health settings, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, and Dharwad Institute of Mental Health and Neurosciences (DIMHANS), Dharwad, Karnataka are practicing the dual role (education and practice) system, the HOD of Nursing department is given the responsibility of managing both the service and the education components. This integration of the education

with service will raise the quality of patient care and also improve the quality of learning experiences for nursing students under the close supervision of teachers who are also practitioners.

In dual responsibility, the challenge is to combine theoretical knowledge with significant technical training so as to assure a competent performance by a professional nurse in the hospital setting. Clearly, a partnership between nurse educators and hospital nursing personnel is essential to meet this challenge. Dovetailing both the clinical and teaching services at the ground level will not only augur well for the system but also bring about ground breaking changes in the times to come.

PREVALENCE AND INCIDENCE OF MENTAL HEALTH PROBLEMS AND DISORDERS

The WHO declared the World Health Day theme for the year 2001 as "Mental Health: Stop Exclusion—Dare to Care", in order to focus global public health attention on this relatively neglected problem. Information regarding the prevalence of mental disorders in India needs to be generated to establish a database for mental health planners to assess the status of mental health in the country. The Bhore Committee concluded that mental patients requiring institutional treatment would be 2 per 1000 in the country.

During the last two decades many epidemiological studies have been conducted in India, which shows that the prevalence of major psychiatric disorder is about the same all over the world. The prevalence reported from these studies range from the population of 18 to 207 per 1000 with the median 65.4 per 1000. Most of these patients live in rural areas remote from any modern mental health facilities. A large number of adult patients coming to the general OPD are diagnosed mentally ill. However, these patients are usually overlooked because either the medical officer or the general practitioner

Box 1.2: Prevalence of mental disorders

- » All mental disorders—73/1000 population (with rural and urban rates of 70.5 and 73/1000, respectively)
- » Schizophrenia—2.5/1000 population
- » Affective disorder (depression)—34/1000 population
- » Anxiety neurosis—16.5/1000 population
- » Hysteria—3.3/1000 population
- » Mental retardation—5.3/1000 population

at the primary health care unit does not inquire detailed mental health history. Due to the under-diagnosis of these patients, unnecessary investigations and treatments are offered which cost the health provider heavily.

Analysis of 15 epidemiological studies shows prevalence rates as shown in Box 1.2 (Ganguli HC, 2000).

According to health information of India 2005, mental morbidity rate is not less than 18–20/1000 and the types of illness and their prevalence are very much the same as in other parts of the world.

Analysis of 10 epidemiological studies shows prevalence rates as follows:

National prevalence rates for all mental disorders was 65.4/1000 population; with rural and urban rates of 64.4 and 66.4/1000, respectively. Thus, the urban rate is marginally higher than the rural rate. The most widely prevalent disorders were observed to be depression and anxiety. The urban morbidity rate was observed to be 2 per 1000, higher than the rural morbidity rate (Madhav MS, 2001). (Box 1.3).

Box 1.3: National prevalence rates for specific disorders

- » Schizophrenia—2.3/1000 population
- » Affective disorder—31.2/1000 population
- » Anxiety neurosis—18.5/1000 population
- » Hysteria—4.1/1000 population
- » Mental retardation—4.2/1000 population

According to community based epidemiological studies under the WHO Mental Health GAP Action Program, in India the estimated life-time prevalence of mental disorders ranges from 12.2 to 48.6%. The Ministry of Health and Family Welfare suggests that 6–7% of India's population suffers from mental disorders with about 1% suffering from severe mental disorders while three in 10,000 people experience an episode of acute psychosis every year, about 25% of mentally ill people are homeless. Mental Illnesses like schizophrenia and bipolar disorder are prevalent in about 200 cases per 10,000 people. The burden of these disorders is likely to increase to 15% by 2020 (Ghanashyan B, Nagarathinam S. India is failing the mentally ill as abuses continue. *The Lancet*. 2010; 376:9753).

The common psychiatric illnesses encountered in a clinic of a General Hospital are—Neurotic disorders (for example, anxiety neurosis, obsessive-compulsive disorder and reactive depression), psychosomatic disorders (for example, hypertension, diabetes mellitus, peptic ulcer, tension headaches, etc.), functional psychosis (for example, schizophrenia, mania and depression and organic psychosis).

In a child guidance clinic, the common mental illnesses include mental retardation, conduct disorder, hyperkinetic syndrome, enuresis, etc.

In a geriatric clinic, the common disorders are depression, dementia, delusional disorders, etc.

In a psychosexual clinic the common problems include Dhat syndrome, premature ejaculation, erectile impotence and so on.

The prevalence of psychiatric disorders is 58.2 per thousand which means that there are about 5.7 crore people suffering from some sort of psychiatric disturbance. Out of this 4 lakh people have organic psychosis, 26 lakh people have schizophrenia and 1.2 crore people have affective psychosis; thus, there are about 1.5 crore people suffering from severe

mental disorders, besides 12,000 patients in Government mental hospitals in the country (Reddy, et al. 1996).

Various community based surveys show the prevalence of mental disorders in India as 6–7% for common mental disorders and 1–2% for severe mental disorders. In India, the rate of psychiatric disorders in children aged between 4 to 16 years is about 12%. Treatment gap for severe mental disorders is approximately 50% and in case of Common Mental Disorders it is over 90% (Ministry of Health and Family Welfare, Annual Report. 2012–13, p.161).

MENTAL HEALTH ACT

Indian Lunacy Act (ILA), Act 4 of 1912, replaced the Indian Lunatic Asylums Act, Act 36 of 1858. It was enacted to govern reception, detention and care of lunatics and their property and to consolidate and amend the laws relating to lunacy.

The Act was divided into 4 parts and 8 chapters consisting of 100 sections. The enactment of Indian Lunacy Act of 1912 was followed by opening of many new asylums, an improvement in the general conditions of asylums and an increase in awareness regarding the prevailing situation of lunatics in such asylums.

In 1946, the Bhore committee submitted its recommendations. The Indian psychiatric society, established in January 1947, was quick to react to the recommendations of Bhore committee. In January 1949, an ad hoc drafting committee was appointed which consisted of 3 distinguished psychiatrists. They prepared a draft bill called as the "Indian Mental Health Act", which was redrafted and finalized in January 1950 and forwarded to the Government of India. After 37 years the Mental Health Act (MHA) 1987 was finally passed by the Lok Sabha on 19th March 1987. Later, the Government of India issued orders that the Act came into force with effect from April 1, 1993 in all the States and Union Territories of India. It is

an "Act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected those with or incidental thereto". The Act is divided into 10 Chapters consisting of 98 sections.

(Refer Chapter 14, Page 343 for Indian Mental Health Act)

The Mental Health Care Bill, 2013

The Mental Health Care Bill, 2013 was introduced in the Rajya Sabha on August 19, 2013. The Bill abolishes the Mental Health Act, 1987.

Reasons to the Bill

The Government approved the United Nations Convention on the Rights of Persons with Disabilities in 2007. The Convention requires the laws of the country to align with the Convention. The new Bill was introduced as the existing Act does not adequately protect the rights of persons with mental illness nor promotes their access to mental health care.

Key Features of the Bill

- Every person shall have the right to access mental health care and treatment from services run or funded by the Government
- A mentally-ill person shall have the right to make an advance directive that states how he wants to be treated for the illness during a mental health situation and who his nominated representative shall be
- Every mental health establishment has to be registered with the relevant Central or State Mental Health Authority. These authorities are in addition responsible for supervising and maintaining a register of all mental health establishments
- The Mental Health Review Commission will be a quasi-judicial body that will periodically review the use of and the procedure for making advance directives

and advise the Government on protection of the rights of mentally ill persons

- A person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code
- Electroconvulsive therapy is allowed only with the use of muscle relaxants and anesthesia. The therapy is prohibited for minors.

Chapters

- | | |
|------------|---|
| Chapter 1 | Preliminary information on definitions, short titles, extent and commencement. |
| Chapter 2 | Mental illness and capacity to make mental health care and treatment decisions. |
| Chapter 3 | Advance directive. |
| Chapter 4 | Nominated representative. |
| Chapter 5 | Rights of persons with mental illness. |
| Chapter 6 | Duties of appropriate Government. |
| Chapter 7 | Central mental health authority. |
| Chapter 8 | State mental health authority. |
| Chapter 9 | Finance, accounts and audit. |
| Chapter 10 | Mental health establishments. |
| Chapter 11 | Mental health review commission. |
| Chapter 12 | Admission, treatment and discharge. |
| Chapter 13 | Responsibilities of other agencies. |
| Chapter 14 | Restriction to discharge functions by professionals not covered by profession. |
| Chapter 15 | Offences and penalties. |
| Chapter 16 | Miscellaneous. |

NATIONAL MENTAL HEALTH POLICY VIS-À-VIS NATIONAL HEALTH POLICY

National Mental Health Policy 2014

In April 2011, the Government of India Constituted a policy group to recommend

a mental health policy for the country. After due deliberations and intense discussions, the group has submitted recommended policy. The suggested Mental Health Policy has been duly considered by the Ministry of Health and Family Welfare, Government of India in 2014. This National Mental Health Policy is in accordance with the intent of World Health Assembly resolution. This policy incorporates an integrated, participatory rights and evidence based approach.

Vision

The vision of the National Mental Health Policy 2014 is to promote mental health, prevent mental illness, enable recovery from mental illness, promote destigmatization and desegregation and ensure socioeconomic inclusion of persons affected by mental illness by providing accessible, affordable and quality mental health and social care to all persons through their life-span, within a right-based framework.

Goals

- To reduce distress, disability, exclusion morbidity and premature mortality associated with mental health problems across life-span of the person
- To enhance understanding of mental health in the country
- To strengthen the leadership in the mental health sector at the National, State and District levels.

Objectives

- To provide universal access to mental health care
- To increase access to and utilization of comprehensive mental health services by persons with mental health problems
- To increase access to mental health services for vulnerable groups including homeless persons, persons in remote and difficult areas, educationally, economically and socially deprived sections

- To reduce prevalence and impact of risk factors associated with mental health problems
 - To reduce risk and incidence of suicide and attempt suicide
 - To ensure respect for rights and protection from harm of persons with mental health problems
 - To reduce stigma associated with mental health problems
 - To enhance availability and equitable distribution of skilled human resources for mental health
 - To progressively enhance financial allocation and improve utilization for mental health promotion and care
 - To identify and address the social, biological and psychological determinants of mental health problems and provide appropriate interventions.
- The Life Skill Education (LSE) program should be offered to school children and college going young people
 - Signs and symptoms of many mental disorders first appear during the adolescent years. Individual attention in the school by teachers trained in mental health promotion is important
 - Design appropriate curricula and pedagogy, teacher-student relationship, provision of suitable infrastructure including access to toilets within the school system
 - Programs to assist adults in handling of stressful life circumstances should be incorporated in workplace and residence support programs
 - Mass media programs should be organized to disseminate mental health information
 - Encourage actions to change poor living conditions such as homelessness, overcrowding, lack of access to safe drinking water, toilets and sanitation and provide adequate nutrition to prevent mental health problems and mental illness. The role of social factors, low grade infections, micronutrient deficiency (iron, folate, vitamins and other trace elements) is also linked to increased incidence of mental disorders, and slow and poor recovery in response to treatment
 - Implement programs to reduce risk factors for women's mental health, such as acts of violence against women
 - Practitioners of Ayurveda and Yoga systems are a resource who need to be included as activists for promotion of mental health
 - Create an environment and encourage persons with mental health problems to take part in social, economic and regular activities and are not discriminated against. Mental disability should be treated on par with any other form of disability.

The strategic areas identified for action are:

1. Effective governance and delivery mechanisms for mental health

- Develop relevant policies, programs, laws, regulations and adequate budgetary provisions to implement evidence-based mental health actions
- Motivate and engage stakeholders, civil society leaders, caregivers, family members, persons with mental health problems in the development, implementation and evaluation of mental health policies, laws and services and also develop suitable mechanisms at the Central, State, District and local levels to plan, monitor and evaluate implementation of mental health policies, laws and programs.

2. Promotion of mental health

- Redesign anganwadi centers and train anganwadi workers and school teachers with knowledge and skill to provide positive environment for the growth and development of children and for providing protection against harmful behavior

3. Prevention of mental illness, reduction of suicide and attempted suicide
 - Implement programs to address alcohol abuse and other drugs of abuse
 - Restrict access to means of suicide, in particular distribution and storage of highly toxic pesticides
 - Frame guidelines for responsible media reporting of suicide
 - Decriminalize attempted suicide
 - Train key community leaders in recognizing risk factors for suicide
 - Set up crisis intervention centers and help-lines as part of the district mental health program
 - Improve data collection on suicides and attempted suicides by the National Crime Records Bureau to improve understanding of the issue
 - Address alcohol abuse/dependence and depression as key risk factors for suicide and attempted suicide
4. Universal access to mental health services
 - Mental health services should be family centric to address needs of persons with mental health problems across life-span. All multispecialty government hospitals should provide mental health services to improve access.
 - Increase availability of community based rehabilitation services like day care centers, short stay facilities and long stay facilities to promote recovery with support from local bodies and other sources of support.
 - Caring for the caregiver is a neglected area. Formation of caregivers groups with professional inputs to facilitate a better and accurate understanding of the particular mental health problem their family member is having. Caregivers to be encouraged to pursue other activities to give them space for their own personal growth.
 - Implement programs for screening, early identification and treatment of mental health problems and mental illness.
- Shortage of inpatient beds for acute mental health care needs to be addressed by making provisions for the same in general health facilities, such as district hospitals, teaching hospitals attached to medical colleges and other general hospitals
- Improve infrastructure and enhanced resources to provide quality services in mental hospitals
- Monetary benefits and tax benefits to the primary caregivers needs to be addressed
- A multidimensional, dynamic and well-being oriented approach is essential to address the needs of homeless persons with mental illness
- Extending assisted living in one's own home could be a good option for various categories of families across the social strata.

- The largest women health work force in the country is that of auxiliary nursing midwives. This group should be offered skill upgradation in mental health as it directly caters to mothers and children and hence their involvement in child and adolescent mental health services will be useful
 - Training programs must acknowledge that along with biomedical approach psychosocial interventions are also equally important, which need to be incorporated into programs across all disciplines that would help to alleviate distress in small ways. This would help broaden scope and reach of mental health interventions, and thus help decrease stigma and position mental health more positively.
6. Community participation for mental health and development
- There is a need to simplify procedures for disability certification of persons with mental illness and enhancing compensation for mental disability
 - Remove legislative policy and programmatic barriers to protect rights of persons with mental illness
 - Promote the full participation of persons with mental illness in all areas of life including education, housing, employment and social welfare
 - Involve persons living with mental illness and caregivers in village health, sanitation, water and nutrition committees (*Swasthya Gram Samiti*) and patient welfare committees (*Rogi Kalyan Samiti*) so that they can participate in community planning and monitoring of the public health system and in community action for health
 - Increase the space for voice of persons with mental illness and caregivers in planning and feedback of mental health services.
7. Research
- Invest in building research capacity in mental health both through existing institutions and developing new institutions focused on specific areas
 - Commit equitable funds for promoting mental health research, with a target consistent with the burden of mental health problems in the country
 - Foster partnerships between centers of excellence for mental health and medical college departments of psychiatry with district mental health program and with appropriate NGOs and research institutions to implement priority mental health research
 - Conduct research to evaluate the potential of traditional knowledge, practices and alternative therapies to address mental health problems
 - Develop and facilitate mechanisms for dissemination of research findings and for translating research findings into action at the service delivery level.

National Health Policy

National Health Policy (NHP) was formulated in 1983 and revised in 2002.

Objectives

The main objective of NHP-2002 is to achieve an acceptable standard of good health amongst the general population in the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions.

Specific Recommendation with Regard to Mental Health

- Upgrading infrastructure of institutions at Central Government expense so as to

- secure the human rights of this vulnerable segment of society
9. Envisages a network of decentralized mental health services for ameliorating the more common categories of disorders.

Specific Discussion Regarding Mental Health

Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality-of-life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP-2002 will address itself to these deficiencies in the public health sector.

NATIONAL MENTAL HEALTH PROGRAM

The Government of India launched the National Mental Health Program (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it.

Aims

- Prevention and treatment of mental neurological disorders and their associated disabilities.
- Use of mental health technology to improve general health services.
- Application of mental health principles in total national development to improve quality of life.

Objectives

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population.
- To encourage application of mental health knowledge in general health care and social development.
- To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

Strategies

- Integration of mental health with primary health care through the NMHP.
- Provision of tertiary care institutions for treatment of mental disorders.
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental Health Authority.

Approaches

- Integration of mental health care services with the existing general health services.
- Utilization of the existing infrastructure of health services and also deliver the minimum mental health care services.
- Provision of appropriate task-oriented training to the existing health staff.
- Linkage of mental health services with the existing community development program.

Components

• Treatment: Multiple levels

- Village and Sub-center Level Multi-purpose Workers (MPW) and Health Supervisors (HS), under the supervision of Medical Officer (MO) to be trained for:
 - Management of psychiatric emergencies

- Administration and supervision of maintenance treatment for chronic psychiatric disorders
- Diagnosis and management of grand mal epilepsy, especially in children
- Liaison with local school teachers and parents regarding mental retardation and behavioral problems in children
- Counseling problems related to alcohol and drug abuse
- Medical Officer of Primary Health Center (PHC) aided by HS, to be trained for:
 - Supervision of MPW's performance
 - Elementary diagnosis
 - Treatment of functional psychosis
 - Treatment of uncomplicated cases of psychiatric disorders associated with physical diseases
 - Management of uncomplicated psychosocial problems
 - Epidemiological surveillance of mental morbidity
- District hospital: It was recognized that there should be at least one psychiatrist attached to every district hospital as an integral part of the district health services. The district hospital should have 30-50 psychiatric beds. The psychiatrist in a district hospital was envisaged to devote only a part of his time to clinical care and a greater part in training and supervision of non-specialist health workers.
- Mental hospitals and teaching psychiatric units: Major activities of these higher centers of psychiatric care include:
 - Help in care of 'difficult' cases
 - Teaching
 - Specialized facilities like occupational therapy units, psychotherapy, counseling and behavioral therapy
- **Rehabilitation:** The components of this sub-program include treatment of epileptics and psychotics at the community level and development of rehabilitation

centers at both the district level and higher referral centers.

- **Prevention:** The prevention component is to be community-based, with initial focus on prevention and control of alcohol-related problems. Later on, problems like addictions, juvenile delinquency and acute adjustment problems like suicidal attempts are to be addressed.

MENTAL HEALTH TEAM OR MULTIDISCIPLINARY TEAM

Multidisciplinary approach refers to collaboration between members of different disciplines who provide specific services to the patient. The multidisciplinary team includes:

- A psychiatrist
- A psychiatric nurse
- A clinical psychologist
- A psychiatric social worker
- An occupational therapist or an activity therapist
- A pharmacist and a dietitian
- A counselor
- A dietitian

A **Psychiatrist** is a medical doctor with special training in psychiatry. He is accountable



Fig. 1.1: Mental health team or multidisciplinary team

for the medical diagnosis and treatment of patient. Other important functions are:

- Admitting patient into acute care setting
- Prescribing and monitoring psychopharmacologic agents
- Administering electroconvulsive therapy
- Conducting individual and family therapy
- Participating in interdisciplinary team meetings
- Owing to their legal power to prescribe and to write orders, psychiatrists often function as leaders of the team.

A **Psychiatric nurse** is a registered nurse with specialized training in the care and treatment of psychiatric patients; she may have a Diploma, MSc, MPhil or PhD in psychiatric nursing. She is accountable for the bio-psychosocial nursing care of patients and their milieu. Other functions include:

- Administering and monitoring medications
- Assisting in numerous psychiatric and physical treatments
- Participate in interdisciplinary team meetings
- Teach patients and families
- Take responsibility for patients' records
- Act as patient's advocate
- Interact with patients' significant others.

A **Clinical psychologist** should have a Masters Degree in Psychology or PhD in clinical psychology with specialized training in mental health settings. He is accountable for psychological assessments, testing, and treatments. He offers direct services such as individual, family or marital therapies.

A **Psychiatric social worker** should have a Masters Degree in Social Work or PhD degree with specialized training in mental health settings. He is accountable for family case work and community placement of patients. He conducts group therapy sessions. He emphasizes intervention with the patient in social environment in which he will live.

An **Occupational therapist or an Activity therapist** is accountable for recreational,

occupational and activity programs. He assists the patients in gaining skills that help them cope more effectively, retain employment and use their leisure time.

A **Counselor** provides basic supportive counseling and assists in psychoeducational and recreational activities (Fig. 1.1).

NATURE OF MENTAL HEALTH NURSING

Psychiatric nursing is a profession, possessing its unique history, ideology, knowledge and skills. It provides services to individuals whose primary health needs are related to mental, emotional and developmental problems, especially serious disorders and persistent disabilities. It is committed to the maintenance, promotion and restoration of optimal mental health for individuals, families, community groups and society through the use of therapeutic relationships and interventions.

Psychiatric nursing is a specialized area of nursing practice, employing the wide range of explanatory theories of human behavior as its science and purposeful use of self as its art. (American Nurses Association, 2000).

Psychiatric nursing is both an art and a science. During actual practice, both art and science of nursing are inextricable. The art of caring is professionally embodied in a therapeutic alliance that develops between the nurse and patient, and is referred to as the nurse-patient relationship. The alliance is a vehicle for the patient to learn and practice skills for the purpose of gaining insight, effecting change, healing mental and emotional wounds and promoting growth.

The science of psychiatric nursing includes understanding and use of principles of nursing on all levels. In addition, there is required commitment to remain current in knowledge and to practice all learned skills

and procedures that ensure patient safety and well-being.

The Philosophical Beliefs of Psychiatric Nursing Practice

- Every individual has intrinsic worth and dignity and is worthy of respect.
- Each person functions as a holistic being who acts on, interacts with and reacts to the environment as a whole.
- All behavior of an individual is meaningful. It arises from personal needs and goals and can be understood only from the person's internal frame of reference and within the context in which it occurs.
- Behavior consists of perceptions, thoughts, feelings and actions.
- Individuals vary in their coping capacities, which depend on genetic endowment, environmental influences, nature and degree of stress, and available resources. All individuals have the potential for both health and illness.
- The goal of nursing care is to promote wellness, maximize integrated functioning and enhance self-actualization.
- An interpersonal relationship can produce change and growth within the individual. It is a vehicle for application of nursing process and the attainment of the goal of nursing care.
- The psychiatric nurse uses knowledge from the psychosocial and biophysical sciences and theories of personality and human behavior. From these sources, the nurse derives a theoretical framework on which to base the nursing practice.

SCOPE OF MENTAL HEALTH NURSING

Psychiatric mental health nursing is a specialized area of nursing practice which uses nursing, neurobiological and psychosocial theories and research evidence as its science

and purposeful use of self as its art, to promote mental health through the assessment, diagnosis and treatment of human responses to mental health problems and psychiatric disorders.

Psychiatric nurses provide patient centered comprehensive psychiatric care in a variety of settings across the entire continuum of care. The continuum of care levels span from illness to wellness states. The primary goal of a continuum of care is to provide treatment that allows the patient to achieve the highest level of functioning in the least restrictive environment.

The essential components of psychiatric nursing practice include, promotion of mental health, prevention of mental health problems, care and treatment of persons with psychiatric disorders and rehabilitation of mentally ill individuals.

The areas of concern for a psychiatric nurse include a wide range of actual or potential mental health problems, such as:

- Promotion of well-being, mental and physical health
- Prevention of mental illnesses
- Emotional stress or crisis related to illness, pain, disability and loss
- Impaired ability to function related to mental health problems
- Alteration in thinking, perceiving and communicating due to mental health problems
- Behavioral and mental states that indicate potential danger to self or others
- Self-concept and body image changes, developmental issues, life process changes, physical symptoms that occur due to psychological changes
- Psychological symptoms that occur along with altered physiological status
- Side effects or complications associated with psychopharmacological interventions and other treatment modalities
- Alcohol and substance abuse and dependence problems

- Interpersonal, organizational or other environmental circumstances and their effects on mental well-being of the individual, family and community.

Today, the scope of mental health nursing is not restricted within the confines of the bedside nursing care. A mental health nurse needs to be skilled and clinically competent, sensitive to the social environment, the advocacy needs of the patients and their families as well as be aware of the legal and ethical dilemmas.

Roles of the Psychiatric-Mental Health Nurse in Contemporary Mental Health Care

Trends and issues in the health care system affect the roles of the psychiatric-mental health nurse. Although psychiatric nurses have traditionally worked on inpatient psychiatric units, they have continued to expand their role into the community.

There are two levels of psychiatric-mental health nurses: The generalist (registered psychiatric nurse) and the specialist (CNS). The scope and roles of both are guided by nurse practice acts and by standards of care.

Role of the Generalist

The psychiatric mental health generalist nurse is a licensed registered nurse for delivering primary mental health care. It incorporates both physical and mental health care. Generalist exercises a holistic approach to practice and performs psychiatric nursing in prevention programs, community and day treatment centers, psychiatric rehabilitation facilities, homeless shelters and many other settings.

Role of the Specialist

Psychiatric Clinical Nurse Specialist (CNS) holds a masters degree in psychiatric mental health nursing. CNS is an advanced practice

nurse who is usually a primary health care provider, functions autonomously, often works in a semi-isolated situation, has medication prescription privileges (depending on individual state laws), manages the overall care of people with emotional and psychiatric problems, and usually has a consultative arrangement with a psychiatrist. For example, the advanced practice nurses in Minnesota are psychotherapists, consultants, milieu specialists, role models, teachers, administrators, crisis intervention specialists and co-ordinators.

Community Mental Health Nurse

Community mental health nursing (CMHN) is the application of knowledge of psychiatric nursing in preventing mental illness, promoting and maintaining mental health of the people. It includes early diagnosis, appropriate referrals, care and rehabilitation of mentally ill people.

Psychiatric Home Care Nurse

Home health care is one aspect of community health nursing. Psychiatric home care nurses provide holistic psychiatric nursing care on a visiting basis to people needing assistance. These nurses provide comprehensive care, including psychiatric and physical assessment, direct nursing care, behavioral management crisis intervention, psychoeducation, in-home detoxification, medication management, case management and consultation with colleagues.

Forensic Psychiatric Nurse

Forensic nursing is a growing specialty in other countries around the globe, especially in the UK, Australia, Germany, Japan and Canada, and it is an expanded scope of practice. The forensic psychiatric nurse works with individuals who have mental health needs and who have entered the legal system.

Nurses in this role perform physical and psychiatric assessment and develop plans of care for the patients entrusted to their care.

Psychiatric Consultation-Liaison Nurse

Psychiatric consultation-liaison nurse (PCLN) has arisen in response to the increased recognition of the importance of psycho-physiological inter-relationships and their impact on physical illness, recovery and wellness. It is an advanced practice nurse who practices psychiatric and mental health nursing in a medical setting/non-psychiatric setting providing consultation and education to patients, families, and health care team and the community. PCLN may provide assessment, recommendations and supportive therapy to patients who are anxious, depressed or experiencing other psychological problems or emotional distress.

Case Manager

Nurse case managers act as advocates for patients and their families by coordinating care and linking the patient with the

physician, other members of the healthcare team, resources and the payers (Fig. 1.2).

Factors that indicate the need for a nurse case manager include:

- A complex treatment plan that requires co-ordination
- An injury or illness that may permanently prevent the patient from returning to a previous level of health
- Pre-existing medical condition that may complicate or prolong recovery
- A need for assistance in accessing health-care resources
- Environmental stressors that may interfere with recovery.

In the community, the case manager works with patients on a broad range of issues from accessing needed medical and psychiatric services to carrying out tasks of daily living such as using public transportation, managing money and buying groceries.

Case management can be provided by an individual or a team. It may include both face-to-face and telephone contact with the patient, as well as contact with other service providers.

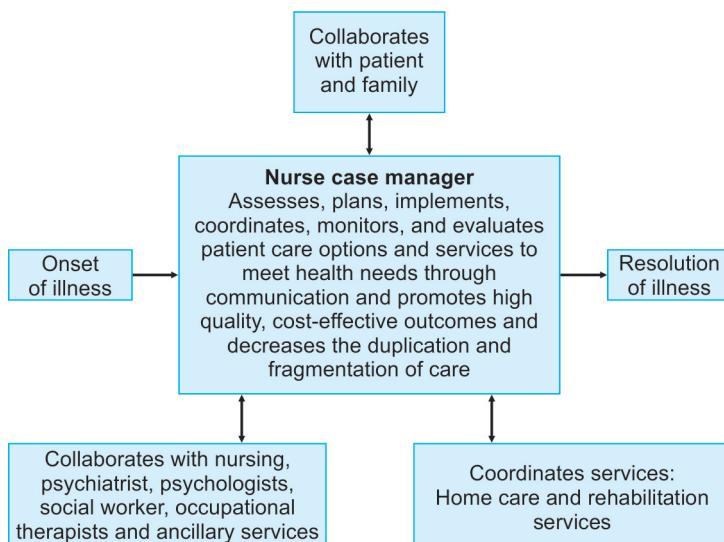


Fig. 1.2: Case management model

One of the most valuable assets case managers possess is their ability to synthesize patient data and act as conduits between patients and the health care system.

Geropsychiatric Nurse

Geronursing is expanding the psychiatric nursing practice to aged people who have been affected by emotional and behavioral disorders such as dementia, chronic schizophrenia, delirium, etc.

Parish Nurse

Parish nursing is another area of expansion in the role of a psychiatric nurse. Parish nursing is a program that promotes health and wellness of body, mind and spirit. The parish nurse is a pastorally called, spiritually mature, licensed registered nurse, with a desire to serve the members and friends of his or her congregation. In 1998, the American Nursing Association recognized parish nursing as a specialty focusing on disease prevention and health promotion. It is a noninvasive type of nursing in which no hands-on nursing care is provided, rather parish nurses are conduits of health information, support and social services. They evaluate the unique needs of various age groups within the congregation, including children, adults and the elderly. They serve as the community link between health institution and home by providing physical and mental health screenings, outreach education and visits to the home, hospital or long-term care facility.

Telehealth/Telenurse

Nurses engaged in telenursing practice use technologies such as internet, computers, telephones, digital assessment tools and telemonitoring equipments to deliver nursing care. In India, around 10 hospitals are having tele-medicine departments. For example, at Apollo hospitals, Narayana Hrudayalaya

and Hosmat hospital at Bengaluru, job opportunities are available for tele-nurses. Chaithanya Medical Foundation, Bengaluru, is providing tele-nursing education. IT companies are recruiting telehealth nurses in Hyderabad, Bengaluru and Chennai. For example: Infosys, Vivus, etc.

Nurse Researcher

Nurse researchers are scientists who seek to find answers to questions through methodical observations and experimentation. They design studies, conduct research and disseminate findings at professional meets and in peer reviewed journals. They are doctorally or post-doctorally prepared persons who initiate or participate in all phases of the research process. They work in a variety of settings.

Psychiatric Nurse Educator

The psychiatric nurse educator works in educational institutions, staff development department of health care agencies and patient education department as well (teach the mentally ill patients and their families about care to provide at home). Another function of a nurse educator is planning and changing the curriculum according to the needs of the society and learner.

Nurse Administrator/Manager

A nurse manager works less directly with patients, but has the responsibility to provide nursing leadership to ensure that an appropriate therapeutic milieu is maintained. Key responsibility is to support and aid development of nurses and represent nursing views to senior managers. Nurse manager plays an important role in negotiating and allocating nursing resources within clinical directorates. Individuals who assume a nurse executive role typically hold a masters degree. They serve at all management levels in health care organizations and in the community.

Psychiatric Nurse as Collaborative Member of the Interdisciplinary Team

Collaboration implies a commitment to common goals, with shared responsibility for the outcome of care. It also implies helping to facilitate the mental health of the patient, family or community within the context of the treatment team. Nurses bring their own specialized knowledge to the treatment process, thereby, enhancing information about the patient's assessment, treatment needs and progress. Seven characteristics of effective collaboration include: Trust, respect, commitment, co-operation, coordination, communication and flexibility.

Nurse Psychopharmacologist

One of the latest roles is that of the nurse psychopharmacologist—the psychiatric clinical nurse specialist with prescriptive authority.

Holistic Nurse

Holistic nursing integrates complementary and alternative modalities such as relaxation, meditation, guided imagery, body mind interventions, bio-feedback, reikhi, etc. along with traditional nursing interventions. A holistic nurse uses theories of wholeness, expertise, caring and intuition. In CAM therapies, patients become therapeutic partners in a mutually evolving process towards healing, balance and wholeness. Holistic nurses conduct holistic assessments, select appropriate interventions and assist the patient in exploring self-awareness, spirituality and personal transformation in healing. The most frequently employed therapies used by the nurses are massage, music, exercise, diet, prayer and counseling.

The new opportunities for psychiatric nursing practice that are emerging throughout the continuum of mental health care are exciting for the specialty. They allow psychiatric

nurses to demonstrate their flexibility, accountability, and self-direction as they move forward into these expanding areas of practice. The expansion of mental health treatment settings is providing psychiatric nurses with the opportunity to implement primary, secondary and tertiary prevention functions from a holistic, biopsychosocial perspective, thus expanding their base of practice to better meet the mental health needs of individuals, families, groups and communities.

Focused Areas of Psychiatric Nursing Practice

Areas of focus within psychiatric nursing have emerged based on current and anticipated societal needs. These areas of focus include adult, child-adolescent, geriatric, developmental disability, forensic, addiction, community and family psychiatry.

Clinical practice settings for psychiatric nurses include psychiatric emergency services, crisis intervention centers, acute inpatient care, chronic inpatient care, rehabilitation centers, outpatient department, day care centers, partial hospitalization centers, child-adolescent psychiatry centers, family therapy units, psychotherapy units, home settings, community based centers, tele-nursing, hospice care centers, medical inpatient wards, industrial medical centers, forensic psychiatric wards and private practice.

Current Issues and Trends in Care

A psychiatric nurse faces various challenges because of changes in the inpatient care approach. Some of these changes that affect her role are as follows:

Trends in Health Care

- Increased mental health problems
- Provision for quality and comprehensive services

- Multidisciplinary team approach
- Providing continuity of care
- Care provided in alternative settings.

Economic Issues

- Industrialization
- Urbanization
- Raised standard of living.

Changes in Illness Orientation

- Shift from illness to prevention (modification of style), specific to holistic, quantity of care to quality of care.

Changes in Care Delivery

- Care delivery is shifted from institutional services to community services, genetic services to counseling services, nurse-patient relationship to nurse-patient partnership.

Information Technology

- Telenursing
- Telemedicine
- Mass media
- Electronic systems
- Nursing informatics.

Consumer Empowerment

- Increased consumer awareness
- Awareness of the community in early detection and treatment of mental illness as well as proper utilization of available psychiatric hospitals
- Patients are health care consumers demanding quality health care services at affordable cost with less restrictive and more humane rates.

Deinstitutionalization

- Bringing mental health patients out of the hospital and shifting care to community.

Physician Shortage and Gaps in Service

- Physician shortage can provide the opportunity for new roles, for example, nurse practitioner. In respect to gaps in services, nurses always meet the needs of people for whom services are not available, for example, home visiting nurse.

Demographic Changes

- Increasing number of the elderly group
- Type of family (increased number of nuclear families).

Change in Patient Needs

- Wanting a more holistic orientation in health care.

Challenges in Psychiatric Nursing

- Knowledge development, dissemination and application
- Overcoming stigma
- Health care delivery system issues
- Impact of technology.

Educational Programs for the Psychiatric Nurse

- Diploma in Psychiatric Nursing (The first program was offered in 1956 at NIMHANS, Bengaluru)
- MSc in Psychiatric Nursing (The first program was offered in 1976 at Rajkumari Amrit Kaur College of Nursing, New Delhi)
- MPhil in Psychiatric Nursing (1990, MG University, Kottayam)
- Doctorate in Psychiatric Nursing (offered at MAHE, Manipal; RAK College of Nursing, Delhi; NIMHANS, Bengaluru, National Consortium for PhD in Nursing under RGUHS, Karnataka, etc.)

- Short-term training programs for both the degree and diploma holders in nursing

Standards of Mental Health Nursing

The development of standards for nursing practice is a beginning step towards the attainment of quality nursing care. The adoption of standards helps to clarify nurses' areas of accountability, since the standards provide the nurse, the health agency, other professionals, patients, and the public, with a basis for evaluating practice. Standards also define the nursing profession's accountability to the public. These standards are therefore a means for improving the quality of care for mentally ill people.

Development of Code of Ethics

This is very important for a psychiatric nurse as she takes up independent roles in psychotherapy, behavior therapy, cognitive therapy, individual therapy, group therapy, maintains patient's confidentiality, protects his rights and acts as patient's advocate.

Legal Aspects in Psychiatric Nursing

Knowledge of the legal boundaries governing psychiatric nursing practice is necessary to protect the public, the patient, and the nurse. The practice of psychiatric nursing is influenced by law, particularly in its concern for the rights of patients and the quality of care they receive.

The patient's right to refuse a particular treatment, protection from confinement, intentional torts, informed consent, confidentiality, and record keeping are a few legal issues in which the nurse has to participate and gain quality knowledge.

Promotion of Research in Mental Health Nursing

The nurse contributes to nursing and the mental health field through innovations in theory and practice and participation in research.

Cost-effective Nursing Care

Studies need to be conducted to find out the viability in terms of cost involved in training a nurse and the quality of output in terms of nursing care rendered by her.

Focus of Care

A psychiatric nurse has to focus care on certain target groups like the elderly, children, women, youth, mentally retarded and chronic mentally ill.

FUNCTIONS OF MENTAL HEALTH NURSE IN VARIOUS SETTINGS

Practice Setting for Psychiatric Nurses

For many years, the majority of mental health care was provided in the hospital setting. Since the 1970s, the trend has changed to treat patients in less restrictive or community based settings.

While traditional practice settings for psychiatric nurses are psychiatric hospitals, community mental health centers, psychiatric units in the general hospitals, residential treatment facilities and private clinics, more recently alternative treatment settings have emerged. These are partial hospitalization settings, day care centers, home care, out patient departments or ambulatory care centers. Community based treatment settings have expanded to group homes, hospice, care centers, crisis intervention centers, schools and universities, hospitals for the criminally insane, jails and prisons.

Functions of Psychiatric Nurse in Various Settings

Inpatient Psychiatric Ward

- Provide for environmental safety including protecting the patient and others from injury
- Perform psychosocial, high-risk and physical assessment
- Promotion of self-care activities
- Medication management
- Assisting for somatic therapies
- Accurately observing and documenting the patient's behavior
- Providing opportunities for the patient to make his own decisions and to assume responsibility for his life
- Providing feedback to the patient based on observations of his behavior
- Participation in various therapies, (psychotherapy, behavior therapy, group therapy, playtherapy, family therapy, etc.) individual interactions, formal and informal group situations, role play, advocating on behalf of the patient and so forth
- Delivering psychoeducation
- Counseling the patient and family members
- Cooperating with other professionals in various aspects of the patient care; thereby, facilitating an interdisciplinary approach to care
- Teaching social skills and stress management strategies
- Discharge planning and community referral and follow-up care
- Supervise the work of subordinates
- Maintain ward cleanliness.

Psychiatric Outpatient Department

- Performing clinical assessment
- Assisting for psychometric assessment
- Assisting or providing psychotherapy or behavior therapy

- Counseling the patient and family members
- Conducting group therapy
- Delivering psychoeducation.

ECT Treatment Setting

- Teaching the patient prior to ECT treatment
- Preparing the patient for ECT
- Providing care during the procedure
- Assisting with post-treatment
- Providing reassurance to reduce anxiety
- Delivering psychoeducation regarding ECT.

Psychotherapy Unit

Nurses who possess a masters degree in psychiatric nursing and are certified clinical nurse specialists may conduct individual or group psychotherapy.

- Establishing a therapeutic relationship with the patient
- Providing an opportunity for the patient to release tension as problems are discussed
- Assisting the patient in gaining insight about the problem
- Providing opportunity to practice new skills
- Reinforcing appropriate behavior as it occurs
- Providing consistent emotional support.

Day Care Centers or Day Hospitals

In day treatment programs patients return home at night.

- Performing clinical assessment
- Accurately observing and documenting the patient's behavior
- Medication management
- Teaching social skills
- Counseling patient and family members
- Delivering psychoeducation
- Providing occupational or recreational therapy and vocational assistance

Family Therapy Units

Psychiatric nurses' work with families at all levels of functioning.

- Assessing individual and family needs and resources
- Facilitation of a family's use of positive coping strategies
- Promote adaptive family functioning by teaching communication skills and problem solving skills
- Delivering psychoeducation.

Child Psychiatric Ward

- Assessing for biological and psychological need of the child
- Determine the child's strengths and abilities and develop a care plan to maintain and enhance capabilities
- Monitor the child's developmental levels and initiate supportive interventions, such as speech, language or occupational skills as needed
- Provide a safe therapeutic environment, including protecting the child and others from injury
- Cooperate with other professionals in an interdisciplinary approach to care
- Provide adequate environmental stimulation
- Teach the child adaptive skills, such as eating, dressing, grooming and toileting
- Demonstrate and help the child to practice self care skills
- Provide genetic counseling if necessary
- Deliver psychoeducation
- Medication management
- Provide emotional support to the parents
- Participate in various therapies (behavior therapy, play therapy, expressive therapies, bibliotherapy, etc.).

Home Setting

- Assessment of symptoms

- Teaching the patient and family regarding nutrition, exercise, hygiene and the relationship between physical and emotional health
- Stress management
- Daily living skills (basic money management, for example, bank accounts, rent, utility bills, use of the telephone, grocery shopping, etc.)
- Medication management—monitoring blood levels, signs and symptoms of overdose or toxicity, teaching on dosage, side effects and purposes
- Administration of parenteral injections
- Venipuncture for laboratory analysis
- Act as a case manager and coordinate an array of services that include physical therapy, occupational therapy, social work and community services
- Appropriate referrals to community agencies
- Provide supportive counseling and brief psychotherapy
- Promotion of mental health and prevention of mental illnesses.

Community Mental Health Centers

- Identification of patients in the community
- Refer the patients to appropriate hospitals
- Home visiting and providing direct care to the patients in the community
- Follow up care with special emphasis on medication regimen, improvement made and side effects, patient's occupational function
- Conducting public awareness programs to remove misconceptions regarding mental disorders
- Training of paraprofessional, community leaders, school teachers and other care giving professionals in the community
- Management of resources planning and coordination
- Direct services, like care of families at risk for violence, abuse and dysfunction, care of homeless mentally ill patients, etc. (Box 1.4).

Box 1.4: Various roles of community psychiatric nurse

- » Addiction counselor
- » Counselor
- » Crisis worker
- » Advocate
- » Case manager
- » Educator
- » Researcher
- » Community developer and consultant

Hospice Care Centers

- Helping cancer patients or terminally ill individuals through the grieving process
- Provide supportive psychotherapy
- Provide support groups for families of terminally ill patients.

Emergency Departments

- Crisis intervention during natural disasters, accidents, unexpected illnesses causing increased anxiety, stress or immobilization
- Obstetric nursing centers
- Helping the mother in labor and support person to cope with anxiety/stress during labor
- Providing support to bereaved parents in the event of fetal demise, abortion, birth of an infant with congenital abnormalities.

Medical Inpatient Wards

Psychosocial intervention for chronic illnesses with major psychological effects, e.g. Alzheimer's disease, HIV/AIDS, diabetes mellitus, Parkinson's disease, multiple sclerosis, hemophilia, colostomy, amputation, etc.

Industrial Medical Centers

- Implementing or participating in industrial substance abuse programs for employees
- Providing crisis intervention during accidents or the acute onset of a physical or mental illness (for example, heart attack)
- Teaching stress management.

Hospitals for Criminal Insane, Jails and Prisons

- Forensic psychiatric nurses assist patients with self-care, administration of medications and monitor the effectiveness of the treatment
- Promote coping skills
- Advanced nurses are able to diagnose and treat individuals with psychiatric disorders and are allowed to prescribe medications
- Provide psychotherapy and act as consultants
- Forensic evaluation for legal sanity
- Assessment of potential for violence
- Parole/probation considerations
- Assessment of racial/cultural factors during crime
- Sexual predator screening and assessment
- Competency therapy
- Formal written reports to court
- Review of police reports
- On scene consultation to law enforcement.

FACTORS AFFECTING LEVEL OF NURSING PRACTICE

The level at which psychiatric nurses practice is determined by various factors such as:

- Nurse practice acts (Laws)
- Professional practice standards
- Educational qualification and experience
- Health care organization's philosophy
- Self-motivation and personal initiatives.

Nurse practice acts regulate entry into the profession and define the legal limits of nursing practice that must be adhered to by all nurses. Nurses must be familiar with the nurse practice act of their state and limit their practice accordingly.

Professional practice standards define nursing practice and performance; first developed by the ANA in 1973 and recently revised in 2000.

Nurses' qualifications include education, work experiences and certification status

which determine the level of practice. The ANA has identified two levels of psychiatric nurses (Table 1.1).

A health care organization's philosophy of mental health and mental illness and its approach towards treatment help to share the expectations of both the nurse and the patient.

The personal competence and initiative of the individual nurse determine one's interpretation of the nursing role and the success of its implementation. Other personal factors which influence the nurse's level of performance are—willingness to act as an agent of change, thorough knowledge of personal strength and weakness, realization of clinical competence.

CONCEPTS OF NORMAL AND ABNORMAL BEHAVIOR

Psychiatry as evident from the above is concerned with abnormal behavior in its broadest sense, but defining the concepts of normal and abnormal behavior as such has been found to be difficult. These concepts are much under the influence of sociocultural factors.

Several models have been put forward in order to explain the concept of normal and abnormal behavior. Some of them are:

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 and psychomotor activities. The normal are the ones who are free from these disturbances.

Statistical Model

It involves the analysis of responses on a test or a questionnaire or observations of some particular behavioral 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 distribution curve.

Sociocultural Model

The beliefs, norms, taboos and values of a society have to be accepted and adopted by

Table 1.1: Two levels of psychiatric nurses indentified by ANA

<i>Basic level psychiatric nurses</i>	<i>Advanced level psychiatric nurses</i>
<p>They are registered nurses who carry out doctor's orders. Their duties are:</p> <ul style="list-style-type: none"> » Develop nursing care plans » Provide direct nursing care » Administer medications » Carry out treatment strategies as ordered by physician » Teach family members about the patient's disorder and needs » Determine the community's mental health needs and assist with crisis intervention and counseling » Help plan community programs 	<p>They have a master's degree in psychiatric mental health nursing. They have the authority to work independently. In addition to the above, advanced psychiatric nurses can perform the following duties:</p> <ul style="list-style-type: none"> » Assess patients using a variety of methods » Make a diagnosis based on the assessment » Develop a plan of care and treatment » Prescribe medications (in most states) » Provide counseling » Provide psychotherapy (in most states) » Conduct research » Serve as an administrator » Teach in universities

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 to be taken into account when distinguishing between normal and abnormal behavior.

Behavior Model

Behavior that is adaptive, is normal, maladaptive is abnormal. Abnormal behavior is a set of faulty behaviors acquired through learning.

THE MENTAL HEALTH—MENTAL ILLNESS CONTINUUM

The individual's state of health is one of continual change. He moves back and forth from health to illness and back to health again. His condition is rarely constant. The individual must continually adapt to these

changes to maintain good health and well-being. All human behavior lies somewhere along a continuum of mental health and illness. One of the approach in defining mental illness and mental health is based on evaluating individual behavior in two-dimensions.

- On a continuum from adaptive to maladaptive
- On a continuum from constructive to destructive

Along the adaptive-maladaptive continuum, adaptive behavior solves problems encountered in daily living and enhances an individual's life. Maladaptive behavior allows a problem to continue and often generates new problems. On a continuum from constructive to destructive behavior, while the constructive behavior contributes to psychological growth and biological functioning in an individual and others, the destructive behavior results in failure to deal with it (Tables 1.2 and 1.3).

MENTAL HEALTH CONTINUUM MODEL

Table 1.2: Mental health and mental illness continuum

<i>Healthy</i>	<i>Reacting</i>	<i>Injured</i>	<i>Illness</i>
<i>Normal function</i>	<i>Common and reversible distress</i>	<i>Emotional impairment</i>	<i>Clinical disorder</i>
» Well-being » Occasional stress to mild distress » No impairment		» Emotional problems or concerns » Mild to moderate distress » Mild or temporary impairment	» Mental illness » Marked distress » Moderate to severe disability or chronic impairment
Observed behavior			
» Physically well and socially active » Good energy level and performing well » Normal sleep patterns » Normal mood fluctuations » Calm and takes things in steps » Good sense of humor	» Muscle tension and headaches » Low energy level and decreased activity » Trouble sleeping » Irritable/impatient/nervous » Intrusive thoughts » Nightmares » Forgetfulness » Procrastination	» Increased aches and pains » Increased fatigue » Poor performance » Disturbed sleep » Recurrent images/nightmares » Anger » Anxiety » Poor concentration » Increased alcohol use/gambling is difficult to control	» Physical illness » Cannot perform duties/cannot concentrate » Constant fatigue » Sleeping too much or too little » Excessive anxiety/panic attacks » Depressed/suicidal thoughts

» In control mentally » No or limited alcohol use or gambling	» Regular but controlled alcohol use/gambling		» Anger outbursts/aggression » Alcohol or gambling addiction and other addictions
Mental health nurses role			
<i>Health promotion</i>	<i>Prevention</i>	<i>Treatment</i>	<i>Treatment and maintenance</i>
<ul style="list-style-type: none"> » Know the capabilities of the person » Set goals for achievement » Reinforce desired actions » Promote healthy work environment » Educate on general instructions to mental and physical health » Watch for behavioral changes 	<ul style="list-style-type: none"> » Assess for stressors and unhealthy situations » Listen to the patient » Minimize stressors » Identify resources » Provide opportunity to rest » Teach on adaptive coping mechanisms and stress management strategies » Provide support during difficult times » Provide interventions » Refer if it is necessary » Watch for symptoms » Follow-up 	<ul style="list-style-type: none"> » Assess, identify and observe symptoms » Use resources » Provide interventions to manage unacceptable behavior » Ensure support from family members and friends » Encourage regular activities » Refer to consultation » Watch for symptoms » Follow-up 	<ul style="list-style-type: none"> » Assess and observe symptoms » Use resources » Provide interventions to manage unacceptable behavior » Ensure support from family members and friends » Encourage regular activities » Refer to consultation » Watch for symptoms » Follow-up » Prevent relapses » Rehabilitation

Table 1.3: Mental health versus mental illness

<i>Signs of mental health</i>	<i>Signs of mental illness</i>
<i>Happiness:</i> Finds life pleasurable, seeks satisfaction in activities and people for meeting one's needs	<i>Depression:</i> Loss of interest in pleasurable activities. Mood as described by person is depressed, sad, hopeless, discouraged
<i>Control over behavior:</i> Can respond to the rules, routines and customs of the group to which one belongs	<i>Conduct disorder:</i> Under-socialized, Aggressive behavior
<i>Appraisal of reality:</i> Can comprehend what is happening around him, can see the difference between 'as if' and 'for real' in situations	<i>Schizophrenic disorder:</i> Loss of touch with reality, bizarre delusions such as delusions of being controlled, delusions with persecutory or jealous content, auditory hallucinations
<i>Effectiveness in work:</i> Can do well in task attempted. Optimum use of his capacities.	<i>Adjustment disorder:</i> Decline in work output or academic performance
<i>Healthy self-concept:</i> Have reasonable self-confidence, as capable of meeting demands	<i>Dependent personality disorder:</i> Passively allows others to assume responsibility for major areas of life because of inability to function independently. Lacks self-confidence
<i>Satisfying relationships:</i> Experiences satisfaction and stability in relationships. Can rely on social support	<i>Borderline personality disorder:</i> Shows pattern of unstable and intense interpersonal relationships, and also has chronic feeling of emptiness
<i>Effective coping strategies:</i> Uses adaptive coping strategies and stress reduction strategies like-problem solving, cognitive restructuring, etc.	<i>Substance abuse:</i> Uses maladaptive coping strategies like repeated use of substances despite significant substance related problems

REVIEW QUESTIONS

Long Essays

1. Write a note on development of modern psychiatric nursing.
2. Write in detail about scope of psychiatric nursing.
3. Describe various functions of mental health nurse in various settings.

Short Essays

1. Components of mental health
2. Prevalence and incidence of mental health problems
3. Multidisciplinary team
4. Concepts of normal and abnormal behavior.

Short Answers

1. Criteria for mental health
2. Characteristics of a mentally healthy person
3. Mental illness
4. Mental health.

MULTIPLE CHOICE QUESTIONS

1. Which of the following is a criterion for mental health?

- a. Efficiency in work and play
- b. Disturbance in day to day activity
- c. Able to perform activities independently
- d. Personal insecurity.

2. Which of the following is an important characteristic of a mentally healthy person?

- a. Ability to perform activities independently
- b. Ability to make adjustments
- c. Feeling secure
- d. Changes in behavior.

3. Chlorpromazine drug was introduced in:

- a. 1942
- b. 1952
- c. 1962
- d. 1972.

4. Who wrote the book ‘the mind that found itself’?

- a. Clifford Beers
- b. Linda Richards
- c. Maxwell Jones
- d. Philippe Pinel.

5. Who is the first psychiatric nurse?

- a. Hildegard Peplau
- b. Betty Neuman
- c. Linda Richards
- d. Florence Nightingale.

6. Who introduced therapeutic community?

- a. Maxwell Jones
- b. Philippe Pinel
- c. Benjamin Rush
- d. Bleuler.

7. The Indian Nursing Council included psychiatric nursing as a compulsory course in BSc Nursing Program during:

- a. 1945
- b. 1947
- c. 1952
- d. 1965.

8. The Indian Nursing Council included psychiatric nursing subject as a component of general nursing and midwifery course during _____

- a. 1956
- b. 1965
- c. 1974
- d. 1986

9. The Indian Society of Psychiatric Nurses was formed in the year _____

- a. 1986
- b. 1989

- c. 1991
- d. 1995

10. Lithium was first introduced for the treatment of Mania in:

- a. 1938
- b. 1949
- c. 1952
- d. 1955

11. ECT was first used for the treatment of psychosis in:

- a. 1938
- b. 1949
- c. 1952
- d. 1955

12. A post-certificate course in psychiatric nursing was introduced at NIMHANS, Bengaluru in:

- a. 1938
- b. 1949
- c. 1952
- d. 1956

13. The Indian Mental Health Act was passed in the year:

- a. 1912
- b. 1952
- c. 1980
- d. 1987

14. The following are the approaches of National Mental Health Program, except:

- a. Integration of mental health care services in existing general health services
- b. Eradication of stigma regarding mental illness
- c. Utilization of existing infrastructure in health services to deliver mental health care services

- d. Imparting training to existing health staff in mental health care

15. Government of India launched the National Mental Health Program in the year:

- a. 1982
- b. 1989
- c. 1995
- d. 2000

16. The following professionals are a part of the multidisciplinary team, *except*:

- a. Psychiatric Nurse
- b. Clinical Psychologist
- c. Psychiatric Social Worker
- d. Nurse manager

17. The Nurse manager acts as a/an:

- a. Advocate for patient
- b. Therapist for family members
- c. Educator for family members
- d. Specialist for patient

18. Factor/s influencing level of nursing practice is/are:

- a. Nurse practice acts
- b. Nurse's qualification
- c. Professional practice standards
- d. All of the above

19. Medical model considers the cause of mental disorders a result of:

- a. Organic pathology in the brain
- b. Use of maladaptive behavior
- c. Strict societal norms
- d. Abnormal cultural practices

20. Behavioral model considers the cause of mental disorders a result of:

- a. Organic pathology in the brain
- b. Use of maladaptive behavior

- c. Strict societal norms
- d. Abnormal cultural practices
-
- d. Formulation of acts related to mental illness

21. The main aim of National Mental Health Program is:

- a. Prevention and treatment of mental illnesses
- b. Curing of mental illnesses
- c. Eradication of stigma

22. The term 'Schizophrenia' was coined by:

- a. Philippe Pinel
- b. William Tuke
- c. Eugen Bleuler
- d. Benjamin Rush

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. a | 2. b | 3. b | 4. a | 5. c | 6. a | 7. d | 8. d | 9. c | 10. b |
| 11. a | 12. d | 13. d | 14. b | 15. a | 16. d | 17. a | 18. d | 19. a | 20. b |
| 21. a | 22. c | | | | | | | | |

Chapter 2

Principles and Concepts of Mental Health Nursing

Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity. Both physical and mental healths are inter-dependent. A nurse who is responsible for total health care of a person must take care of both physical and emotional needs; therefore, she should develop a basic understanding and skill in psychiatric nursing to achieve total health care.

PSYCHIATRY

It is a branch of medicine that deals with the diagnosis, treatment and prevention of mental illness.

PSYCHIATRIC NURSING

It is a specialized area of nursing practice, employing theories of human behavior as it is a science, and the purposeful use of self as it is an art, in the diagnosis and treatment of human responses to actual or potential mental health problems (American Nurses Association, 1994).

Thus, psychiatric nursing deals with the promotion of mental health, prevention of mental illness, care and rehabilitation of mentally ill individuals both in hospital and community.

SIGNS AND SYMPTOMS OF MENTAL ILLNESS

Alterations of Personality and Behavior

Personality refers to the sum total of an individual's thinking, feeling and behavior, which is more or less stable and enduring. Any alteration in personality may be the initial or only symptom which a patient exhibits as suggestive of an illness. A confirmed atheist turning into a God-fearing individual overnight observing religious rituals or a habitually social and outgoing person isolating himself from others are examples.

Alterations of Biological Functions

Sleep: Disturbances of sleep are very common complaints in psychiatry. Sleep is disturbed in several ways, in its pattern, quality and duration. In some pathological conditions like mania, insomnia may occur. Delay in falling asleep (initial insomnia) occurs in anxiety. Depression is characterized by early waking up (late insomnia) and the sleep is usually non-refreshing. The sleep-wake pattern is reversed in certain organic conditions like delirium and dementia. The patient sleeps in

the daytime and remains awake during night (reversal of rhythm).

Various types of impairment occur in schizophrenia. Sleeping for excessively long periods at night is called hypersomnia. Somnolence is abnormal drowsiness in the daytime. Hypersomnia and somnolence may occur to compensate insufficient night-time sleep and pathologically in many central nervous system (CNS) diseases.

Appetite: Appetite is reduced in anxiety states and depression and increased in conditions like mania and thyrotoxicosis. Overeating may sometimes be a feature of anxiety. In schizophrenia, appetite is increased or decreased or perverted (pica). Pica refers to eating unedible items like soil, paper, hair, etc. and is seen in other conditions also like mental retardation, brain damage and autism.

Sexual desire: Sexual desire is altered in many psychiatric conditions; it increases in conditions like mania and some cerebral lesions, and reduces in conditions like anxiety, depression and drug abuse. Loss of libido, erectile dysfunctions, ejaculatory disturbances and pain are the presenting symptoms in psychosexual disorders.

Disorders of Consciousness

Consciousness is awareness of self and environment. Unconsciousness is lack of awareness of self and environment and lack of subjective experience. Alterations of sensorium are usually indicative of organic pathology. Levels of consciousness range from full alertness to coma with intervening stages of clouding, drowsiness and stupor. The etiology is multiple and non-specific like intoxication, infections, trauma, metabolic disorders and others.

Clouding of consciousness: There is diminution of alertness. This occurs in several organic conditions as well as in functional psychosis where it is part of an overall cognitive deficit.

Drowsiness: Though the patient appears awake he may slip into sleep unless constantly stimulated. The patient's thinking is muddled, speech is slurred and activities are sluggish but all reflexes are preserved.

Coma: In coma, the patient is unconscious and is in a state of non-responsiveness to external stimuli. In deep coma the patient is no longer in a state of arousal even with painful stimuli and his reflexes are lost.

Qualitative changes in consciousness: Some quantitatively different alterations of consciousness are confusion, delirium, somnolence, twilight states, automatisms, fugue and dissociation and stupor. Confusion is an inability to think clearly. The person is disoriented to time, place and person and wears a perplexed look. It occurs both in organic and functional disorders. Delirium is a state of impaired consciousness with global disturbances of cognitive functions. Somnolence is excessive daytime sleepiness. Twilight states are transient states of altered sensorium during which patient's perceptions are faint and indistinct. Activities carried out during this period may be simple or complex. The patient is not aware of these activities afterwards. Automatisms are repetitive stereotypic behavior of which the patient is not aware of and over which he has no control. Automatisms are the result of brain dysfunction and occur in a confusional setting. Both twilight states and automatisms occur as epilepsy-related events.

Fugue and dissociation: Dissociation is a reversible and temporary alteration in the integrative functions of consciousness and identity, during which the patient has no memory of his previous identity or events of that period. Fugue is similar to dissociation. The patient has a mistaken identity and tends to wander away from normal surroundings. Both dissociation and fugue resemble states of alteration of consciousness, but have no true organic dysfunction.

Stupor: Stupor in psychiatry refers to a state where the patient though conscious, is unresponsive to his environment. His eyes are open and he is mute and immobile. Retrospectively, he may be able to give an account of the happenings around while he was in stupor, indicating that there was no loss of consciousness. Stupor occurs in schizophrenia and depression.

Disorders of Attention and Concentration

While attention is the focus of consciousness on a particular object or idea, concentration refers to persistence of attention to the same stimulus or "focused attention". Distraction is the inability to shut off irrelevant stimuli so that any stimulus in the environment takes away his attention. Disorders of attention are present in the form of narrowing of attention and its span, undue distractibility and lack of concentration. Narrowing of attention occurs where a person is able to focus his attention only on small part of his awareness field. Attention is impaired in anxiety, mania, depression, schizophrenia and organic states. Fatigue and substance abuse disrupt attention and concentration.

Disorders of Orientation

Orientation is the proper and continuous awareness of time, place and person in relation to self and surroundings. In several organic conditions, this may fluctuate from time to time or diurnally. Disorientation to time occurs first in a progressive illness followed by disorientation to place and person in that order. Disorientation to one's own identity (i.e. failing to recognize one's own name and identity) indicates an advanced stage of deterioration.

Volitional Disturbances

Volition is the willful initiation and control of one's behavior. Volitional disturbances

are seen in organic and functional disorders. Lesions of mid-brain, the area of brain where centers of biological drives are located (sleep, appetite, thirst, etc.), cause volitional disturbances by reducing drives. Will and motivation are affected in functional psychosis as in schizophrenia, presenting as lack of initiative and other negative symptoms. In its extreme form, volitional disturbances may present themselves as immobility, mutism and stupor.

Disorders of Motor Activity

Disturbances in the Level of Activity

Increased activity level (hyperactivity): Hyperactivity may be goal directed or not. In hypomania and mania, it appears as goal directed and purposeful, but the goal is often not reached due to distraction. Impulsivity implies lack of forethought or deliberation of the consequences of action and is often carried out forcefully. Restlessness is the inability to remain still and being uneasily active. Agitation is restlessness with anxiety or depression. Agitation is seen in several psychiatric conditions, organic and functional, such as dementia, epilepsy, depression and schizophrenia. Excitement is an emotionally roused state with added hyperactivity shown as accelerated speech, motor activity and hypervigilance.

Decreased activity level (retardation): The level of activity is reduced in depression and in some types of schizophrenia. There is slowness in initiation and in carrying out an activity. In its extreme form it is present as stupor, which is a state of akinesia (lack of movement), mutism and non-responsiveness to environment. Stupor is common in depression, schizophrenia and also in certain organic conditions.

Qualitative disturbances in movement: Tics are sudden involuntary twitching of small groups of muscles. They are brief, repetitive and stereotypic and may be single or multiple. Typically, they involve the face, like blinking or

distortion of expression. But other variations include sniffing, lip smacking, throat clearing, tongue darting or shoulder shrugging. Tics involving the diaphragm are present as grunting or coughing. In one variety they are multiple, associated with vocalization (usually obscene words or curses—coprolalia) and are known as Gilles de Tourette's Syndrome (GTS).

Mannerisms are odd stilted and idiosyncratic movements or activities characteristic of the particular individual. They may or may not be goal directed and are purposeful, for example, scratching the head, stroking and nose pulling. Bizarre mannerisms are characteristic of schizophrenia.

Tremors are rhythmic oscillatory movements due to alternative contraction of agonist and antagonist muscles. Simple tremors involve only a single group of muscles, but in compound tremors several groups of muscles are involved. They may be slow in frequency or rapid, coarse or fine in amplitude. They may be present at rest or may be related to posture, movement or specific tasks.

Stereotype is a repetitive and non-purposeful movement which is carried out uniformly in the absence of any external stimulus. Perseveration is continuation of a goal directed activity even beyond the fulfillment of purpose where the patient is unable to stop the action. It is a common feature of frontal lobe dysfunction.

Negativism is resistance to all passive movements or commands of the examiner. Automatic obedience is a pathological compliance to the examiner's commands, like automation.

Disturbances of Posture and Expression

Disturbance in posturing is a voluntary assumption of inappropriate and bizarre positions of the body. Waxy flexibility is the maintenance of a particular posture imposed on the patient

by the examiner, even if the posture is bizarre and uncomfortable. Some patients lie with their head raised a few inches above the bed and maintain this posture for very long periods ("psychological pillow").

Expressive movements are exaggerated, diminished or distorted. In mania, the patient is extremely cheerful or irritated at any trifling provocation and uses wide expansive gestures. Face is expressionless in some types of schizophrenia. Grimacing and facing contortions are distortions of expression.

Disturbances of Motor Speech

Echolalia is repetition of words or sentences uttered by another person. Palilalia is a variant of echolalia where only the last word or syllable is repeated.

Disorders of Perception

Perception is the meaningful organization of sensory data and their interpretation in the light of one's past experience.

Anomalies of perception are of four types:

- Sensory distortions
- Sensory deceptions (false perceptions)
- Perceptual disturbances of time and space
- Perceptual disturbances of body image.

Sensory Distortions

These occur in all sensory modalities and involve changes in intensity and quality. In the former the sensations become more intense and vivid (hyperesthesia). In hyperesthesia sounds appear louder, colors brighter and pain unbearable. In hypoesthesia they are all diminished. Hyperesthesia occurs under intense emotions, acute psychoses and prior to epileptic seizures. Hypoesthesia occurs in depression and delirium where more intense stimuli are needed to arouse the patient.

Sensory Deceptions

They occur in all sensory modalities and can mainly be classified into two types: Illusions and hallucinations.

Illusions are misperceptions of external stimuli. In the fading light a rope is misperceived as a snake. Illusions may occur in normal life when the sensory data are inadequate or when one is fearful and apprehensive.

Hallucinations are false perceptions which occur in the absence of corresponding sensory stimuli. Hallucinations occur during intoxication, delirium, sensory deprivations, epilepsy and in psychotic conditions, like schizophrenia and depression. Hallucinations may be described in terms of their sensory modality as visual, auditory, olfactory, gustatory and tactile.

- *Auditory hallucinations:* It is a false perception of sound, these are by far the most common, and may be experienced as noise, music or voices. Voices may seem to address the patient directly (second-person hallucinations) or talk to one another referring to the patient as 'he' or 'she' (third-person hallucinations). Third-person hallucinations may be experienced as voices commenting on the patient's intentions or actions. Such commentary voices are strongly suggestive of schizophrenia.
- *Visual hallucination:* False perception involving sight consisting of both formed images (for example, people) and unformed images (for example, flashes of light); most common in medically determined disorders.
- *Olfactory hallucination:* False perception of smell; most common in medical disorders.
- *Gustatory hallucination:* False perception of taste, such as unpleasant taste, caused by seizure; most common in medical disorders

- *Tactile (Haptic) hallucination:* False perception of touch or surface sensation, as from an amputated limb (phantom limb); crawling sensation on or under the skin (formication)
- Other types of hallucinations
Hallucinations are classified in several ways (Box 2.1).

Perceptual Disturbances of Time and Space

Disturbances of time perception take several forms. The passage of time is perceived as too slow (as in depression and anxiety) and too fast as in mania and drug abuse. Depressed patients often report that time is standing still. Anxious patients often fear that they would not be able to complete a task in the stipulated time (pressure of time). Disturbances of space perception are experienced as seeing objects being nearer and larger (macropsia) and smaller and far away (micropsia). This occurs in schizophrenia, delirium and as premonitory symptoms of epilepsy.

Perceptual Disturbances of Body Image

In organic lesions, there are disturbances of bodily experience like right-left disorientation, anosognosias (ignoring the presence of an illness like paralysis) and autotopagnosia (inability to recognize one's own body parts. The body appears mishappen and grotesque, body parts appear reduplicated. Parts of body like the nose appear to have assumed change in size or are misplaced. The body may appear to be floating in space). Such changes occur in drug intoxications and under the influence of hallucinogenic drugs. Phantom limb and autoscopy are other examples of bodily disturbances.

Box 2.1: Special types of hallucinations

- » Hypnagogic and hypnopompic hallucinations which are usually visual in nature, occur prior to falling asleep or waking up in a drowsy state. However, they may occur in other sensory modalities also. For example, hearing the patient's own name being called.
- » Functional hallucinations: Hallucination accompanies a provoking stimulus and both are perceived at the same time. For example, water trickling from a leaking tap is heard along with voices of the patient's neighbor cursing him.
- » Synesthesia (reflex hallucinations): Stimulation in one sensory modality produces sensations pertaining to another. For example, when the light flashes, the patient gets a tingling sensation. Synesthesia are common under the influence of LSD (Lysergic acid diethylamide) and other hallucinogenic drugs.
- » Extracampine hallucinations: They are hallucinations experienced outside the limits of one's sensory fields. For example, hearing voices of people who are talking several kilometers away; seeing through the back of one's head.
- » Scenic (panoramic) hallucinations: Here the hallucinations are vivid, continuous and complex as if one sees a movie.
- » In negative autoscoppy the patient looks in the mirror but is unable to see his image in it.
- » Pseudohallucinations are those perceptions which the patient recognizes as false, in spite of his experiencing them either exterocepted or interocepted, i.e. in external or internal space. They are not pathognomonic of any mental illness.
- » Somatic hallucination: False sensation of things occurring in or to the body, most often visceral in origin (also known as cenesthetic hallucination).
- » Mood-congruent hallucination: Hallucination in which the content is consistent with either a depressed or a manic mood (for example, the depressed hears voices saying that the patient is a bad person; a manic hears voices saying that the patient is of inflated worth, power and knowledge).
- » Mood-incongruent hallucination: Hallucination in which the content is not consistent with either depressed or manic mood (for example in depression, hallucinations not involving such themes as guilt, deserved punishment, or inadequacy; in mania, hallucinations not involving such themes as self-inflated worth or power).
- » Command hallucination: False perception of orders that a person may feel obliged to obey or unable to resist.

Disorders of Mood

Affect is the feeling tone and refers to the emotional state of an individual. Affect sustained for a long time is called mood. These two terms are akin to the terms 'weather' and 'season'. Disorders of mood are present in several ways:

- Their abnormal presence
- Abnormality in depth and duration
- Inappropriateness, and
- Their abnormal swings

Abnormal Presence

Fear, anxiety, depression, elation and anger are examples.

Abnormality in Depth and Duration

Emotions vary in their depth. They may be excessive and out of proportion to the event or markedly reduced (blunted or flattened) and lost (apathetic). Blunting refers to lack of emotional sensitivity, whereas flattening is a limitation of the usual range of

emotions. Blunting and apathy are common in schizophrenia, whereas the others are characteristic of affective disorders. Anhedonia is the total inability to enjoy or experience pleasure. Anhedonia is seen in depression and in schizophrenia.

Inappropriateness

A mood is said to be appropriate and congruent when it is proper to the occasion, thinking and action. A mood is said to be inappropriate when it is not proper to the occasion (feeling happy when a tragedy strikes) and incongruent (laughing when a sad event is narrated). In schizophrenia, incongruent affect is very common.

Abnormal Swings

A mood is said to be labile when the emotional changes are very rapid, i.e. from sorrow to joy. Emotional incontinence refers to spilling of emotions and the patient's inability to control them. Lability and incontinence are particularly common in organic conditions and in cerebral arteriosclerosis. Ambivalence refers to coexistence of contradictory feelings and attitudes towards the same object simultaneously. This is seen in schizophrenia.

Disorders of Memory

Disorders of memory are present as:

- Amnesias
- Hypermnesia, and
- Paramnesia

Amnesia

Amnesia is the partial or total failure to recall past happenings and is due to disturbances of memory. Defective registration occurs when the level of consciousness is diminished, person is inattentive, drowsy or under the effect of drugs like alcohol. It also occurs in various lesions of the brain due to trauma, infection, etc.

Hypermnesia

Hypermnesia is not truly abnormal. It is an extreme degree of retention and recall of events. Every minor detail is recalled accurately. This is seen in mania, delusional disorders and obsessive-compulsive disorders.

Paramnesia

Paramnesia are distorted or falsified recall of events in relation to details or their temporal relationships.

Confabulation is the unintentional filling of gaps of memory with material which is untrue and fanciful. Such recall changes from moment to moment and occurs in clear consciousness where organically determined amnesias coexist.

Déjà vu is an error of recognition where an event or situation though occurring for the first time, strikes a familiar chord, as if it had happened earlier. In contrast, jamais vu is a feeling of strangeness to familiar situations or events. Both déjà vu and jamais vu are not primarily disorders of memory but disturbances of the associated familiarity feeling.

Ganser Syndrome

Otherwise known as the syndrome of approximate answers, this is an example of psychologic paramnesia characterized by:

- Approximate answers (For example, Q. "How many legs do cows have?" Ans. "Three")
- Somatic conversion features
- Pseudohallucinations
- Clouding of consciousness.

Disorders of Thought

Thought disorders are of four types:

- Disorders of form
- Disorders of progression
- Disorders of content
- Disorders of possession.

Disorders of Form

Disordered form of thought is present as various logical and syntactical errors of conceptualization. The common errors are the following:

- **Incoherence:** The sequential connection between one idea and the next is lost so that the talk seems to be muddled up and incoherent. In extreme cases, the speech is full of jargon and is meaningless. For example, the term word “animal” is followed by, “I think it is delightful for the cylindrical dog and my scooter go flying.”
- **Illogical thinking:** Here the thought is totally illogical, for example, “Suresh has a beard. I have a beard, so I am Suresh.”
- **Over inclusion:** Themes which are irrelevant to the context and which are only distantly related to the main theme are included in thinking.
- **Neologism:** Neologism refers to coining new words—which almost always have a private meaning known to the patient alone. For example, “The Malitors are coming to get me.” These new words are indicative of disconnected thought process.

Disorders of Progression

They are disorders of productivity, tempo and direction.

- ***Disorders of productivity (volume):*** The rate at which thoughts are produced is altered in different clinical settings. It may be rapid (logorrhea) giving rise to crowding of thoughts and pressure of speech. On the other hand, there may be low productivity and poverty of ideas.
- ***Disorders of tempo (speed):*** The tempo is accelerated and the flow of words is rapid in several conditions like mania. In a flight of ideas, the patient flies from one topic to another so rapidly that it is often incomprehensible even to the extent of being incoherent. In thought block, there is a sudden break in the flow of thought or speech and the patient feels that his mind has gone blank.

- ***Disorders of direction:*** Direction of thoughts is lost in ‘derailment’ and the thought goes away from the intended theme. In circumstantiality the thought reaches its ultimate goal in a long and roundabout manner—taking too many digression and irrelevant elaborations on its way. The goal is not reached in tangentiality where the thought is sidetracked more and more away from the natural end. Tangentiality is a form of derailment.

Disorder of Content

Disturbances of thought content are seen as various abnormal beliefs and convictions, obsessions, phobias and strange experiences.

- Overvalued ideas are abnormal beliefs, unique to the individual which dominates his life. They differ from delusions in being less intense and less ‘unbelievable’.
- Fantasies are vivid imaginations with a wishful content perceived as unreal by the individual. In ‘autism’, they predominate the psychic life of the individual.
- Ideas of reference are false interpretations with a self-referential quality. All happenings around are interpreted as having special reference to the individual. A man spitting on the ground is taken by the patient as spitting at him.
- Delusions are defined as fixed false beliefs which are not shared by others, are out of keeping with one’s educational, social and cultural background and are unshakable in the face of evidence to the contrary.

Delusions are classified in several ways. Primary (autochthonous) delusions spring up suddenly with no preceding mental events, for example, the patient has a sudden revelation that his neighbor has plans to kill him. Secondary delusions can be understood in the light of happenings which preceded the delusion. The delusions are called systematized when they are well organized and several interrelated beliefs are ‘logically’ woven into them. Unsystematized delusions

Table 2.1: Types of delusions

Parameter	Types
Depending on origin	Primary and secondary
Depending on organization	Systematized and non-systematized
Depending on the reality value	Partial and complete
Depending on complexity	Simple and complex
Depending on the theme	Grandiose, persecutory, etc.

are fragmented and poorly organized. Partial delusions are less 'sticky' and less strong than the complete ones. Simple delusions retain only a few delusional elements unlike the complex ones (Table 2.1).

Themes of Delusions

The themes of delusions are influenced by the patient's educational and cultural background as well as to a great degree by the type of illness. Various types of delusions are:

- Persecutory delusions
- Delusions of references
- Delusions of jealousy
- Delusions of love
- Hypochondriacal delusions
- Nihilistic delusions
- Somatic delusions
- Obsessions and compulsions
- Phobias
- Strange experiences.

Disorders of Possession

Normal thinking has a quality of possession, that is, the individual is aware that the thoughts are his own and that he has control over them. He knows that his thoughts cannot be revealed to another person without his will. This is lost in some thought disorders and the patient believes that other persons can play upon his thinking.

In thought insertion the patient thinks that others' thoughts are inserted in his mind. In thoughts withdrawal his own thoughts are

taken away from him. In thought diffusion the patient thinks that thoughts escape from his mind and become accessible to others. In its severe form the patient might say that his thoughts are read aloud in public. This is called thought broadcasting. Disorders of thinking are elicited through the patient's speech or writing samples.

Disorders of Intelligence

Mental retardation is a subnormal level of intellectual functioning. It is of several grades: mild, moderate, severe and profound, depending on the IQ level. Intellectual deterioration occurs in dementias and other organic conditions and in schizophrenia.

Disorders of Insight and Judgment

Judgment is impaired in many organic conditions and in psychoses. It is usually intact in neuroses. Insight is the patient's awareness of his disability and need for help. There are several grades of insight. When there is total lack of insight the patient denies any illness and need for treatment. Preservation of insight implies his awareness of his symptoms and their causal relationship to his psychic life. It implies a readiness to effect a change by altering his behavior and to follow medical advice.

CLASSIFICATION OF MENTAL DISORDERS

Classification is a process by which complex phenomena are organized into categories, classes or ranks so as to bring together those things that most resemble each other and to separate those that differ.

Purposes of Classification

- Makes generally acceptable diagnosis
- Provides standardized vocabulary that permits effective communication between psychiatrists, other doctors and professionals

- Makes generalizations in treatment response, course and prognosis of individual patients
- Makes framework for research in psychiatry.

At present, there are two major classifications in psychiatry, namely, ICD 10 (1992) and DSM-5 (2013). In both the ICD and DSM, the mental disorders are at present grouped by their symptoms in categories that compose the classification.

1. ICD10 (International Statistical Classification of Disease and Related Health Problems)—1992

This is WHO's classification for all diseases and related health problems. The chapter 'F' classifies psychiatric disorders as mental and behavioral disorders and codes them on an alphanumeric system from F00 to F99.

The main categories in ICD10 are:

F00-F09	Organic, including symptomatic, mental disorders
F10-F19	Mental and behavior disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood (affective) disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

In parallel to the further development of ICD-10 of WHO, work on a fundamental

Eleventh Revision is in progress. ICD-11 is expected to be published in 2017.

2. DSM-5

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was published on May 18, 2013, overriding the DSM-IV-TR. In the United States, the DSM serves as a universal authority for psychiatric diagnosis. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance.

Until now, DSM has organized clinical assessment into five areas or axes, addressing the different aspects and impact of any disorder. The five axes of DSM IV are:

AXIS I: Clinical psychiatric diagnosis

AXIS II: Personality disorder and mental retardation

AXIS III: General medical conditions

AXIS IV: Psychosocial and environmental problems

AXIS V: Global assessment of functioning in current and past one year

This multiaxial system was introduced to help guide clinical assessment and ensure adequate attention to all mental disorders. But serious problems emerged, which have had negative consequences for clinicians, patients and researchers alike. To address these issues, DSM-5 uses unified system of clinical assessment that is aligned with international classification systems. It combines the first three axes into one that contains all mental and other medical diagnoses. Doing so removes artificial distinctions among conditions, benefitting both clinical practice and research use.

The diagnostic criteria and codes in DSM-5

1.2.1 Neurodevelopmental disorders

1.2.2 Schizophrenia spectrum and other psychotic disorders

- 1.2.3 Bipolar and related disorders
- 1.2.4 Depressive disorders
- 1.2.5 Anxiety disorders
- 1.2.6 Obsessive-compulsive and related disorders
- 1.2.7 Trauma- and stressor-related disorders
- 1.2.8 Dissociative disorders
- 1.2.9 Somatic symptom and related disorders
- 1.2.10 Feeding and eating disorders
- 1.2.11 Sleep-wake disorders
- 1.2.12 Sexual dysfunctions
- 1.2.13 Gender dysphoria
- 1.2.14 Disruptive, impulse-control, and conduct disorders
- 1.2.15 Substance-related and addictive disorders
- 1.2.16 Neurocognitive disorders
- 1.2.17 Paraphilic disorders
- 1.2.18 Personality disorders

3. Indian Classification

In India, Neki (1963), Wig and Singer (1967), Vahia (1961) and Varma (1971) have attempted some modifications of ICD8 to suit Indian conditions. They are broadly grouped as shown in Figure 2.1.

In everyday practice, classification is made after the history and examination of mental state have been completed.

REVIEW OF PERSONALITY DEVELOPMENT

Personality refers to deeply ingrained patterns of behavior, which include the way one relates to, perceives and thinks about the environment and one-self.

—American Psychiatric Association—1987

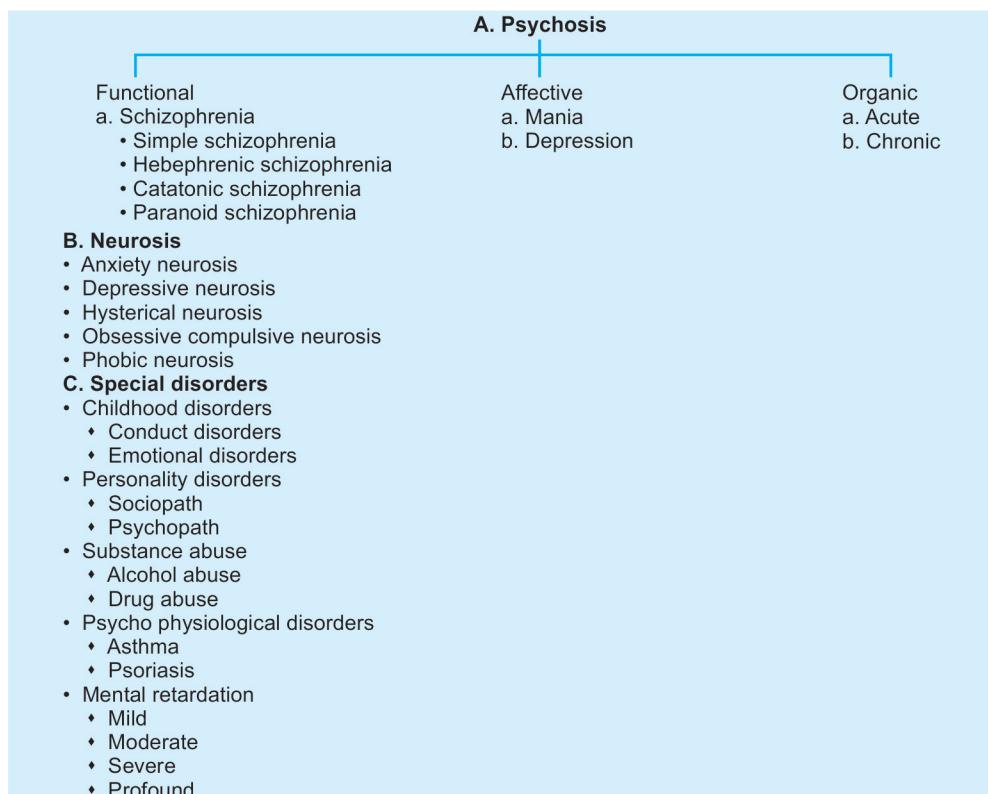


Fig. 2.1: Indian classification of psychiatric disorders

Factors Influencing Personality

The factors affecting personality can be divided into two classes—biological and environmental.

Biological Factors

Biological factors affecting the development of personality are heredity, endocrine glands, physique and nervous system.

Heredity

At conception, when the egg cell of the female is fertilized by the sperm cell of the male, each new human being receives a genetic inheritance that provides potentialities for development and behavioral traits throughout a lifetime.

The principal raw materials of personality—physique, intelligence and temperament—are the result of heredity. How they will develop will depend on environmental influences. Many aspects of human behavior and development ranging from physical characteristics, such as height, weight, eye and skin color, the complex patterns of social and intellectual behavior, are influenced by a person's genetic endowment.

Endocrine glands

- The secretions of endocrine glands affect physical growth, emotional growth and mental growth. These will have an impact on the total personality of an individual.
- The thyroid gland secretes a hormone called thyroxin, and the main function of this hormone is regulation of body metabolism. If the thyroid gland is under-active, the result is usually mental dullness, inactivity, depression, fatigue and poor appetite. Hypersecretion of these glands leads to extreme over-activity.
- The parathyroid gland regulates calcium metabolism. Excitability of the nervous system is directly dependent on the amount of calcium in the blood. Deficient working of this gland leads to the development of an irritable, quick-reactive, distracted, nervous and a tense person.

- Similarly, other glands namely pituitary, the adrenal and the gonads have their tremendous impact on various personality traits.

Physique

An individual's size, strength and general appearance determines to a large extent the way in which he behaves towards others and how others react towards him. An individual with an imposing body-build and a healthy appearance definitely influences those around him. Even if he has not proved himself, yet he gains recognition and status through his physical appearance. Contrary to this is the small lean person; even if he has some merits, they are over-looked because of his physique. People are apt to judge him according to his appearance.

Nervous system

Entire behavior is effectively managed and controlled by the coordination and functioning of the nervous system. How we will behave in a particular situation depends upon the judgment of our brain. The sense impressions, which are received through sense organs, do not bear any significance unless they are given a meaning by the nervous system.

Environmental Factors

Family

- Among environmental factors, the most important is the family environment. The reaction of the family environment towards an individual and the role of parents are very important in the molding of personality. Parents serve as a model whom the child imitates, and their influence is considerable on the child. Parents influence the development of a child's personality in a wide variety of ways. Children learn the moral values, code of conduct, social norms and methods of interacting with others from parents.

- On the whole, friendly and tolerant fathers help children to have greater emotional stability and self-confidence. Domineering and rigid fathers will only foster the development of submissive and frightened dependent children.
- Over-protective mothers will influence children in the direction of dependence and a total disregard for others. Nagging mothers will cause children to be shy, submissive and emotionally unstable.
- Besides the role of the parents, the atmosphere in the family is greatly influencing. A peaceful and loving atmosphere results in children being orderly, peace-loving and very affectionate. Without undue strain they develop mature and pleasant personalities. In a family, where there is tension, constant quarrels and incompatibility among parents, the child is likely to develop strong feelings of insecurity and inferiority.
- Birth order: This is another familial factor that can have an important influence on the personality development. Every child has a unique position in the family, such as the eldest, youngest, second or third. This position has a definite influence on personality. The eldest child is very often overburdened with responsibility, hence he grows up to be very independent, while the youngest being the baby of the family is petted and spoilt. The common view of an only child would be that he will be pampered and spoilt.

School

- The children spend much of their time in the schools, and hence, it can play a very significant part in the formation of the personality of the child.
- The following factors at school will have a direct role in shaping the child's personality:
 - The friendships and acquaintances which are made among the children themselves

- The type of curriculum in the schools
- Well-furnished laboratories, adequate play-ground, etc.

A nurturing school atmosphere provides for all-round development of the child. Consistency, structure, warmth and responsiveness can provide a great deal of help to the children for developing a favorable personality and cope with changing life circumstances.

Teacher

A teacher is the most important person in the school who can help in modifying the children's personalities. He is the most powerful source of stimulation for the child. If he/she possess desirable personal and social modes or reactions, he will inculcate them among his students. On the other hand, effects of prejudicial treatment on the part of teachers can make the child lose self-confidence and develop low self-esteem.

Peer group

Developmental psychologists believe that interactions with peers are critical to many of the social skills and advances that occur during childhood. Peer group refers to other children of the same age who study with or play with the child. Peer group is much more influential than siblings or parents.

Even at preschool age, playmates are highly influential. Children imitate peers and try to be like them in many respects. The peer group serves as an important reference group in shaping personality traits and characteristics of the growing child. As the child grows up peers become progressively more influential in molding the child's self-concept. From their peers, children learn many forms of behavior, some socially appropriate and others socially undesirable.

For example, by striving to be accepted and liked by their peers, they gain new insights into the meaning of friendship. Through give and take with peers, they learn the importance of sharing, reciprocity and co-operation. By trying to get peers to understand their thoughts

and feelings, they learn to communicate more effectively. Within the peer group, children also learn sex-role norms. In general, boys become rougher, boisterous, more compulsive, and form larger groups, while girls tend to form more intimate and exclusive groups. Feelings of masculine superiority, sex bias and other attitudes and behaviors develop with gender identification.

Sibling relationships

The number of siblings as well as their sex and age has a considerable influence on the development of both favorable and unfavorable personality traits like cooperativeness, sharing, aggressiveness, jealousy, etc. Although sibling rivalry is common, older siblings invariably teach the infant a great deal and they can even function as a source of security. On the other hand, unhealthy comparisons can also develop, for instance, an athletic child who is favored by an athletic father over a less active sibling, may suffer from an inferiority complex or develop low self-esteem.

Mass media

Mass media includes films, television, radio, printed literature, etc. Mass media has a considerable impact on attitudes, values, beliefs and behavior patterns. Baron and Bryne (1986) have shown that individuals, especially children, imitate specific aggressive acts of models. They have proposed that human personality formation is a result of modeling and imitating the behavior of significant others. Many abnormal forms of behavior can be learned by imitating models from the mass media.

Culture

Culture influences personality because every culture has a set of ethical and moral values, beliefs and norms which considerably shapes behavior. Cross-cultural studies have pointed out the importance of cultural environment in shaping our personality. Individuals of certain cultures are more generous, open-

hearted and warm, whereas individuals of some other cultures are suspicious, introverted and self-centered. It has also been found that certain cultural communities are more prone to develop certain abnormal behaviors as compared to others, probably due to the influence of geographical, dietary, hormonal or genetic influences within the community.

Theories of Personality Development

Developmental theories identify behaviors associated with various stages through which individuals pass, thereby specifying what is appropriate or inappropriate at each developmental level. Nurses must have a basic knowledge of human personality development to understand maladaptive behavioral responses commonly seen in the mentally ill. Knowledge of the appropriateness of behavior at each developmental level is vital to the planning and implementation of quality nursing care.

Psychoanalytic Theory

Sigmund Freud (1856–1939), an Austrian neurologist, is considered as the father of psychoanalytic theory. He emphasized the unconscious processes or psychodynamic factors as the basis for motivation and behavior. Freud categorized his personality theory according to structure, dynamics and development. Freud organized the structure of the personality into three major components: the id, ego and superego.

The id contains all our biologically based drives, it operates according to the 'pleasure principle'. Id driven behaviors are impulsive and may be irrational. The ego functions on the basis of 'reality principle'. It maintains harmony between the external world, the id and the superego. The superego is referred to as the perfection principle. The superego is important in the socialization of the individual as it assists the ego in the control of id impulses.

A person who is well-adjusted or mentally healthy, has all three components of the personality. Freud would expect anyone in whom any of the component is absent or out of balance to display maladaptive behaviors. Defense mechanisms have been associated strongly with Freud's theories.

One of the Freud's main beliefs is that behaviors resulting from ineffective personality development are unconscious. He believed that ineffective personality development was in some way related to the relationship of the child to the parent and that it was related to what he called psychosexual development.

Freud's stages of personality development

Freud described formation of personality through five stages of psychosexual development (Table 2.2).

Theory of Psychosocial Development

Erik Erikson (1902–1994) was a German-psycho analyst who extended Freud's work on personality development across the life span, while focusing on social and psychological development in the life stages. In his view, psychosocial growth occurs in sequential phases, and each stage is dependent on completion of previous stage and life task. For example, in the infant stage, the infant must learn to develop basic trust (the positive outcome) such as that he or she will be fed and taken care of. The formation of trust is essential: mistrust, the negative outcome of this stage, will impair the person's development throughout his or her life (Table 2.3).

Theory of Cognitive Development

Jean Piaget (1896–1980) explored how intelligence and cognitive functioning develop in children. He believed that a person must complete each stage of development before he or she can progress to the next stage.

According to Piaget, development is influenced by biological maturation, social experiences, and experiences with the physical

environment. During cognitive development, the individual strives to find equilibrium between self and environment (Table 2.4).

Piaget's theory is useful when working with children. The nurse may better understand what the child means, if the nurse is aware of his or her level of cognitive development. Also, teaching for children is often structured with their cognitive development in mind.

Theory of Moral Development

Lawrence Kohlberg was a believer in a Piaget's theories, but he perceived that very young people have the ability to understand and judge right and wrong. Kohlberg's theory is, therefore, called the development of moral judgment. He defined three major levels of moral development.

Level I: Pre-conventional Level (Self-centered orientation—Ages 4 to 10 years)

This stage consists of three substages:

1. Egocentric judgment: In which children make decisions based on what they like or wish with no obligations to obey authority figures.
2. Punishment and obedience orientation: Moral decisions are based on avoidance of punishment. Children realize that there are physical consequences in the form of punishment for bad behaviors. In this stage, children learn the authority role; the child is responsive to cultural guidelines of good and bad, right and wrong, but primarily in terms of the known related consequences.
3. Instrumental relativist orientation: During this stage moral decisions are motivated by desire for rewards rather than avoiding punishment, and belief that by helping others they will get help in return. Behaviors of this stage, are guided by egocentrism and concern for self. There is an intense desire to satisfy one's own needs, but occasionally the needs of others are considered.

Level II: Conventional Level (Able to see victim's perspective - Ages 10 to 13 years)

This stage consists of two substages:

Table 2.2: Freud's stages of personality development		
<i>Stage of development</i>	<i>Main characteristics</i>	<i>Examples of unsuccessful task completion</i>
Oral Birth to 18 months	Use mouth and tongue to deal with anxiety (For example, sucking feedings)	Smoking, alcoholism, obesity, nail biting, drug addiction, difficulty trusting
Anal 18 months to 3 years	Muscle control in bladder, rectum, anus provides sensual pleasure; toilet training can be a crisis	Constipation, perfectionism, obsessive compulsive disorder
Phallic 3–6 years	Learn sexual identity and awareness of genital area as source of pleasure; conflict ends as child represses urge and identifies with same sex parent. The development of electra complex and oedipus complex occurs during this stage of development. Freud described this as the child's unconscious desire to eliminate the parent of the same sex and to possess the parent of the opposite sex	Homosexuality, trans-sexuality, sexual identity problems in general, difficulty accepting authority
Latency 6–12 years	Quite stage in sexual development; learn to socialize	Inability to conceptualize; lack of motivation in school or job
Genital 12 years to adulthood	Sexual maturity and satisfactory relationships with the opposite sex	Frigidity, impotence, premature ejaculation, unsatisfactory relationships

Table 2.3: Erikson's eight stages of psychosocial development			
<i>Stage and approximate ages</i>	<i>Virtue</i>	<i>Task</i>	<i>Consequences of unsuccessful task completion</i>
Infant Trust vs Mistrust Birth to 18 months	Hope	Viewing the world as safe and reliable, relationships as nurturing, stable and dependable	Suspiciousness, trouble with personal relationships
Toddler Autonomy vs Shame and Doubt 1 to 3 years	Will	Achieving a sense of control and free will	Low self-esteem, dependency (on substances or people)
Pre-school initiative vs Guilt 3 to 6 years	Purpose	Development of a conscience, learning to manage conflict and anxiety	Passive personality, strong feelings of guilt
School-age Industry vs Inferiority 6 to 12 years	Competence	Emerging confidence in own ability taking pleasure in accomplishments	Unmotivated, unreliable

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<i>Stage and approximate ages</i>	<i>Virtue</i>	<i>Task</i>	<i>Consequences of unsuccessful task completion</i>
Adolescence Identity vs Role confusion 12 to 20 years	Fidelity	Formulating a sense of self and belonging	Rebellion, substance abuse, difficulty keeping personal relationships. May regress to child play behaviors
Young-adult Intimacy vs Isolation 18 to 25 years	Love	Formulating adult, loving relationships and meaningful attachments to others	Emotional immaturity, may deny need for personal relationships
Middle-adult Generativity vs Stagnation 21 to 45 years	Care	Being creative and productive; focus is on establishing family and guiding the next generation	Inability to show concern for anyone but self
Maturity Ego Integrity vs Despair 45 years to death	Wisdom	Accepting responsibility for one's self and life	Has difficulty dealing with issues of ageing and death; may have feelings of hopelessness

Table 2.4: Four stages of Piaget's theory of development

<i>Stage and approximate age</i>	<i>Expected cognitive development</i>
Sensorimotor Birth to 2 years	<ul style="list-style-type: none"> » Uses senses to learn about self » Develops a sense of self as separate from the external environment » Develops a greater understanding regarding objects within the external environment and their effect upon him or her
Pre-operational 2 to 6 years	<ul style="list-style-type: none"> » Develops the ability to express self with language of symbolic gestures and begins to classify objects
Concrete operations 6 to 12 years	<ul style="list-style-type: none"> » Learns to apply logic to thinking; develops understanding of reversibility and spatiality; and is increasingly social and able to apply rules » Able to think about past and present events but not future, however, thinking is still concrete
Formal operations 12 to 15 years and beyond	<ul style="list-style-type: none"> » Learns to think and reason in abstract terms, further develops logical thinking and reasoning, and achieves cognitive maturity

- 1. Interpersonal concordance orientation:** Moral decisions are based on desire for approval from others and on avoiding guilt experienced by not doing the right thing.

Behavior at this stage is guided by the expectations of others.

- 2. Law and order orientation:** In this stage moral decisions are defined by rights,

assigned duty, rules of the community and respect for authority.

Level III: Post-conventional Level (Underlying ethical principles are considered that take into account societal needs – Ages 13 years and above)

This stage consists of two substages:

- 1. Social contract legalistic orientation:** Moral decisions are based on a sense of community respect and disrespect. This stage focuses on the legal point of view but is also open to considering what is moral and good for the society. Individuals who reach this stage have developed a system of values and principles that determine for them what is right or wrong.
- 2. Universal ethical principle orientation:** This stage deals with abstract and ethical moral values, rather than concrete moral rules. These include universal principles such as equality, justice and beneficence. Behavior is motivated by internalized principles of honor, justice, and respect for human dignity and guided by the conscience.

Humanistic Theories

Humanism represents a significant shift away from the psychoanalytic view of the individual as a neurotic, impulse-driven person with repressed psychic problems. Humanistic theories emphasize the importance of people's subjective attitudes, feelings, and beliefs, especially with regard to the self. Carl Rogers's theory focuses on the impact of disparity between a person's ideals, self and perceived real self. Maslow focuses on the significance of self-actualization.

Rogers' Person-centered approach

Rogers' emphasized that each of us interprets the same set of stimuli differently, so there are as many different 'real worlds' as there are people on this planet (Rogers, 1980).

Self-actualization

Carl Rogers' used the term self-actualization to capture the natural, underlying tendency

of humans to move forward and fulfill their true potential. He argued that people strive towards growth, even in less than favorable surroundings.

Personality development

Carl Rogers' proposed that even young children need to be highly regarded by other people. Children also need positive self regard to be esteemed by self as well as others. Rogers believed that everyone should be given unconditional positive regard, which is a non-judgmental and genuine love, without any strings attached.

Maslow's hierarchy of needs

Abraham Maslow (1921–1970) was an American psychologist who studied the needs or motivations of the individual. He focused on the total person, not just on one facet of the person and emphasized health instead of simply illness and problem.

Maslow (1954) formulated the hierarchy of needs, in which he used a pyramid to arrange and illustrate the basic drives or needs that motivate people. The most basic needs—the physiologic needs of food, water, sleep, shelter, sexual expression and freedom from pain—must be met first.

The second level involves safety and security needs, which include protection, security and freedom from harm. The third level is love and belonging needs, which include enduring intimacy, friendship and acceptance. The fourth level involves esteem needs, which include the need for self-respect and esteem from others. The highest level is self-actualization, the need for beauty, truth and justice (Fig. 2.2).

Maslow hypothesized that the basic needs at the bottom of the pyramid would dominate the person's behavior until those needs were met, at which time the next level of needs would become dominant. For example, if needs for food and shelter are not met, they become the overriding concern in life: the hungry person risks danger and social ostracism to find food. Maslow used the term

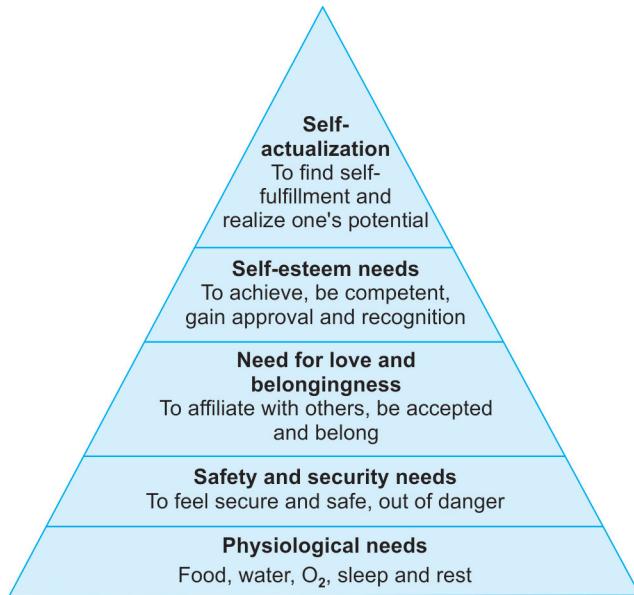


Fig. 2.2: Schematic representation of Maslow's hierarchy of needs

self-actualization to describe a person who has achieved all the needs to the hierarchy and has developed his or her fullest potential in life.

Maslow's theory explains individual differences in terms of a person's motivation, which is not necessarily stable throughout life. Traumatic life circumstances or compromised health can cause a person to regress to a lower level of motivation. This theory helps nurses understand how patient's behavior changes during life crises.

Behavioral Theories

Behaviorists believe that behavior can be changed through a system of rewards and punishments. For example, adults' receiving a regular pay cheque is a constant positive reinforcer that motivates people to continue to go to work every day and to try to do a good job. It helps motivate positive behavior in the workplace. If someone stops receiving a pay cheque, he or she is most likely to stop working.

Ivan Pavlov: Classical conditioning (1849-1936)

Behavior can be changed through conditioning with external or environmental conditions or stimuli. His experiment with dogs involved his observation that dogs naturally began to salivate (response) when they saw or smelled food (stimulus). Pavlov set out to change this salivating response or behavior through conditioning. He would ring a bell (new stimulus), then produce the food, and the dogs would salivate (the desired response). Pavlov repeated this ringing of the bell along with the presentation of food many times. Eventually, he could ring the bell and the dog would salivate without seeing or smelling food. The dog had been conditioned or learned a new response—to salivate on hearing the bell. Dog's behavior had been modified through classical conditioning. This was a great breakthrough in the study of causes of behavior and ways in which behavior can be manipulated.

BF Skinner: Operant conditioning (1904–1990)

Operant conditioning says people's behavior is determined by the events or consequences that follow the response. If the consequences are favorable, the individual will repeat the same behavior. In this case, the consequences are said to have provided positive reinforcement and cause the repetition of the behavior. Alternatively, if the consequences are unfavorable, they reduce the chances of the same behavior from getting repeated. In such a case, the consequences are said to have provided negative reinforcement and reduce the chances of the behavior from recurring again. These behavioral principles of rewarding or reinforcing behaviors are used to help people change their behaviors in a therapy known as behavior modification. Behavior modification is a method of attempting to strengthen a desired behavior or response by reinforcement either positive or negative. Conditioned responses, such as fears or phobias can be treated with behavioral techniques.

DEFENSE MECHANISMS

Coping is the way one adapts to a stressor psychologically, physically and behaviorally. The ego usually copes with anxiety through rational means. When anxiety is too painful, the individual copes by using defense mechanisms to protect the ego and diminish anxiety.

Defense mechanisms are methods of attempting to protect self and cope with basic drives or emotionally painful thoughts, feelings or events. The purpose of defense mechanisms is to reduce or eliminate anxiety. They can be helpful when used in very small doses, and if overused, become ineffective and can lead to a breakdown of the personality. Most defense mechanisms operate at the unconscious level of awareness (Table 2.5).

Relevance to nursing practice: The nurse must recognize and understand maladaptive

defense mechanisms that patients use. The nurse has to carefully point out these mechanisms and work with patients to encourage such behaviors and discourage adaptive ones.

MALADAPTIVE BEHAVIOR OF INDIVIDUALS AND GROUPS: STRESS, CRISIS AND DISASTER (S)

Roy (1976) defined adaptive response as behavior that maintains the integrity of the individual. Adaptation is viewed as positive and is correlated with a healthy response. When behavior disrupts the integrity of the individual, it is perceived as maladaptive. Maladaptive responses by the individual are considered to be negative or unhealthy.

Adaptation affects three important areas: health, psychological well-being and social functioning. A period of stress may compromise any or all of these areas. If a person copes successfully with stress, he returns to a previous level of adaptation. Successful coping results in an improvement in health, well-being and social functioning.

A **maladaptation** in any one area can negatively affect the others. For example, the appearance of psychiatric symptoms can cause problems in performance in the work environment that in turn elicit a negative self-concept. The behavior is considered to be maladaptive when it is age inappropriate and interferes with adaptive functioning. Factors that influence the adaptive functioning are adequate perceptions of the situation, adequate social support, and adequate coping. Adaptive functioning leads to growth, learning and goal achievement. Maladaptive behavior prevents growth, decreases autonomy and interferes with mastery of the environment.

Like an individual, a **group** may need to adapt to a stressor. Group adaptation is a process by which the group maintains a balance so that it can promote growth of

Table 2.5: Commonly used defense mechanisms		
Defense mechanism and description	Example	Overuse can lead to
Repression: Unconscious and involuntary forgetting of painful ideas, events and conflicts	Forgetting: A loved one's birth day after a fight	
Denial: Unconscious refusal to admit an unacceptable idea or behavior. Usually, the first defense learned and used	The mother of a child who is fatally ill may refuse to admit that there is anything wrong even though she is fully informed of the diagnosis and expected outcome. It is because she cannot tolerate the pain that acknowledging reality would produce	Repression, dissociative disorders
Displacement: Unconsciously discharging pent-up feelings to a less threatening object	A husband comes home after a bad day at work and yells at his wife	Loss of friends and relationships, confusion in communication
Reaction formation: Replacing unacceptable feelings with their exact opposites	A jealous boy who hates his elder brother may show him exaggerated respect and affection towards him	Failure to resolve internal conflict
Rationalization: It is a process in which an individual justifies his failures and socially unacceptable behavior by giving socially approved reasons	A student who fails in the examination may complain that the hostel atmosphere is not favorable and has resulted in his failure	Self-deception
Sublimation: Consciously or unconsciously channeling instinctual drives into acceptable activities	Aggressiveness might be transformed into competitiveness in business or sports	
Compensation: Consciously covering up for a weakness by over emphasizing or making up a desirable trait.	A student who fails in his studies may compensate by becoming the college champion in athletics	
Projection: Unconsciously (or consciously) blaming someone else for one's difficulties	A person who blames another for his own mistakes is using the projection mechanism. A surgeon whose patient does not respond as he anticipated, may tend to blame the theater nurse who helped that surgeon at the time of operation	Fails to learn to take personal responsibility. May develop into delusional tendencies
Intellectualization: Separation of the emotions of a painful event or situation from the facts involved; acknowledging the facts but not the emotions	Person shows no emotional expression when discussing serious car accident	
Undoing: Consciously doing something to counteract or make up for a transgression or wrong doing	Giving a treat to a child who is being punished for a wrong doing	May send double message

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Defense mechanism and description	Example	Overuse can lead to
Regression: Unconscious return to an earlier and more comfortable developmental level	An adult throws a temper tantrum when he does not get his own way	May interfere with progression and development of personality
Dissociation: The unconscious separation of painful feelings and emotions from an unacceptable idea, situation or object	Amnesia that prevents recalls of previous days auto accident /Adult remembers nothing of childhood sexual abuse	One of the dissociative disorders
Conversion: The unconscious expression of intrapsychic conflict symbolically through physical symptoms	A student awakens with a migraine headache the morning of a final examination and feels too ill to take the test	Anxiety not dealt with can lead to actual physical disorders such as gastric ulcers

individual and group members. For a group to adapt successfully there must be good communication skills, mutual respect for each other, adequate resources available for adaptation, previous experience with stressors.

Stress is the nonspecific response of the body to any kind of demand made upon it. Most often, stress is associated with negative situations, but good things also produce stress. Stress from positive experiences, such as becoming newly married, promoted at work, etc. is called eustress. A stressor is any person or situation that produces anxiety responses. Stress and stressors are different for each person; therefore, it is important that the nurse knows the stress producers for each of her patient. What is extremely stressful for one person might be relaxing to someone else.

Crisis is a turning point in an individual's life that produces an overwhelming emotional response. Individuals experience a crisis when they confront some life circumstance or stressor that they cannot effectively manage through use of their customary coping skills.

Caplan (1964) identified the following stages of crisis:

1. The person is exposed to a stressor, experiences anxiety, and tries to cope in a customary fashion.

2. Anxiety increases when customary coping skills are ineffective.
3. The person makes all possible efforts to deal with the stressor, including attempts at new methods of coping; and
4. When coping attempts fail the person experiences disequilibrium and significant distress.

A **disaster** is defined by the WHO as a severe disruption, ecological and psychosocial which greatly exceeds the coping capacity of the affected community. Disaster can be natural such as cyclone, famine, flood, earthquake, etc. or man-made such as accidents, bomb blasts, communal riots, etc. Psychological and behavioral responses common in adults following disaster include anger, disbelief, sadness, anxiety, fear, irritability, numbing, sleep disturbance and increase in alcohol, caffeine, and tobacco use. The most essential element of psychiatric mental health intervention during a crisis or disaster is the ability of the nurse to provide emotional support while assessing the individual's emotional and physical needs and enlisting his or her cooperation. Description of stress and crisis are given in Chapter 13.

Etiology: Biopsychosocial Factors

Many factors are responsible for the causation of mental illness. These factors may

predispose an individual to mental illness, precipitate or perpetuate the mental illness.

Predisposing Factors

These factors determine an individual's susceptibility to mental illness. They interact with precipitating factors resulting in mental illness. They are:

- Genetic make-up
- Physical damage to the central nervous system
- Adverse psychosocial influence.

Precipitating Factors

These are events that occur shortly before the onset of a disorder and appear to have induced it. They are:

- Physical stress
- Psychosocial stress.

Perpetuating Factors

These factors are responsible for aggravating or prolonging the diseases already existing in an individual. Psychosocial stress is an example. Thus, etiological factors of mental illness can be:

- Biological factors
- Physiological changes
- Psychological factors
- Social factors.

Biological Factors

Heredity

What one inherits is not the illness or its symptoms, but a predisposition to the illness, which is determined by genes that we inherit directly. Studies have shown that three-fourths of mental defectives and one-third of psychotic individuals owe their condition mainly to unfavorable heredity.

Biochemical Factors

Biochemical abnormalities in the brain are considered to be the cause of some psychological disorders. Disturbance in neurotransmitters in the brain is found to play

an important role in the etiology of certain psychiatric disorders.

Brain Damage

Any damage to the structure and functioning of the brain can give rise to mental illness. Damage to the structure of the brain may be due to one of the following causes:

- Infection: Example, Neurosyphilis, encephalitis, HIV infection, etc.
- Injury: Loss of brain tissue due to head injury
- Intoxication: Damage to brain tissue due to toxins such as alcohol, barbiturates, lead, etc.
- Vascular: Poor blood supply, bleeding (intracranial hemorrhage, subarachnoid hemorrhage, subdural hemorrhage)
- Alteration in brain function: Changes in blood chemistry that interfere with brain functioning such as disturbance in blood glucose levels, hypoxia, anoxia, and fluid and electrolyte imbalance
- Tumors: Brain tumors
- Vitamin deficiency and malnutrition, in particular deficiency of vitamin B complex
- Degenerative diseases: Dementia
- Endocrine disturbances: Hypothyroidism, thyrotoxicosis etc.
- Physical defects and physical illness: Acute physical illness as well as chronic illnesses with all their handicapping conditions may result in loss of mental capacities.

Physiological Changes

It has been observed that mental disorders are more likely to occur at certain critical periods of life, namely—puberty, menstruation, pregnancy, delivery, puerperium and climacteric. These periods are marked not only by physiological (endocrine) changes, but also by psychological issues that diminish the adaptive capacity of the individual. Thus, the individual becomes more susceptible to mental illness during this period.

Psychological Factors

- It is observed that some specific personality types are more prone to develop certain

psychological disorders. For example, those who are unsocial and reserved (schizoid) are vulnerable to schizophrenia when they face adverse situations and psychosocial stresses

- Strained interpersonal relationships at home, place of work, school or college, bereavement, loss of prestige, loss of job, etc.
- Childhood insecurities due to parents with pathological personalities, faulty attitude of parents (over-strictness, over leniency), abnormal parent-child relationship (over-protection, rejection, unhealthy comparisons), deprivation of child's essential psychological and social needs, etc.
- Social and recreational deprivations resulting in boredom, isolation and alienation
- Marriage problems like forced bachelorthood, disharmony due to physical, emotional, social, educational or financial incompatibility, childlessness, too many children, etc.
- Sexual difficulties arising out of improper sex education, unhealthy attitudes towards sexual functions, guilt feelings about masturbation, pre- and extra-marital sex relations, worries about sexual perversions
- Stress, frustration and seasonal variations are sometimes noted in the occurrence of mental diseases.

Social Factors

- Poverty, unemployment, injustice, insecurity, migration, urbanization

- Gambling, alcoholism, prostitution, broken homes, divorce, very big family, religion, traditions, political upheavals and other social crises (Fig. 2.3).

PSYCHOPATHOLOGY OF MENTAL DISORDERS

Psychopathology is the scientific study of mental disorders, including efforts to understand their genetic, biological, psychological and social causes; effective classification schemes; course across all stages of development; manifestations and treatment.

Psychopathology is a branch of psychiatry which deals with the study of manifestations of behavior and experiences indicative of mental illness.

The scientific discipline of psychopathology was founded by Karl Jaspers in 1913, whose object of study was 'mental phenomena'. Many different specialities may be involved in study of psychopathology. For example, while a neuroscientist may focus on brain changes related to mental illness, a psychiatrist is interested in describing the symptoms and syndromes of mental illness.

Before diagnosing a psychological disorder, clinicians must study the abnormalities within psychological disorders. These are deviance, distress, dysfunction and danger. These themes are known as four Ds.

A description of the four Ds when defining abnormality:

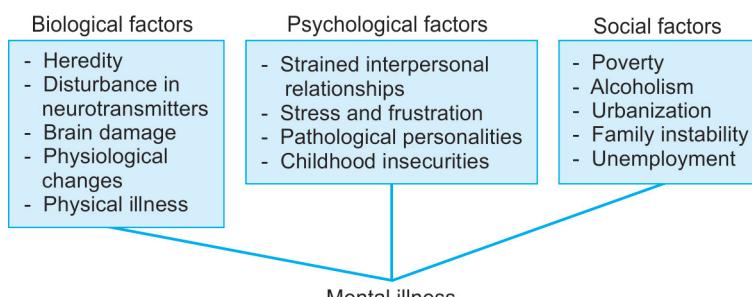


Fig. 2.3: Etiological factors contributing to mental illness

Deviance: The individual actions are deviant or abnormal when his or her behavior is deemed unacceptable by the culture he or she belongs to.

Distress: The individual feels deeply troubled and is affected by the illness.

Dysfunction: It is a maladaptive behavior that impairs the individual's ability to perform normal daily functions.

Danger: It involves dangerous or violent behavior directed at the individual or others in the environment.

REVIEW OF STRUCTURE AND FUNCTIONS OF BRAIN, LIMBIC SYSTEM AND ABNORMAL NEUROTRANSMISSION

Nervous System

The human nervous system can be divided into two parts: the central nervous system and the peripheral nervous system. While the central nervous system constitutes of the brain and the spinal cord, the peripheral

nervous system constitutes of the somatic system and the autonomic system (Fig. 2.4).

Central Nervous System

Consists of brain and the spinal cord. Brain is composed of three main divisions: Forebrain, midbrain and hindbrain (Fig. 2.5).

Forebrain: Important structures of the forebrain are thalamus, hypothalamus, limbic system and the cerebrum. All sensory impulses pass through thalamus to the higher centers, therefore, it is usually known as the relay station. In addition, the thalamus has some control over the autonomic nervous system and also plays a role in the control of sleep and alertness.

Hypothalamus lies below the thalamus. It exerts a key influence on all kind of emotional as well as motivational behavior. Centers in the hypothalamus have control over the important body processes like eating, drinking, sleeping, temperature control and sex. It also has control over the activities of pituitary gland.

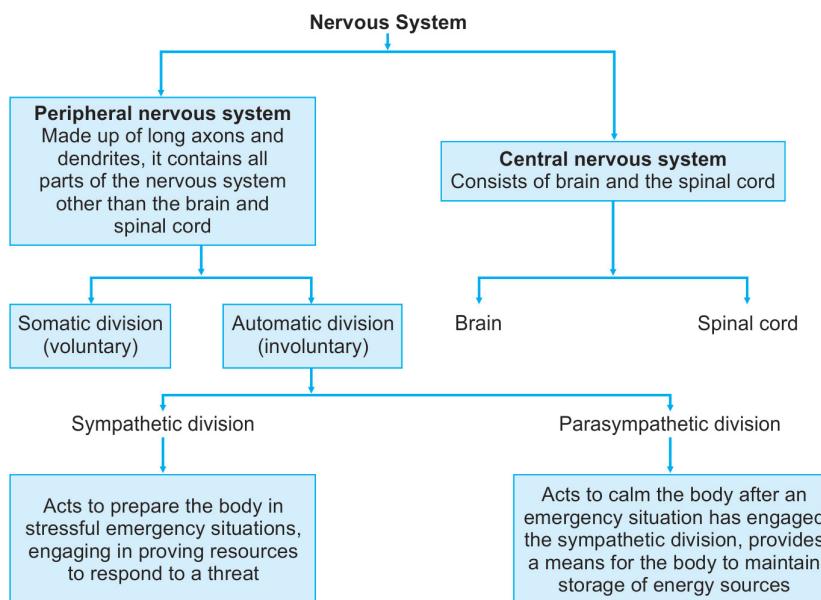


Fig. 2.4: Schematic diagram of the relationship between parts of the nervous system

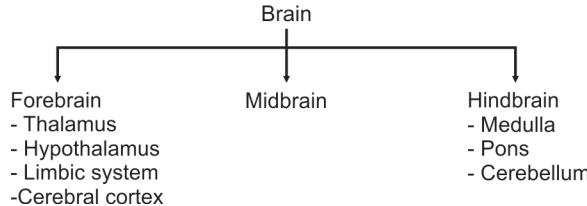


Fig. 2.5: The schematic diagram of main divisions of brain

The limbic system consists of structures in the thalamus, hypothalamus and cerebrum which form a ring around the lower part of the forebrain. Major structures within this system include the olfactory bulb, the septal nuclei, the hippocampus, the amygdala and the cingulated gyrus of the cerebral cortex. The limbic system often called the emotional brain, functions in emotional aspects of behavior related to survival, memory, smell, pleasure and pain, rage and aggression, affections, sexual desire, etc.

The cerebrum is the most complex and largest part of the brain. The cerebrum is covered by a thick layer of tightly packed neurons called the cerebral cortex. It is divided into two hemispheres; the left and right hemispheres. Different areas of the cerebral cortex like sensory projection areas, motor projection areas, association areas, etc. are responsible for different functions like storing sensory information, controlling body movements, coordinating all information that comes to the brain and regulating highly cognitive functions such as thinking, reasoning and problem solving. Each cerebral hemisphere is divided in four lobes; frontal, parietal, occipital and temporal lobes. The different parts of the cerebrum are connected with different mental functions. The visual area lying in the occipital lobe is connected with the visual organs or eye through the optic nerve. It is the seat of visual sensations. The auditory area lies in the temporal lobe and is connected with the

auditory organs or ears through the auditory nerves. It is the seat of auditory sensations and also involved in memory. The parietal lobe lies in the upper rear portion of the brain and is connected with the information about special relationship and structure. Frontal lobes contain several parts and are concerned with organizing and planning our actions, learning new tasks generating motivation and regulation of behavior (Fig. 2.6).

Midbrain

It is concerned with the relaying of messages to higher brain centers, particularly those related to hearing and sight. One of its important structures is known as reticular activating system (RAS). With the help of this structure an individual is able to decide which impulses should be registered consciously and which should be rejected.

Hindbrain

It is composed of three structures, the medulla, the pons and the cerebellum. Medulla controls breathing and many important reflexes, such as those that help us maintain our upright postures. It also regulates the highly complex processes like digestion, respiration and circulation. The pons assist in breathing, transmitting impulses from the cerebellum to the higher brain regions and in coordinating the activities of both sides of the brain. Cerebellum is responsible for body balance and the coordination of body movements like dancing, typing, playing, etc. (Fig. 2.7).

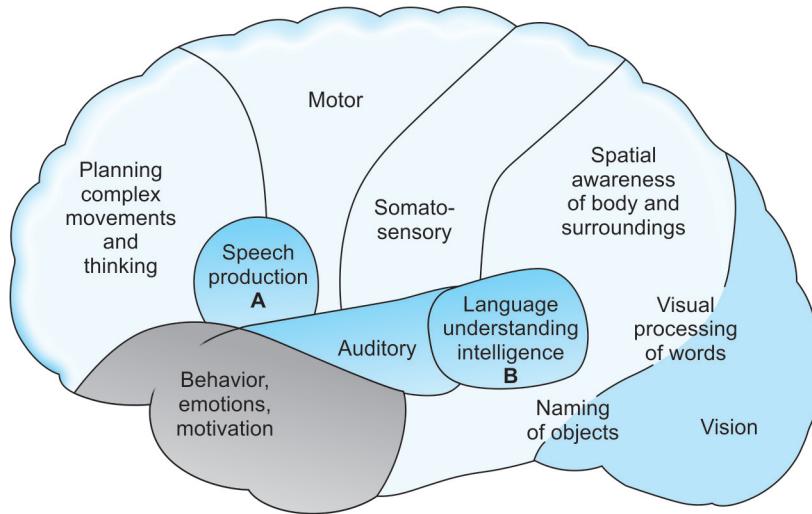


Fig. 2.6: Localization of mental functions in the brain

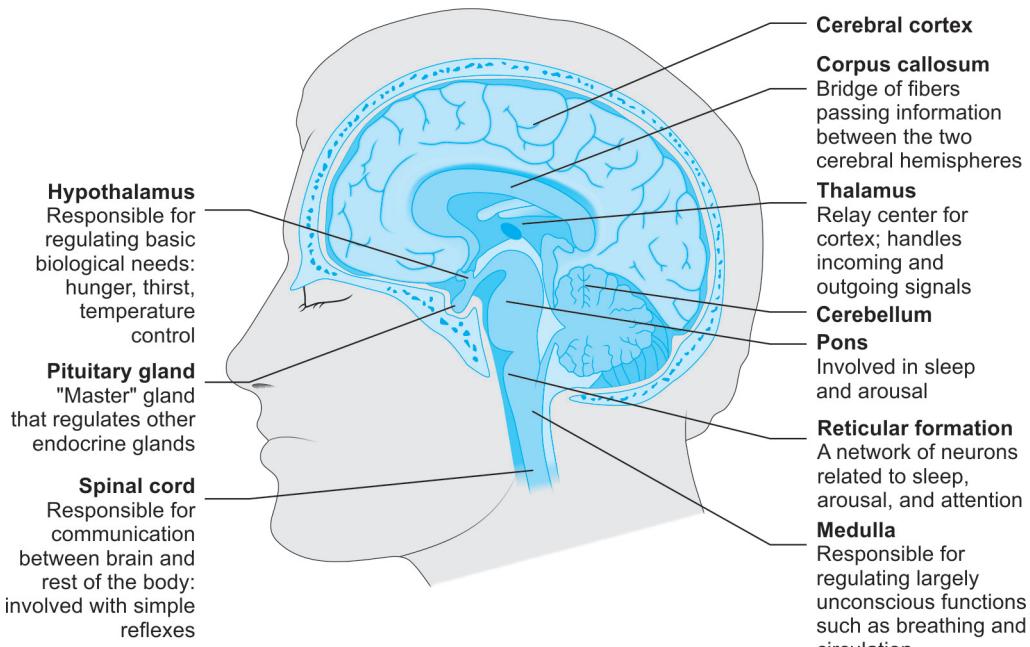


Fig. 2.7: The major structures in the brain

Spinal Cord:

It works as a channel of communication from and to the brain. It is a rope-like structure made up of long round nerve fibers. It also works as an

organ for effective reflex actions like withdrawal of the hand when something is hot. These reflex actions are almost automatic in nature.

Peripheral Nervous System

The nerve tissues lying outside the bony case of the central nervous system come in the region of the peripheral nervous system. It consists of a network of nerves which helps in passing the sense impressions to the central nervous system as well as in conveying the orders of the central nervous system to the muscles. This peripheral nervous system is subdivided into two parts, the somatic system and the autonomic system.

The somatic system is both a sensory and a motor system. The autonomic system is only a motor system consisting of two divisions, the sympathetic and para-sympathetic system. The sympathetic system is connected to the spinal cord and carries messages to the muscles and glands, particularly in stress situations to prepare for an emergency. The para-sympathetic system is connected to the brain and to the lower portion of the spinal cord. It tends to be active when we are calm and relaxed. The messages conveyed by the nerve fibers of this system direct the organs to do just the opposite of what the sympathetic system had done. It directs the body organs to return to the normal state after the emergency has passed. The sympathetic and para-sympathetic divisions of the autonomic nervous system work in close coordination for maintaining the equilibrium of the body function.

Brain and Behavior

The entire behavior is effectively managed and controlled by the co-ordination and functioning of nervous system. How we will behave in a particular situation depends upon the judgment of our brain. The sense impressions which are received through the sense organs do not bear any significance unless they are given a meaning by the nervous system.

Learning also, to a great extent, is controlled by the nervous system. The proper growth and development of nerve tissues and nervous

system as a whole helps in the task of proper intellectual development. Any defect in the spinal cord or the brain seriously affects the intellectual growth.

The emotional behavior is also influenced by the nervous system, especially at the time of anger, fear and other emotional changes. During emotional outbursts nerve tissues cause the change in the secretion of hormones by some glands and consequently influence the emotional behavior of an individual.

The process of growth and development is also directly and indirectly controlled by the functioning of the nervous system. The personality of an individual is greatly influenced through the mechanism of the nervous system.

Integrative Function of the Nervous System

The cerebral cortex has primary areas which control the incoming sensory stimuli and the outgoing motor responses. An individual is able to adjust himself effectively to the environment because the various nerve impulses are systematically integrated by the brain. There are millions of nerve fibers which connect the various neurons of the brain. The connecting nerve fibers are known as 'associate fibers'. The associate fibers are the foundations of memory, language, reasoning and other higher mental processes. There is great coordination between the various parts of the brain.

Autonomic nervous system is autonomous and works independent of voluntary control. It is made up of the nerves connecting with the glands and smooth muscles which are involved in respiration, circulation and digestion. These processes go on automatically without our knowledge. The system operates actively during emotional states. When we are well, physical and mental activities are integrated. We receive stimuli and are able to think, learn and remember. We are able to

experience the various types of feelings. In illness, the normal healthy functioning of the body and its various organs is upset. Illness affects the threshold levels of our nervous system and may cause abnormal reactions to ordinary stimuli. It may adversely affect our coordination and disturb the thinking processes. Even the process of association is adversely affected, resulting in funny and stray thoughts. Specific diseases and conditions have their own effects, some causing permanent damage to the nervous system and others causing a temporary damage only.

Neuron

A nerve cell with all its branches is called a neuron. These are the basic elements of the nervous system. A neuron has a nucleus, a cell body, and a cell membrane to enclose the whole cell. There are tiny fibers extending out from the cell body called dendrites. Their role is to receive messages through electrical impulses from the sense organs or adjacent neurons and carry them to the cell body. The messages from the cell body further travel the length of a nerve fiber known as the axon. A group of axons, bundled together like parallel wires in an electrical cable, is referred to as a nerve. The axon (but certainly not all of them) is surrounded by a fatty covering called the myelin sheath. It serves to increase the velocity with which the electrical impulses travel through the axons. Those axons that carry the most important and urgently required information have the greatest concentrations of myelin. If our hand touches a hot stove, the information regarding the burning sensation is passed through axons in the hand and arm that have a relatively thick coating of myelin, speeding the message of burning pain to the brain. In certain diseases, for example, multiple sclerosis, the myelin sheath surrounding the axon deteriorates, exposing parts of the axon that are normally covered. This short-circuits messages between the brain and the muscles

resulting in symptoms such as the inability to walk, difficulties in vision and general muscle impairment. The messages, thus transmitted are further carried to a muscle or a gland or a neighboring neuron through the terminal branches of the nerve fiber.

There are three types of neurons. The sensory neurons—they help in the process of sensation and perception. The motor neurons—they are responsible for physical movements and activation of glands. The interneurons or association neurons—they carry signals in the form of memories and thoughts and add reflex or automatic activities (Fig. 2.8).

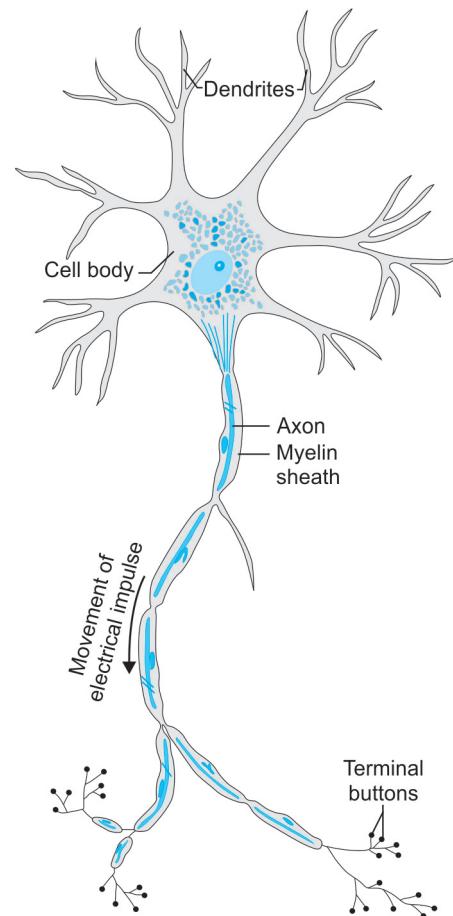


Fig. 2.8: The structure of neuron

Neural Impulse

Neurons are the receivers and transmitters of messages. These messages are always in the form of electrochemical impulses. A neuron in its resting position is supposed to maintain a sort of electrical equilibrium, i.e. state of polarization. This state of polarization may be disturbed on account of the effect of trigger like action of a stimulus applied to the membrane. It causes a sudden change in the electrical potentiality of the neuron. It gets depolarized and neural impulse is initiated. These impulses are carried along the neuron axons.

There is a fluid-filled space called the synapse between the axon of the neuron and the receiving dendrite of the next neuron. Enlargements of the axon endings of the transmitting neurons called buttons contain neuro-transmitter chemicals which are stored in small vesicles. A nerve impulse reaching these buttons causes a neurotransmitter to be released into the synapse. With the help of the release of a neurotransmitter into the synapse, one neuron is capable of sending its message on to many other neurons. It makes it possible for a single neuron to receive messages from thousands of other neurons.

Synapses

Information is transmitted through the body from one neuron to another. The junction between two neurons is called a synapse. The small space between the axon terminals of one neuron and the cell body or dendrites of another is called the synaptic cleft. Neurons conducting impulses toward the synapse are called presynaptic neurons and those conducting impulses away are called postsynaptic neurons.

A chemical, called neurotransmitter is stored in the axon terminals of the presynaptic neuron. An electrical impulse through the neuron causes the release of this neurotransmitter into the synaptic cleft. The neurotransmitter then

diffuses across the synaptic cleft and combines with receptor sites that are situated on the cell membrane of the postsynaptic neuron.

The cell body or dendrite of the postsynaptic neuron also contains a chemical inactivator that is specific to the neurotransmitter that has been released by the presynaptic neuron. When the synaptic transmission has been completed, the chemical inactivation quickly inactivates the neurotransmitter to prevent unwanted continuous impulses.

Neurotransmitters

Neurotransmitters play an essential function in the role of human emotion and behavior. These are chemicals that convey information across synaptic cleft to neighboring target cells. They are stored in small vesicles in the axon terminals of neurons. When electrical impulse reaches this point, the neurotransmitters are released from the vesicles. They cross the synaptic cleft and bind with receptor sites on the cell body of dendrites of the adjacent neuron to allow the impulse to continue its course or to prevent the impulse from continuing. After the neurotransmitter has performed its function in the synapse it either returns to the vesicles to be stored and used again or is inactivated and dissolved by enzymes. The process of being stored for reuse is called reuptake.

Major categories of neurotransmitters include cholinergics, amino acids and monoamines, neuropeptides (Tables 2.6 and 2.7).

Most important neurotransmitters that a psychiatric nurse should know

Psychotropic drugs work by affecting neurotransmitter systems. The foundation for understanding psychotropic drugs rests on knowledge of neurotransmitters.

- Acetylcholine is important in conceptualizing the pathology and treatment of Alzheimer's disease and parkinsonism
- Dopamine is important in conceptualizing the pathology and treatment of schizophrenia and parkinsonism

Table 2.6: Neurotransmitters functions and implications for mental illness

<i>Neurotransmitter</i>	<i>Function</i>	<i>Implications for mental illness</i>
I. Cholinergics		
» Acetylcholine	Sleep, arousal, pain perception, movement, memory	Decreased levels—alzheimer's disease Increased levels—depression
II. Monoamines		
» Norepinephrine	Mood, cognition, perception, locomotion, cardiovascular functioning, sleep and arousal	Decreased levels—depression Increased levels—mania, anxiety states, schizophrenia
» Dopamine	Movement and coordination, emotions, voluntary judgement, release of prolactin	Decreased levels—Parkinson's disease and depression Increased levels—mania and schizophrenia
» Serotonin	Sleep, arousal, libido, appetite, mood, aggression, pain perception, co-ordination, judgment	Decreased levels—depression Increased levels—anxiety states
» Histamine	Control of gastric secretions, smooth muscle control, cardiac stimulation, stimulation of sensory nerve endings; and alertness	Decreased levels—depression
III. Amino acids		
» Gamma-amino butyric acid (GABA)	Slowdown of body activity	Decreased levels—anxiety disorders, schizophrenia and various forms of epilepsy
» Glycine	Recurrent inhibition of motor neurons	Increased levels—glycine encephalopathy Decreased levels—are correlated with spastic motor movements
» Glutamate and aspartate	Relay of sensory information and in the regulation of various motor and spinal reflexes	Increased levels—Huntington's disease, temporal lobe epilepsy, spinal cerebellar degeneration
IV. Neuropeptide		
» Endorphins and enkephalins	Modulation of pain and reduced peristalsis	Modulation of dopamine activity by opioid peptides. May indicate some link to the symptoms of schizophrenia
» Substance P	Regulation of pain	Decreased levels—Huntington's disease and Alzheimer's disease Increased levels—Depression
» Somatostatin	Inhibits release of norepinephrine; stimulates release of serotonin, dopamine and acetylcholine	Decreased levels—Alzheimer's disease Increased levels—Huntington's disease

Table 2.7: Neurotransmitters and related mental disorders

<i>Neurotransmitter related state</i>	<i>Mental disorder</i>
Increase in dopamine level	Schizophrenia
Decrease in norepinephrine level	Depression
Decrease in serotonin level	Alzheimer's disease
Decrease in GABA level	Anxiety
Decrease in glutamate level	Psychotic thinking

- GABA is important in conceptualizing the pathology and treatment of anxiety
- Glutamate is an excitatory neurotransmitter and might be important in conceptualizing the pathology and treatment of Alzheimer's disease
- Norepinephrine is important in conceptualizing the pathology and treatment of mania and depression
- Serotonin is important in conceptualizing the pathology and treatment of mania and depression.

Biological theories say that, many of the psychiatric disorders are caused by dysregulation (imbalance) in the complex process of brain structures communicating with each other through neurotransmission.

The neuroendocrine system deals with the interaction between the nervous and endocrine systems and the hormones that react to stimulation from the nerve cells (Table 2.8).

Psychoimmunology: A relatively new field of study, examines the effect of psychosocial stressors on the body's immune system. A compromised immune system could contribute to the development of a variety of illnesses, particularly in populations already genetically at risk.

GENERAL PRINCIPLES OF MENTAL HEALTH NURSING

The following principles are general in nature and form guidelines for emotional care of

a patient. These principles are based on the concept that each individual has an intrinsic worth and dignity and has potentialities to grow. These are guidelines for nurses to observe in practice.

Patient is Accepted Exactly as He Is

Accepting means being non-judgmental. Acceptance conveys the feeling of being loved and cared. Acceptance does not mean complete permissiveness, but setting of positive behaviors to convey to him the respect as an individual human being. A nurse should be able to convey to the patient that she may not approve everything what he does, but he will not be judged or rejected because of his behavior.

Acceptance is expressed in the following ways:

Being Non-judgmental and Non-punitive

The patient's behavior is not judged as right or wrong, good or bad. Patient is not punished for his undesirable behavior. All direct (chaining, restraining, putting him in a separate room) and indirect (ignoring his presence or withdrawing attention) methods of punishment must be avoided. A nurse who shows acceptance does not reject the patient even when he behaves contrary to her expectations.

Table 2.8: Hormone functions and implications for mental illness

Hormone	Functions	<i>Implications for mental illness</i>
Antidiuretic hormone	Conservation of body water and maintenance of blood pressure	Altered pain response, modified sleep pattern
Oxytocin	Contraction of the uterus for labor; release of breast milk	May play role in stress response by stimulation of ACTH
Growth hormone	Growth in children; protein synthesis in adults	Anorexia nervosa
Thyroid stimulating hormone	Stimulation of thyroid hormone secretion, needed for metabolism of food and regulation of temperature	Increased levels—cause insomnia, anxiety, emotional lability Decreased levels—depression and fatigue
Adrenocorticotrophic hormone	Stimulation of cortisol secretion; which plays a role in response to stress	Increased levels—mood disorders, psychosis Decreased levels—depression apathy, fatigue, Alzheimer's disease
Prolactin	Stimulation of milk production	Increased levels—depression, anxiety, decreased libido, irritability Decreased levels—negative symptoms in schizophrenia
Gonadotrophic hormone	Stimulation of estrogen secretion, progesterone and testosterone	Increased levels—increased sexual behavior and aggressiveness Decreased levels—depression and anorexia nervosa
Melanocyte stimulating hormone	Stimulation of secretion of melatonin	Increased levels—depression

Being Sincerely Interested in the Patient

Being sincerely interested in another individual means considering the other individual's interest.

This can be demonstrated by:

- Studying patient's behavior pattern
- Allowing him to make his own choices and decisions as far as possible
- Being aware of his likes and dislikes
- Being honest with him
- Taking time and energy to listen to what he is saying
- Avoiding sensitive subjects and issues.

Recognizing and Reflecting on Feelings which Patient may Express

When patient talks, it is not the content that is important to note, but the feeling behind the conversation, which has to be recognized and reflected.

Talking with a Purpose

The nurse's conversation with a patient must revolve around his needs, wants and interests. Indirect approaches like reflection, open-ended questions, focusing on a point,

presenting reality are more effective when the problems are not obvious.

Avoid evaluative, hostile, probing questions and use understanding responses, which may help the patient to explore his feelings.

Listening

Listening is an active process. The nurse should take time and energy to listen to what the patient is saying. She must be a sympathetic listener and show genuine interest.

Permitting Patient to Express Strongly-held Feelings

Strong emotions bottled up are potentially explosive and dangerous. It is better to permit the patient to express his strong feelings without disapproval or punishment. Expression of negative feelings (anxiety, fear, hostility and anger) may be encouraged in a verbal or symbolic manner. The nurse must accept the expression of patient's strong negative feelings quietly and calmly.

Use Self-understanding as a Therapeutic Tool

A psychiatric nurse should have a realistic self-concept and should be able to recognize one's own feelings, attitudes and responses. Her ability to be aware and to accept her own strengths and limitations should help her to see the strengths and limitations in other people too. Self-understanding helps her to be assertive in life situations without being aggressive and feeling guilty.

Self-understanding methods are:

- Exchange personal experiences freely and honestly with colleagues
- Discuss own personal reaction with an experienced person
- Participate in group conference regarding patient care

- Keep reflecting on why you feel or act the way you do.

Consistency is used to Contribute to Patient's Security

Consistency means having certain routine pattern that does not change from one day to the other. Consistency helps in knowing what to expect. In psychiatric nursing consistency means there should be consistency in the attitude of the staff, ward routine and in defining the limitations placed on the patient. This consistency in psychiatric wards reduces fear and anxiety among patients.

Reassurance should be Given in a Subtle and Acceptable Manner

Reassurance is building patient's confidence. To give reassurance, the nurse needs to understand and analyze the situation as to how it appears to the patient. False reassurance can also reflect a lack of interest and understanding or unwillingness on the part of the nurse to empathize with the patient's life situation.

Patient's Behavior is Changed Through Emotional Experience and not by Rational Interpretation

Major focus in psychiatry is on feelings and not on the intellectual aspect. Advising or rationalizing with patients is not effective in changing behavior. Role-play and socio-drama are a few avenues of providing corrective emotional experiences to a patient and facilitating insight into his own behavior. Such experiences can truly bring about the desired behavioral changes.

Unnecessary Increase in Patient's Anxiety should be Avoided

The following approaches may increase the patient's anxiety and should, therefore, be avoided:

- Showing nurse's own anxiety
- Showing attention to the patient's deficits
- Making the patient face repeated failures
- Placing demands on patient which he obviously cannot meet
- Direct contradiction of patient's psychotic ideas
- Passing sharp comments and showing indifference.

Objective Observation of Patient to Understand his Behavior

Objectivity is an ability to evaluate exactly what the patient wants to say and not mix up one's own feelings, opinion or judgment. To be objective, the nurse should indulge in introspection and make sure that her own emotional needs do not take precedence over patient's needs.

Maintain Realistic Nurse-Patient Relationship

Realistic or professional relationship focuses upon the personal and emotional needs of the patient and not on nurse's needs. To maintain professional relationship the nurse should have a realistic self-concept and should be able to empathize and understand the feelings of the patient and the meaning of his behavior.

Avoid Physical and Verbal Force as Much as Possible

All methods of punishment must be avoided. If the nurse is an expert in predicting patient behavior, she can mostly prevent an onset of undesirable behavior.

Nursing Care is Centered on the Patient as a Person and not on the Control of Symptoms

Analysis and study of symptoms is necessary to reveal their meaning and their significance to the patient. Two patients showing the same symptoms may be expressing two different needs.

All Explanations of Procedures and other Routines are given According to the Patient's Level of Understanding

The extent of explanation that can be given to a patient depends on his span of attention, level of anxiety and level of ability to decide. But explanation should never be withheld on the basis that psychiatric patients are not having any contact with reality or have no ability to understand.

Many Procedures are Modified but Basic Principles Remain Unaltered

In psychiatric nursing field, many methods are adapted to individual needs of the patients, but the underlying nursing scientific principles remain the same. Some nursing principles to be kept in mind are: Safety, comfort, privacy, maintaining therapeutic effectiveness, economy of time, energy and material.

STANDARDS OF MENTAL HEALTH NURSING

The purpose of Standards of Psychiatric and Mental Health Nursing practice is to fulfill the profession's obligation to provide a means of improving the quality of care. The standards presented here are a revision of the standards enunciated by the Division on Psychiatric and Mental Health Nursing Practice in 1973.

Professional Practice Standards

Standard I: Theory

The nurse applies appropriate theory that is scientifically sound as a basis for decisions regarding nursing practice. Psychiatric and mental health nursing is characterized by the application of relevant theories to explain phenomena of concern to nurses and to provide a basis for intervention.

Standard II: Data Collection

The nurse continuously collects data that are comprehensive, accurate and systematic. Effective interviewing, behavioral observation, physical and mental health assessment enable the nurse to reach sound conclusions and plan appropriate interventions with the patient.

Standard III: Diagnosis

The nurse utilizes nursing diagnoses and/or standard classification of mental disorders to express conclusions supported by recorded assessment data and current scientific premises.

Nurses' logical basis for providing care rests on the recognition and identification of those actual or potential health problems that are within the scope of nursing practice.

Standard IV: Planning

The nurse develops a nursing care plan with specific goals and interventions delineating nursing actions unique to each patient's needs. The nursing care plan is used to guide therapeutic intervention and effectively achieve the desired outcomes.

Standard V: Intervention

The nurse intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain or restore physical and mental health, prevent illness and effect rehabilitation.

- *Psychotherapeutic interventions:* The nurse uses psychotherapeutic interventions to assist patients in regaining or improving their previous coping abilities and to prevent further disability.
- *Health teaching:* The nurse assists patients, families and groups to achieve satisfying and productive patterns of living through health teaching.
- *Activities of daily living:* The nurse uses the activities of daily living in a goal directed way to foster adequate self-care and physical and mental well being of patients.
- *Somatic therapies:* The nurse uses knowledge of somatic therapies and applies related clinical skills in working with patients.
- *Therapeutic environment:* The nurse provides, structures and maintains a therapeutic environment in collaboration with the patient and other health care providers.
- *Psychotherapy:* The nurse utilizes advanced clinical expertise in individual, group and family psychotherapy, child psychotherapy and other treatment modalities to function as a psychotherapist and recognizes professional accountability for nursing practice.

Standard VI: Evaluation

The nurse evaluates patient responses to nursing actions in order to revise the database, nursing diagnoses and nursing care plan.

Professional Performance Standards

Standard VII: Peer Review

The nurse participates in peer review and other means of evaluation to assure quality of nursing care provided for patients.

Standard VIII: Continuing Education

The nurse assumes responsibility for continuing education and professional development

and contributes to the professional growth of others.

Standard IX: Interdisciplinary Collaboration

The nurse collaborates with other health care providers in assessing, planning, implementing and evaluating programs and other mental health activities.

Standard X: Utilization of Community Health Systems

The nurse participates with other members of the community in assessing, planning, implementing and evaluating mental health services and community systems that include the promotion of the broad continuum of primary, secondary and tertiary prevention of mental illness.

Standard XI: Research

The nurse contributes to nursing and the mental health field through innovations in theory and practice and participation in research.

QUALITIES OF A PSYCHIATRIC NURSE

Certain attitudes are necessary for a psychiatric nurse to deal with psychiatric patients. These include:

Self-awareness

A Psychiatric nurse should have a realistic self-concept and should be able to recognize her own feelings, fantasies and fears. She should analyze her own professional strengths and limitations. Her ability to be aware and to accept her own strengths and limitations should help her see the strengths and limitations in other people.

She should have her own beliefs and values related to life and should be able to acknowledge and accept her own feelings and

their influence on her behavior. She should have the ability to recognize when she is under stress and its influence on her physical and mental performance, and also find ways to get adequate release from it. Until the nurse is able to cope with personal fears and anxieties in relation to psychiatric nursing, it is unlikely that she can have a therapeutic influence in the patient's environment.

Self-acceptance

The nurse should not only be aware, but also accept her strengths as well as her limitations. Self-understanding helps her to be assertive in life situations without being aggressive and feeling guilty.

Accepting the Patient

Accepting means, being non-judgmental. Acceptance conveys the feeling of being loved and cared. The nurse should accept the patient as he is, as a sick person, regardless of caste, color, race or behavior.

The ability to talk therapeutically with patients requires an attitude of acceptance, tolerance and genuine interest in the patient. The basis of all helping relationships is acceptance which implies that the nurse treats the patient as an important person and not as a diagnostic entity or a set of psychiatric symptoms.

Being Sincerely Interested in Patient Care

Being sincerely interested in patient care means considering the patients interest.

This can be demonstrated by:

- Studying patient's behavior pattern
- Allowing him to make his own choices and decisions as far as possible
- Being aware of his likes and dislikes
- Being honest with him
- Active listening.

Being Available

Being available means the nurse should always be approachable to the patient. She should convey to the patient that she is available not only to meet his physical care requirements, but also to assist him in dealing with his psychological needs.

Empathizing with the Patient

Empathy is an important tool in understanding others' feelings. Empathy is a process where a person gets into another person's situation and experiences what the other person feels and then is able to step back and analyze the situation. The nurse need not necessarily have to experience it, but has to be able to imagine the feelings associated with the experience.

To be able to empathize with the patient the nurse must be willing to get involved enough to feel what the other person feels and at the same time avoid over-involvement, projection of her own feelings and over-identification.

Reliability

The nurse must demonstrate honesty, truthfulness, resourcefulness and competence in her dealings with the patients and their families. She must prove herself to be trustworthy and as a person who can be relied upon in any situation.

Professionalism

Developing the professional skills of a psychiatric nurse is dependent upon learning as much as possible about the patient, his illness and the helping role of the nurse as it specifically applies to the patient.

Accountability

According to Peplau (1980), the need for personal accountability and professional integrity are greater in psychiatric practice

than in any other type of healthcare. Patients in mental health settings are usually more vulnerable and defenseless than patients in other healthcare settings, particularly because their conditions hinder their thinking processes and their relationships with others. Mental health nurses are accountable for the nature of the effort they make on behalf of patients and answerable to patients for the quality of their efforts.

The Ability to Think Critically

The ability to think critically is crucial for mental health nurses. A critical thinker analyzes information before drawing conclusions about it. It is purposeful, reasonable, reflective thinking that drives problem solving and decision making and aims to make judgments based on evidence.

PSYCHIATRIC NURSING SKILLS

Mental health nursing is the practice of promoting mental health as well as caring for people who have mental illness, potentiating their independence and restoring their dignity. In order to fulfill this arduous occupation, a mental health nurse must possess a sound knowledge base and the requisite skills for good nursing practice.

Prerequisites for a Mental Health Nurse

Personal Skills

Self-awareness: It is a key component of psychiatric nursing experience. It is an answer to the question, "Who am I"? The nurse must be able to examine personal feelings, actions and reactions as a provider of care. A firm understanding and acceptance by the nurse allows acknowledging a patient's differences and uniqueness.

Adaptability: A mental health nurse needs to be adaptable to different settings and cultures. Working within residential settings, for example, may demand attitudes and roles which are different from working in a community, as in a residential setting the nurse may have an authoritative or a supervisory role which she necessarily does not have in a community.

A mental health nurse also needs to cope with a variety of social and cultural settings. Social settings involve the class and status of the individuals while cultural settings involve race, ethnicity and gender. Therefore, she may need to be familiar with the issues that arise in cross-cultural mental health nursing.

Care Values and Attitudes

These include:

- Self-awareness and self-esteem
- Respecting the person's rights
- Listening
- Responding with care and respect
- Supporting with trust and confidence
- Reassuring with explanation and honesty
- Physically nursing the helpless with compassion
- Carrying out procedures skillfully
- Working within personal and ethical boundaries.

Counseling Skills

These include:

- Unconditional positive regard/non-judgmental approach
- Empathy
- Warmth and genuineness
- Confidentiality
- Non-verbal sensitivity, non-verbal attending, non-verbal responding
- Other interpersonal skills required are paraphrasing, reflecting, clarifying, and summarizing.

Behavioral Skills

These are based on Pavlovian principles and Skinner's principles. They include:

1. To increase adaptive behavior
 - Positive reinforcement
 - Negative reinforcement
 - Token economy
2. To decrease maladaptive behavior
 - Extinction
 - Time out
 - Restraining
 - Over correction
3. To teach new behavior
 - Modeling
 - Shaping
 - Chaining
 - Cueing.

Supervisory Skills

Supervision is an integral necessity for any worker in the caring profession, to ensure the best quality service for patients and best quality developmental opportunities for workers. A good supervisor requires interpersonal and professional skills, technical knowledge, leadership qualities and human skills.

Crisis Skills

Aggressive and assaultive behavior of violent patients, self-harm, acute alcohol intoxication are some of the cases a nurse is likely to encounter in the course of her practice. Such situations may cause the nurse to feel overwhelmed with feelings of helplessness, powerlessness and inadequacy. Exercise of self-control, calm, rational thinking and identifying ways of obtaining help from other people are some of the skills to be cultivated by the psychiatric nurse when confronted with such crises situations.

Teaching Skills

This relates to the nurse's ability to explain, enabling full understanding on the part of

the patient. It also involves enhancing the patient's environment in order to maximize his awareness of the things around him. It is necessary for the nurse to be enthusiastic about activities and choices of the patients and also give the patient every opportunity to use his power of judgment in order to make decisions.

CONCEPTUAL MODEL AND THE ROLE OF A NURSE

A model is a means of organizing a complex body of knowledge. For example, the linkage between the various concepts related to human behavior may be represented in the form of a model, which can now be referred to as a conceptual model.

Many theories attempt to explain human behavior, health and mental illness. Each theory suggests how normal development occurs based on the theorists beliefs, assumptions and view of the world. These theories suggest strategies that the clinician can use to work with patients.

No one theory explains all human behavior. No one approach will work with all patients. Becoming familiar with the variety of psycho-social approaches for working with patients will increase the nurse's effectiveness in promoting the patient's health and well-being.

The treatment of the mentally ill depends mainly on the philosophy related to mental health and mental illness. The various models or theoretical approaches influencing current practice are:

Existential Model

The existential model centers on a person's present experiences rather than his past ones. The theorists who particularly emphasized the importance of existential model are Perls, Glasser, Ellis, Rogers, Frankl (Table 2.9).

Roles of Patient and Therapist

Patient participates in meaningful experiences to learn about real self. Therapist helps patient recognize value of self, clarify realities of situation and explore feelings.

Applications to Nursing

Based on the existential model of behavior, nursing developed the concept that the nurse works to restore the patient to a state of 'full life' from a state of self-alienation.

Psychoanalytical Model

Psychoanalytical model has been derived from the work of Sigmund Freud and his followers.

Basic assumptions of psychoanalytical model are:

- All human behavior is caused, and thus, is capable of explanation. Human behavior, however, insignificant or obscure, does not occur randomly or by chance. Rather, all human behavior is determined by prior life events.
- All human behavior from birth to old age is driven by an energy called the libido. The goal of the libido is the reduction of tension through the attainment of pleasure. The libido is closely associated with physiological or instinctual drives (e.g. hunger, thirst, elimination and sex). Release of these drives results in the reduction of tension and experience of pleasure. Hence, the pleasure principle becomes operative when pleasure seeking behaviors are used.
- The personality of the human being can be understood by way of three major hypothetical structures, viz. id, ego and superego. Id represents the most primitive structure of the human personality. It houses the physiological drives. Human behavior originating from the id is

Table 2.9: Existential model

<i>Therapy and therapist</i>	<i>Basic assumption</i>	<i>Therapeutic process</i>
Rational emotive therapy: Albert Ellis	Ellis believes that people have automatic thoughts, that cause them unhappiness in certain situations	A cognitive therapy using confrontation, of 'irrational beliefs'. He used the ABC technique to help people identify these automatic thoughts. A is the activating stimulus or event, C is the excessive inappropriate response, and B is the blank in the person's mind that he or she must fill in by identifying the automatic thought
Logotherapy: Viktor E Frankl	The patient is actually confronted with and oriented towards the meaning of his life. This search for meaning is viewed as a primary life force. This includes meaning in the spiritual sense. Without a sense of meaning life becomes an existential vacuum	Future oriented therapy search for meaning is the central theme in logotherapy. Therapists who work with patients in spirituality and grief counseling often use this therapy
Gestalt therapy: Frederick S Perls	Perls believed that self-awareness leads to self-acceptance and responsibility for one's own thoughts and feelings	Therapists often use gestalt therapy to increase patient's self-awareness by having them write and read letters, keep journals and perform other activities designed to put the past to rest and focus on the present
Reality therapy: William Glasser	Glasser believed that persons who were unsuccessful often blame their problems on other people, the system or society	Glasser believed that people need to find their own identities through responsible behavior. Reality therapy challenges patients to examine the ways in which their own behavior thwarts their attempts to achieve life goals

impulsive, pleasure-oriented, and disconnected from reality.

- The ego represents that part of the human personality, which is in closest contact with reality. Unlike the id, ego is capable of postponing pleasure until an appropriate time, place or object is available. Unlike the superego, the ego is not driven to blind conformity with rules and regulations. Rather, the ego acting as mediator between the id and superego, gives rise to a much more mature and adaptive behavior.
- The superego is the personality structure containing the values, legal and moral regulations and social expectations that thwart free expression of pleasure-seeking

behaviors. The superego, thus functions to oppose the id.

- Understandably, humans occasionally experience anxiety when confronted with situations that challenge the tenuous balance between the id and the superego. At these times, the ego uses defense mechanisms that include repression, denial, regression, rationalization, reaction formation, undoing, projection, displacement, sublimation, isolation, and fixation.
- The human personality functions on three levels of awareness: conscious, preconscious and unconscious. Consciousness refers to the perception, thoughts and feelings existing in a person's immediate awareness.

Preconscious content on the other hand, is not immediately accessible to awareness. Unlike conscious and preconscious, content in the unconscious remain inaccessible for the most part.

- The unconscious affects all the three personality structures—id, ego and the superego. Although the id's content resides totally in the unconscious, the superego and the ego have aspects in all the three levels of consciousness. The ego maintains contact with reality, the id and the superego.
- Human personality development unfolds through five innate psychosexual stages—oral, anal, phallic, latent and genital. Although these stages extend throughout the lifespan, the first 6 years of life determine the individual's long-term personality characteristics.

Psychoanalytical Process

Psychoanalysis, described by Freud, makes use of free association and dream analysis to affect reconstruction of personality. Free association refers to the verbalization of thoughts as they occur, without any conscious screening. Analysis of the patient's dreams helps to gain additional insight into his problem and the resistances. Thus, dreams symbolically communicate areas of intrapsychic conflict. The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation.

The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is also able to relate to others uninhibited by neurotic conflicts.

Roles of the Patient and the Psychoanalyst

The patient is to be an active participant, freely revealing all thoughts exactly as they occur and

describing all dreams. The psychoanalyst is a shadow person; while the patient is expected to reveal all his thoughts and feelings, the analyst reveals nothing personal.

Application to Nursing

This theoretical perspective has helped mental health professionals to understand psychopathology and stress related behaviors. More importantly, this theory illustrates the importance of not taking human behavior at face value. That is, it helps the psychiatric-mental health nurse to discern and explore the meaning behind human behavior.

Behavioral Model

Prominent theorists of behavioral theory include Ivan Pavlov, John Watson, BF Skinner, etc.

Basic assumptions of behavioral model are:

- All behavior is learnt (adaptive and maladaptive)
- All behavior occurs in response to a stimulus
- Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced
- Maladaptive behavior can be unlearnt and replaced by adaptive behavior if the person receives exposure to specific stimuli and reinforcement for the desired adaptive behavior
- Deviations from behavioral norms occur when undesirable behavior has been reinforced. This behavior is modified through application of learning theory.

Therapeutic Approaches

- Systematic desensitization
- Token reinforcement
- Shaping
- Chaining
- Prompting

- Flooding
- Aversion therapy
- Assertiveness and social skills training.
(Refer Chapter 5, Page 152)

Roles of the Patient and the Behavioral Therapist

The approach is that of a learner and a teacher.

Therapist

- The therapist is an expert in behavior therapy who helps the patient unlearn his symptoms and replace them with more satisfying behavior
- The therapist uses the patient's anxiety as a motivational force towards learning
- The therapist teaches the patient about behavioral approaches and helps him develop behavioral hierarchy
- The therapist reinforces desired behaviors.

Patient

- As a learner, the patient is an active participant in the therapy process.
- Patient practices behavioral techniques
- Does homework and reinforcement exercises.

Therapy is considered to be complete when the symptoms subside.

Application to Nursing

Nurses commonly use behavioral techniques in a wide variety of mental health settings. Additionally, nurses who work with patients having physical disability, chronic pain, chemical dependency and rehabilitation centers also apply these techniques.

Interpersonal Model

Harry S Sullivan is the originator of interpersonal relations theory.

Basic assumptions of interpersonal model are:

- Human beings are essentially social beings.

- Human personality is determined in the context of social interactions with other human beings.
- Anxiety plays a central role in the formation of human personality by serving as a primary motivator of human behavior. Especially, anxiety is important in building self-esteem and enabling a person to learn from their life experiences.
- Self-esteem is an important facet of human personality that forms in reaction to the experience of anxiety. Interactions with significant others conveying disapproval or other such negative meanings contribute to self-system formation.
- Security mechanisms are used to reduce or avoid the experience of anxiety. These security mechanisms include sublimation, selective inattention and dissociation.
- Early life experiences with parents, especially the mother, influence an individual's development throughout life.
- Human development proceeds through six stages of development: infancy, childhood, juvenility, pre-adolescence, early adolescence and late adolescence. According to interpersonal theory, juvenile and preadolescent stages hold the greatest potential for correction of previous behavior and personality difficulties.

Interpersonal Therapeutic Process

The interpersonal therapist, like the psychoanalyst, explores the patient's life history. Components of self-esteem are identified, including the security operations that are used to defend the self.

The process of therapy is essentially a process of re-education as the therapist helps the patient identify interpersonal problems and then encourages him to try out more successful styles of relating.

Therapy is terminated when the patient has developed the ability to establish satisfying human relationships, thereby meeting his basic needs.

Roles of the Patient and the Interpersonal Therapist

Sullivan describes the therapist as a participant observer, who should not remain detached from the therapeutic situation. The therapist's role is to actively engage the patient to establish trust and to empathize. He will create an atmosphere of uncritical acceptance to encourage the patient to speak openly.

The patient's role is to share his concerns with the therapist and participate in the relationship to the best of his ability.

The relationship itself is meant to serve as a model of interpersonal relationships. As the patient matures in his ability to relate, he can then improve and broaden his other life experiences with people outside the therapeutic situation.

Application to Nursing

Sullivan's interpersonal theory has been the cornerstone of psychiatric-mental health nursing curricula in the undergraduate and graduate levels.

Nurse-patient one-to-one interaction or interpersonal process is based on Sullivan's interpersonal theory. The use of interpersonal process recordings in the clinical aspect of psychiatric-mental health nursing courses is also derived from Sullivan's interpersonal theory.

Medical Model

The medical model dominates much of modern psychiatric care. Other health professionals may be involved in interagency referrals, family assessment and health teaching, but physicians are viewed as the leaders of the team when this model is in effect. A positive contribution of the medical model has been the continuous exploration for causes of mental illness using the scientific process.

Basic assumptions of medical model are:

- Medical model believes that deviant behavior is a manifestation of a disorder of the central nervous system.
- It suspects that psychiatric disorders involve an abnormality in the transmission of neural impulses, difficulty at the synaptic level, and neurochemicals such as dopamine, serotonin and norepinephrine.
- It focuses on the diagnosis of a mental illness and subsequent treatment based on this diagnosis.
- Environmental and social factors are also considered in the medical model. They may be either predisposing or precipitating factors in an episode of illness.
- Another branch of research focuses on stressors and the human response to stress. These researchers suspect that humans have a physiological stress threshold that may be genetically determined.

Medical Therapeutic Process

The physician's examination of the patient includes history of the present illness, past history, social history, medical history and review of systems, physical examination and mental status examination. Additional data may be collected from significant others, and past medical records are reviewed if available. A preliminary diagnosis is then formulated pending further diagnostic studies and observation of the patient's behavior. After the diagnosis is made treatment is instituted.

Somatic treatments including pharmacotherapy, electroconvulsive therapy and occasionally psychosurgery, are important components of the treatment process.

Roles of the Patient and the Medical Therapist

- The physician, as the healer, identifies the patient's illness and institutes a treatment plan.

- Physician admits the patient in a psychiatric institution.
- The role of the patient involves admitting that he is ill.
- Patient practices prescribed therapy regimen and reports the effects of therapy to the physician.

Application to Nursing

Psychiatric mental health nurse uses this model for assessment, diagnosis, planning and implementing nursing care to the patient.

This model helps psychiatric mental health nurses to understand the physiological changes occurring due to psychiatric disorders.

Nursing Model

Nursing focuses on the individual's response to potential or actual health problems. Under the nursing model, human behavior is viewed from a holistic perspective.

Nursing View of Behavioral Deviations

- Behavior is viewed on a continuum from healthy adaptive responses to maladaptive responses that indicate illness.
- Each individual is predisposed to respond to life events in unique ways. These predispositions are biological, psychological, sociocultural, and the sum of the person's heritage and past experiences.
- Behavior is the result of combining the predisposing factors with precipitating stressors. Stressors are life events that the individual perceives as challenging, threatening or demanding. The nature of the behavioral response depends on the person's primary appraisal of the stressor and his secondary appraisal of the coping resources available to him.
- A stressor that has primary impact on physiological functioning also affects the person's psychological and socio-cultural behavior. For instance, a man who had a myocardial infarction may also become severely depressed, because he fears he will

lose his ability to work. On the other hand, the patient who enters the psychiatric inpatient unit with major depression may be suffering from malnutrition and dehydration because of his refusal to eat or drink. The holistic nature of nursing encompasses all of these facets of behavior and incorporates them into patient care planning.

Nursing Process

Nursing intervention may take place at any point on the continuum. Nursing diagnosis may focus on behavior associated with a medical diagnosis or other health behavior that the patient wishes to change.

A nurse may practice primary prevention by intervening in a potential health problem, secondary prevention by intervening in an actual acute health problem or tertiary prevention by intervening to limit the disability caused by actual chronic health problem. The nursing assessment of the patient includes presenting complaints, past history, family history, personal history, occupational history, sexual history, physical examination and mental status examination. Additional data may be collected from significant others and by reviewing the systems. A nursing diagnosis is then formulated and based on this diagnosis, planning and interventions are carried out. Finally, evaluation will be done to find out the effectiveness of nursing interventions.

Providing nursing care is a collaborative effort, with both the nurse and the patient contributing ideas and energy to the therapeutic process.

Summary of Selected Nursing Theories

Peplau's Theory

Peplau proposed an interpersonal theory applicable to nursing practice in general, and to psychiatric-mental health nursing

in particular. It focuses primarily on the nurse-patient relationship. Peplau's theory describes, explains, predicts and to some extent, permits control of the sequence of events occurring in the nurse-patient relationship.

Peplau describes the interpersonal aspects of nursing as a process consisting of four phases. These are orientation, identification, exploitation and resolution phases.

While working with the patient through these phases, the nurse assumes six roles: resource person, technical expert, teacher, leader, surrogate parent and a counselor.

Peplau's theory continues to apply to today's nursing scene, especially with respect to long-term psychiatric care in outpatient and home health settings.

Orem's Theory

Dorothea E Orem's theory is based on the premise that people need a composite of self-care actions to survive. Self-care actions consist of all behaviors performed by people to maintain life and health. The capacity of the patient and the patient's family to perform self-care is called self-care agency. Orem states that a need for nursing care exists if the patient's self-care demand exceeds the patient's self-care agency. Thus, the goal of nursing is to meet the patient's self-care demands until the patient and his family are able to do so.

Orem's theory describes three types of self-care:

1. Universal self-care behaviors, required to meet physiological and psychosocial needs.
2. Developmental self-care behaviors, required to undergo normal human development.
3. Health deviation self-care behaviors, required to meet patient's needs during health deviations.

The classification of self-care behaviors in this manner helps to ensure complete assessment of the patient's self-care agency.

Assessment focuses on the patient's self-care demand, self-care agency and self-care deficits. A plan is formulated from the information obtained in the assessment that indicates the nursing approach needed to meet the patient's needs. It can be categorized as follows:

- Wholly compensatory, in which the patient does not participate behaviorally in self-care.
- Partially compensatory, in which the patient and nurse participate behaviorally in meeting the patient's self-care needs.
- Educative-developmental, in which the patient meets self-care needs with minimal nursing assistance.

To implement the required nursing approach, the nurse uses one of the five behaviors: acting or doing for the patient, guiding, supporting, providing and teaching.

Roger's Theory

Roger's model focuses on the individual as a unified whole in constant interaction with the environment. The unitary person is viewed as an energy field that is more than as well as different from the sum of the biological, physical, social and psychological parts. In Roger's model, nursing is concerned with the unitary person as a synergistic phenomenon.

Nursing science is devoted to the study of nature and direction of unitary human development. Nursing practice helps individuals achieve maximum well-being within their potential.

Roy's Theory

According to Callista Roy's theory, the goal of nursing is to promote the patient's adaptation in health and illness. This goal is achieved through the nurse's efforts to change, manipulate or block stress-producing stimuli that may impinge on the patient. The theory assumes that this kind of nursing intervention assists the patient to cope more effectively through reducing stress.

Roy's theory assumes that all human beings have adaptive systems, and change in response to stimuli. If the change is viewed as a positive one that promotes the person's integrity, then the change can be considered adaptive. If the change does not promote the person's integrity then the change can be considered maladaptive.

The nursing process used in Roy's theory involves two levels of assessment. The first level includes observation of behavior related to the four adaptive modes: Physiologic, self-concept, role function and interdependence. These four modes represent methods used by the patient to adapt. The second level of assessment consists of identifying focal, contextual and residual stimuli. The focal stimulus represents the immediate dominant stimulus affecting the patient, such as injury, stress or illness. Contextual stimuli include the environment, the patient's family and all other background factors related to the focal stimulus. Residual stimuli consist of the patient's previous background, beliefs, attitudes and traits.

According to Roy's theory, a person's adaptation level is a function of focal, contextual and residual stimuli. When a person encounters stresses from these stimuli that surpass innate and acquired mechanisms to cope effectively, the person behaves ineffectively as demonstrated by one or more of the adaptive modes. At this point, nursing intervention is required. This emphasizes on the patient's behavior, stimuli determining the patient's behavior, and the nurse intervening in some way to interfere with the stimuli.

Holistic Model

The holistic view of the patient, with the body and soul seen as inseparable, and the patient viewed as a member of a family and community was central to Nightingale's view of nursing. The primary goal of nursing is to help patients develop strategies to achieve harmony within themselves and with others, nature and the

world. Integrative functioning of the patient's physical, emotional, intellectual, social and spiritual dimensions is emphasized. Each person is considered as a whole, with many factors contributing to health and illness.

Major Concepts

Five major concepts are generally accepted as premises of holistic health care philosophy:

- First, each person is multidimensional; one's physical, emotional, intellectual, social and spiritual dimensions are in constant interaction with each other:
 - The physical dimension involves everything associated with one's body, both internal and external
 - The emotional dimension consists of affective states and feelings, including motor behavior associated with emotion, the experienced aspect of emotion, and the physiological mechanisms that underlie emotion
 - The intellectual dimension includes receptive functions, memory and learning, cognition and expressive functions
 - The social dimension is based on social interaction and relationships, more so the global concept of culture
 - The spiritual dimension is that aspect of a person from which meaning in life is determined; through which transcendence over the ordinary is possible
- The second premise of holistic care philosophy is that the environment makes significant contributions to the nature of one's existence. Each person's environment consists of many factors that are influential in that person's quality of life. Consequently, people cannot be fully understood without consideration of environmental factors such as family relationships, culture, and physical surroundings. Individuals interact with their unique environments through all dimensions, based on subjective experience as well as external stimuli

- The third premise is that each person experiences development across his life cycle; in each stage of life, the individual experiences and confronts different issues or similar issues in different ways. One's experience of each stage of life, forms the basis for further development as one moves through the life cycle
 - Fourth, the holistic health care model maintains that stress is a primary factor in health and illness. Any event or circumstance can act as a stressor. Regardless of the source, stress has an impact on the whole person. Examples of stressors directly affecting the physical dimension include stressors associated with genetic factors, physiological processes, and body image. Emotional stress may result from any experience or situation. Examples include poor physical conditions, perceived social inequities, a significant loss, intellectual incompetence, and a sense of meaninglessness. Stressors affecting the intellectual dimension may include factors that interfere with receptive functions, memory and learning, cognitive functions, and expressive functions. Social stressors may arise from interactions and relationships with other people, as well as from more general societal and cultural factors. Stressors affecting the spiritual dimension include all such factors that interfere with one's ability to meet spiritual needs
 - Fifth, people are ultimately responsible for the directions their lives take and the lifestyles they choose. Within a holistic framework, people are viewed as active participants in and contributors to their health status; they are willing to learn from illness and strive towards healthier choices. Figure 2.9 is a diagrammatic representation of the patient viewed from a holistic perspective.
- Recognizing all human dimensions encourages a balanced and whole view of a person. Each facet of an individual is important and contributes to the quality of life experience. All dimensions are intricately interwoven, and the person as a whole functioning organism is more than the simple combination of dimensions. The holistic model emphasizes that all the dimensions of the individual should be considered when planning and instituting care.

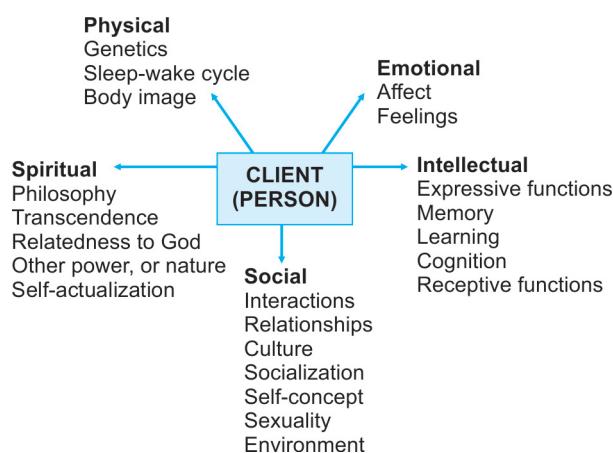


Fig. 2.9: Human dimensions in holistic model

REVIEW QUESTIONS**Long Essays**

1. Describe historical development of psychiatric nursing.
2. Explain the scope of psychiatric nursing.
3. Narrate current trends in mental health nursing.
4. Describe standards of mental health nursing.
5. Describe in detail the etiological factors for psychiatric disorders.
6. Explain the general principles of mental health nursing.

Short Essays

1. Types of hallucinations
2. Classification of mental disorders
3. Defense mechanisms
4. Neurotransmitters and their role in mental illness
5. Existential model
6. Behavioral model
7. Holistic model

Short Answers

1. Stress
2. Crisis
3. Delusions
4. Hallucinations
5. Somnolence
6. Illusions
7. Gausser syndrome
8. Neologism
9. Flight of ideas
10. Psychiatric nurse
11. Pseudohallucinations
12. Echolalia
13. Echopraxia
14. Mutism
15. Pressure of thought
16. Disorders of thought
17. Apathy
18. Thought block

MULTIPLE CHOICE QUESTIONS**1. Apathy means:**

- a. Absence of affect
- b. Absence of mind
- c. Absence of speech
- d. Absence of pain

2. Hallucinations are:

- a. Perceptual abnormalities
- b. Mood abnormalities
- c. Thought abnormalities
- d. Cognitive abnormalities

3. A patient believes that there is a computer in his stomach that controls his bowel movements. This symptom is an example of:

- a. Illusion
- b. Ideas of reference
- c. Somatic delusion
- d. Delusion of grandeur

4. Which of the options best represents neologism?

- a. Coining new words
- b. Making abrupt stops in the flow of conversation
- c. Providing excessive details
- d. Talking excessively while frequently shifting from one idea to another

5. Which of the following examples best illustrate a delusion of reference?

- a. The night shift nurse does not like me
- b. The food is being poisoned
- c. My neighbor is planning to steal all my new inventions
- d. The announcer on TV news is talking about me

6. Perseveration is:

- a. Persistent repetition of words beyond the point of relevance
- b. Persistent irrational fear
- c. Persistent thinking
- d. Persistent and irresistible thought

7. Illusion is a:

- a. False perception
- b. Misinterpretation of actual stimuli

- c. Increased intensity of stimuli
 - d. Sensory distortions
- 8. Which of the following best suits a patient exhibiting flight of ideas?**
- a. Coin new words
 - b. Make abrupt stops in the flow of conversation
 - c. Provide excessive details
 - d. Talk excessively while frequently shifting from one idea to another
- 9. A delusion in which the patient believes that others, oneself or the world do not exist:**
- a. Persecutory delusion
 - b. Nihilistic delusion
 - c. Bizarre delusion
 - d. Secondary delusion
- 10. False perception of taste is termed as:**
- a. Gustatory hallucination
 - b. Tactile hallucination
 - c. Somatic hallucination
 - d. Olfactory hallucination
- 11. The ICD classification is given by:**
- a. World Health Organization
 - b. American Psychiatric Association
 - c. American Psychological Association
 - d. Indian Psychiatric Association
- 12. The DSM classification is given by:**
- a. World Health Organization
 - b. American Psychiatric Association
 - c. American Psychological Association
 - d. Indian Psychiatric Association
- 13. According to Freud, which of the following is in closest contact with reality?**
- a. Id
 - b. Ego
 - c. Superego
 - d. Libido
- 14. Which stage of Erikson's psychosocial development theory deals with adolescence?**
- a. Trust vs Mistrust
 - b. Autonomy vs Shame
- c. Initiative vs Guilt
 - d. Identity vs Role confusion
- 15. Which of the following therapist proposed interpersonal theory applicable to nursing practice:**
- a. Sigmund Freud
 - b. Hildegard Peplau
 - c. Betty Neuman
 - d. Piaget
- 16. A student failed in her psychology exam and spent the entire evening criticizing the teacher and the institution. This behavior is an example of:**
- a. Rationalization
 - b. Compensation
 - c. Projection
 - d. Displacement
- 17. Which among the following is an example of displacement:**
- a. Discharging pent up feelings to a less threatening object
 - b. Replacing unacceptable feelings with exactly opposite feelings
 - c. Blaming someone else for one's difficulties
 - d. Forgetting of painful ideas/conflicts
- 18. Which of the following factors causes abnormal behavior in mentally ill patients?**
- a. Higher education
 - b. Unemployment
 - c. Black magic
 - d. Changes in neuro-chemicals
- 19. Which of the following statements about causation of mental illness is incorrect?**
- a. Biochemical abnormalities in the brain are responsible for mental disorders
 - b. Mental illness is caused by the inability to deal with environmental stresses
 - c. Strained interpersonal relationships at home and work place may contribute to mental illness
 - d. Heredity does not influence one's mental health

- 20. The systematic study of manifestations of behavior and experiences indicative of mental illness is termed as:**
- Epidemiology
 - Ethnology
 - Psychopathology
 - Pathophysiology
- 21. The part of the brain that regulates higher levels of cognitive function is:**
- Cerebellum
 - Cerebrum
 - Limbic system
 - None of the above
- 22. Which part of the brain is responsible for emotional aspects of behavior?**
- Cerebellum
 - Limbic system
 - Pituitary
 - Caudate nucleus
- 23. After a successful presentation at an interview, Mr Daivik felt calm and relaxed, he stopped sweating and felt hungry, which part of his nervous system was activated?**
- Sympathetic
 - Parasympathetic
 - Somatic
 - Autonomic
- 24. Part of the neuron that receives messages from other neurons and carries them to the cell body:**
- Axons
 - Dendrites
 - Terminal buttons
 - Myelin sheath
- 25. The junction between two neurons is called:**
- Neurotransmitter
- 26. _____ conveys the information across synaptic cleft to neighboring target cells:**
- Cell membrane
 - Neurotransmitters
 - Nerve impulses
 - None of the above
- 27. Which of the following is the main neurotransmitter involved in causation of schizophrenia?**
- GABA
 - Glutamate levels
 - Acetylcholine
 - Dopamine
- 28. Which of the following is an appropriate statement for the principle that 'patient is accepted exactly as he is':**
- Objective observation of patient behavior
 - Explaining all the procedures to patient according to his level of understanding
 - Maintaining realistic nurse patient relationship
 - Being non-judgmental and non-punitive
- 29. One of the general principles of psychiatric nursing is:**
- Reassuring the patient
 - Use self understanding as a therapeutic tool
 - Repeated talking
 - Judgment of patient symptoms

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. a | 2. a | 3. c | 4. a | 5. a | 6. a | 7. b | 8. d | 9. b | 10. b |
| 11. a | 12. b | 13. b | 14. d | 15. b | 16. c | 17. a | 18. d | 19. d | 20. c |
| 21. b | 22. b | 23. b | 24. b | 25. b | 26. b | 27. d | 28. d | 29. b | |

Chapter 3

Nursing Process in Psychiatric Nursing and Assessment of Mental Health Status

NURSING PROCESS

Definition

Nursing process is an orderly, systematic manner of determining the patient's problems, making plans to solve them, initiating the plan or assigning others to implement it and evaluating the extent to which the plan was effective in resolving the problems identified.

—Yura and Walsh, 1978

The historical overview of nursing process in psychiatric nursing is provided in Box 3.1.

The steps in the nursing process supply an organized approach for providing quality psychiatric mental health nursing care. The five steps involved are the same as those used in other nursing specialties, such as medical-surgical nursing, maternity nursing, pediatric nursing. Differences for this specialty, however, exist in terms of the manner and focus of the nurse's observations, the particulars of interviewing during data collection and the types of interventions used for identifying problems.

Box 3.1: Historical overview of nursing process in psychiatric nursing

Before World War II	Mental health-psychiatric nurses depended mainly on experience, rote procedure and intuitive judgment as a basis for nursing care
1940s	Mental health-psychiatric nurses had some awareness of theory but still provided primarily custodial care with no attention to systemic approach to nursing care
1950s	Psychiatric nurses were using nursing care plans as a tool for communicating their practice. Peplau developed a model of nursing care that emphasized a systemic approach to the nurse–patient relationship
1960s	Orlando was among the first to describe nursing as deliberative process with a focus on the interpersonal relationship
1970s	Psychiatric nursing texts included the nursing process as a method for organizing nursing care within a conceptual framework
1980s	Mental health-psychiatric nurses continue to refine their use of the nursing process
1990s	With increased understanding, the mental health-psychiatric nurse more deliberately applies the nursing process
Future	Psychiatric nurses will engage in more research to systematically examine the effect of the nursing process on the nurse–patient relationship

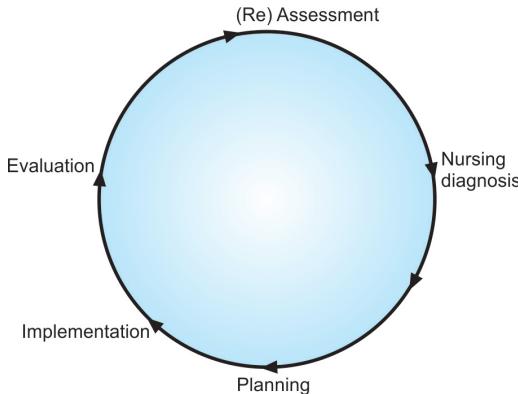


Fig. 3.1: Steps in nursing process

The five steps in nursing process are as follows:

1. Assessment or gathering data.
2. Diagnosis or identifying a problem.
3. Planning or creating a plan to achieve desired outcomes.
4. Implementation or enacting the plan.
5. Evaluation or determining the effectiveness of the plan (Fig. 3.1).

Nursing Assessment

Assessment involves the collection, organization and analysis of information about the patient's health. In psychiatric mental health nursing, this process is often referred to as a psychosocial assessment. The nurse obtains assessment data from several sources (Box 3.2).

Box 3.2: Components of psychosocial assessment

- » Interview with the patient and his family
- » History and physical examination
- » Mental status examination
- » Records from other healthcare facilities or prior treatment
- » Laboratory and psychological tests
- » Assessments by other professional and para-professionals

Box 3.3: Effective interview skills

- » Conduct the interview in a quiet place, ensure privacy
- » Be relaxed and maintain an unhurried posture
- » Maintain eye contact with the patient
- » Be interested and attentive to what he says
- » Pick up verbal and nonverbal cues of distress
- » Allow the patient to talk freely without any interruption
- » When the patient deviates from the theme or loses his track, guide him to the main theme politely
- » Use open-ended questions
- » Use active listening
- » Do not offer premature conclusions and assurance on the outcome of the treatment

Clinical Interview

The interview allows the nurse to hear the patient's perspective on the problem (Box 3.3).

History Taking

History taking proceeds through different headings as follows:

- Identification and demographical details
- Presenting complaints and duration
- History of present illness
- Past psychiatric history
- Family history
- Personal history
- Premorbid personality.

Identification and demographical details

This includes the patient's name, age, sex, religion, address, socioeconomic status, hospital number, marital status, occupation, details of informant, and information relevant or not, adequate or not.

Presenting complaints/chief complaints

Here symptoms are listed in a chronological order with their duration. Sometimes the

patient may deny the existence of any symptoms and say that he was forcibly brought to the hospital by his relatives. In such cases, information is collected from his relatives. It is preferable to use the patient's own words verbatim, without translating or interpreting their meaning. For example, sleeplessness—3 weeks, loss of appetite and hearing voices—2 weeks.

The mode of onset of the illness may be acute or insidious. The progress may be steady and progressive or diminishing and reappearing periodically or staying the same way throughout. These should also be enquired into. Sometimes the patient will be able to point out some antecedent stressful event alluded as precipitants. The temporal relation of the event with the illness, severity of the stress, the patient's preoccupation with the events and the value attached to the event by him, may all give a clue to the presence and nature of the precipitant.

History of present illness

Under this are recorded the evolution of the patient's symptoms from the time they were first noted till the time of consultation. Details of each symptom should be collected. The patient's history may have to be supplemented with data available from other sources.

It is ideal to use the patient's own words. Look for and also ask for any precipitating factors. An attempt should also be made to identify any possible secondary gain to the patient because of his symptoms.

Past psychiatric history

Enquire whether the patient had any psychiatric illness in the past. If so its nature, duration, treatment and outcome should be noted down. If treatment was discontinued in the middle enquire the reason for this as well as the reason for switching over to other models of therapy.

Family history

Enquire about the type and size of family and the general family environment. The presence

of psychiatric illness on the paternal or maternal side should be routinely asked. It would be useful to construct a family tree depicting the living members, their age, deceased members and their age at death. Mark whether any of them has or had a similar illness and if known the type of treatment they received and the outcome. Note specifically any history of suicide, mental retardation, epilepsy or any genetically transmittable disorders (Fig. 3.2).

Personal history

The personal history includes the developmental, educational, occupational as well as the sexual history of the patient. Developmental history includes details of pregnancy and delivery, developmental milestones, health during childhood and adolescence, neurotic symptoms and occurrence of any significant event (for example, separation from parents, bereavements, etc. are recorded).

The educational history relates to details regarding the level of performance in school, relationship with peers and teachers, academic achievements and extracurricular activities.

In occupational history, enquiry should be made about the types of work, job satisfaction, whether jobs were changed frequently and if so, the reasons for this, work skills and relationship with colleagues.

Sexual history includes details about sexual development, practices and attitudes towards sex. In marital history, enquire about married life and details about spouse and children.

Premorbid personality

Personality of a patient consists of those habitual attitudes and patterns of behavior which characterize an individual. Personality sometimes changes after the onset of an illness. The nurse has to get a description of the personality before the onset of the illness and aim to build up a picture of the individual, not a type. Enquiry with respect to the following areas has to be made:

- Attitude to others in social, family and sexual relationship: Ability to trust others,

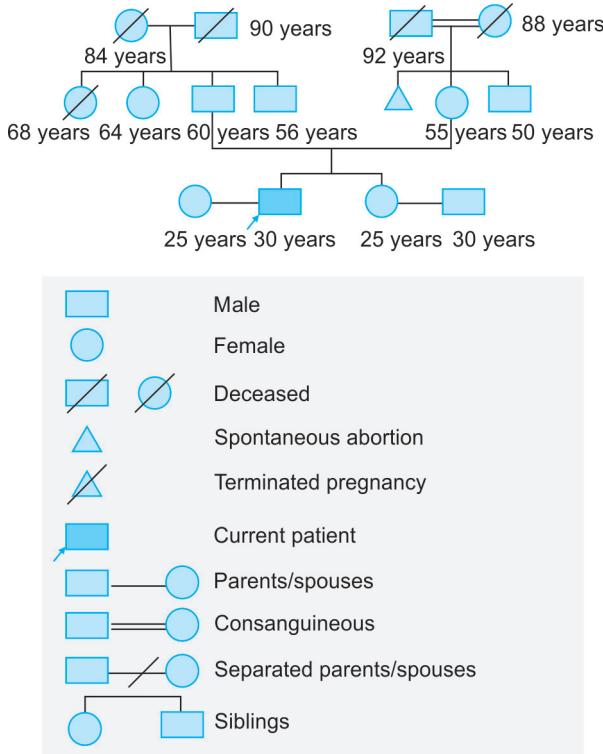


Fig. 3.2: Family genogram

make and sustain relationship, anxious or secure, leader or follower, participation, responsibility, capacity to make decision, dominant or submissive, friendly or emotionally cold, etc. Difficulty in role taking—gender, sexual and familial

- Attitude to self: Egocentric, selfish, indulgent, dramatizing, critical, depreciatory, over concerned, self-conscious, satisfaction or dissatisfaction with work. Attitude towards health and bodily functions. Attitude to past achievements and failure, and to the future
- Moral and religious attitudes and standards: Evidence of rigidity or compliance, permissiveness or over conscientiousness, conformity, or rebellion. Enquire specifically about religious beliefs. Excessive religiosity
- Mood: Enquire about stability of mood, mood swings, whether anxious, irritable, worrying or tense. Whether lively or gloomy. Ability to express and control feelings of anger, anxiety, or depression
- Leisure activities and hobbies: Interest in reading, playing, music, movies, etc. Enquire about creative ability. Whether leisure time is spent alone or with friends. Is the circle of friends large or small?
- Fantasy life: Enquire about content of day dreams and dreams, amount of time spent in day dreaming
- Reaction pattern to stress: Ability to tolerate frustrations, losses, disappointments, and circumstances arousing anger, anxiety or depression. Evidence for the excessive use of particular defense mechanisms, such as denial, rationalization, projection, etc.

(See Appendix 1 for History Taking Format in Psychiatric Nursing)

Mental Status Examination

The mental status examination (MSE) is used to determine whether a patient is experiencing abnormalities in thinking and reasoning ability, feelings or behavior. The MSE includes observations and questions in the following categories:

- General appearance and behavior
- Speech
- Thought
- Mood and affect
- Perception
- Cognitive functions.

General appearance and behavior

Describe patient's appearance and behavior. Is he dressed properly? Assess the patient's sensorium. Is he alert? Drowsy? Stuporous? Comatose? Is he cooperative for the examination? Does he make eye contact with the examiner? What is his level of activity? Is he excited? Retarded? Hyperactive? Restless? Does he have any mannerisms? Gestures? Tics? Involuntary movements?

Speech

The manner of speaking and its defects are recorded under speech, whereas the content and form of speech are recorded under thought disorders. Does he speak spontaneously or only responding to questions posed to him? Assess the rate, quantity and flow of speech. It is worthwhile to record a sample of speech for later analysis.

Thought

Inference about the thought process and its disorders are made from the speech sample or the writing sample of the patient. Disorders of form, progression, content and possession may be present. Does the patient have delusions, obsessive ruminations and thought alienation? How does the delusion affect his behavior?

Mood and affect

The patient should be asked about his affective state. Compare the subjective report with what is objectively observed. Is his mood appropriate or not? Congruent or incongruent? Labile? Is the emotional expression blunt? Is the affective expression adequate and appropriate?

Perception

Has the patient any perceptual abnormalities like illusions and hallucinations? If hallucinating, what is the type of hallucination and what is his reaction?

Cognitive function

Is the patient attentive? Can his attention be easily aroused and sustained? How is his concentration? To assess cognitive function some simple tests can be administered. The patient is asked to name the days of the week or names of the months forwards and backwards. He may be asked to serially subtract 7 or 3 from 100 and tell the numbers.

Is the patient oriented to time, place and other persons? Orientation to time involves ability to tell correctly the time of the day, date, week, month, year and other related data. Orientation to a place includes correct information of his whereabouts, how he came to be there and other details. Correct identification of people around him ensures orientation to other persons.

Patient's intelligence can be inferred from his conversation and behavior, educational level, vocabulary, ability for abstract thinking and reasoning, general information, etc. Specific tests are used when a more accurate measurement of intelligence is needed. The patient's awareness of his disabilities and readiness for treatment are reflected in insight. Judgment may be inferred from his plans for the future (See Appendix 2 for MSE Format).

Physical Examination

A thorough physical examination should be carried out in all cases. The physical examina-

tion should include body system review, neurological status and laboratory tests.

Particular attention is paid to recent head trauma, episodes of hypertension, changes in personality, speech, or ability to handle activities of daily living. Also note for any movement disorders. Available laboratory data are reviewed for any abnormalities and documented. Particular attention is paid to any abnormalities of hepatic or renal function because these systems metabolize or excrete many psychiatric medications. In addition, abnormal white blood cell and electrolyte levels should be noted (See Appendix 4 for Physical Examination Format).

Psychological Tests

Psychological tests are another source of data for the nurse to use in planning care for the patient. Commonly used psychological tests are instruments for assessing symptoms (See Page 101 for details).

Nursing Diagnosis

Nursing diagnosis is defined as clinical judgments about individual, family or community responses to actual and potential health problems. Nursing diagnoses are used to describe an individual patient's condition, to prescribe nursing interventions, and to delineate the parameters for developing outcome criteria.

An nursing diagnosis statement consists of the problem of patient response and one or more

Box 3.4: Effective planning involves

- » Specific patient needs
- » Consideration of the patient's strengths and weaknesses
- » Encouragement of the patient to help set achievable goals and participate in his own care
- » Feasible interventions

related factors that influence or contributes to the patient's problem or response; signs and symptoms or deficiency characteristics or subjective and objective assessment data that support the nursing diagnosis.

The basic level psychiatric nurse identifies nursing problems by using the nomenclature specified by the North American Nursing Diagnoses Association (NANDA).

A nursing diagnosis describes an existing or high-risk problem and requires a three-part statement.

1. The health problem (Problem, 'P')
2. The etiological or contributing factors (Etiology, 'E')
3. The defining characteristics (Signs and symptoms, 'S')

For example:

- High-risk for self-directed violence related to depressed mood, feeling of worthlessness, anger turned inward on the self
- Powerlessness related to dysfunctional grieving process, lifestyle of helplessness, evidenced by feelings of lack of control over life situations, over dependence on others to fulfill needs.

Planning

Planning involves setting and prioritizing goals, formulating nursing interventions and developing a care plan in conjunction with the patient based on the nursing diagnoses chosen (Box 3.4).

Nursing interventions with rationales are selected in the planning phase based on the patient's identified risk-factors and defining characteristics. The process of planning includes:

- Collaboration by the nurse with patients, significant others, and treatment team members
- Identification of priorities of care
- Critical decisions regarding the use of psychotherapeutic principles and practices

Box 3.5: Criteria for effective outcome identification

- » Relate directly to the nursing diagnosis
- » Be measurable, time limited, and realistic
- » Be stated as a desired patient outcome of nursing care
- » Reflect the desires of the patient and his family
- » Be stated in a way that the patient and his family can understand

Diagnosis

Impaired social interaction (isolates self from others)

Outcome

Patient will attend group sessions everyday

Intervention

Using a contract format explain the role and responsibility of patients

Correct and Incorrect Outcome Statements*Nursing diagnosis*

Anxiety

Correct outcome

Verbalizes feeling, calm, relaxed, with absence of muscle tension and diaphoresis; practices deep breathing

Incorrect outcome

Exhibits decreased anxiety, engages in stress reduction

Ineffective coping

Makes own decisions to attend groups; seeks staff for interaction

Demonstrates effective coping abilities

(identify the most appropriate nursing intervention)

- Coordination and delegation of responsibilities.

In this, the nurse will choose nursing interventions appropriate to an individual's identified problem with specific expected outcomes.

Once the nursing diagnoses are identified, the next step is the prioritization of the problems in order of importance. Highest priority is given to those problems that are life threatening. Next in the priority are those problems that are likely to cause destructive changes. Lowest in priority are those issues that are related to normative or developmental experiences. Psychiatric nurses often use Maslow's hierarchy of needs to prioritize nursing diagnosis.

Outcome Identification

Outcomes can be defined as a patient's response to the care received. Outcomes are the end

result of the process. Measuring outcomes not only demonstrates clinical effectiveness, but also helps to promote rational clinical decision-making on the part of the nurse. Each outcome must follow certain criteria (Box 3.5).

Implementation

In the implementation phase nurse sets interventions prescribed in the planning phase.

Nursing interventions (also known as nursing orders or nursing prescriptions) are the most powerful pieces of the nursing process. Interventions are selected to achieve patient outcome and to prevent or reduce problems. Implementation serves as a blueprint of plan.

Nursing interventions are classified as independent, interdependent and dependent.

Nursing Intervention in Psychiatric Nursing**Interventions for biological dimension:**

- Self-care activities
- Activity and exercise

- Nutritional interventions
- Hydration interventions
- Thermoregulation intervention
- Pain management
- Medication management.

Interventions for psychological dimension:

- Counseling interventions
- Conflict resolutions
- Bibliotherapy
- Reminiscence therapy
- Relaxation interventions
- Behavior therapy
- Cognitive therapy
- Psychoeducation
- Spiritual interventions

Interventions for social dimensions:

- Group interventions
- Family intervention
- Milieu therapy

Evaluation

Evaluation is the process of determining the value of an intervention. Nurses determine the effectiveness of interventions with particular patients. Nurses evaluate selected interventions by judging the patient's progress towards the outcome set down in the nursing care plan.

METHODS OF ASSESSMENT IN PSYCHIATRY

- History taking (See Page 88)
- Mental status examination (See Page 91)
- Mini-mental status examination
- Neurological examination
- Investigations
- Psychological tests.

Mini-Mental Status Examination

The mini-mental status examination is a cognitive test used to screen for the presence of cognitive impairment.

Uses of MSE

- It provides measures of orientation, registration and short-term memory, attention, voluntary movement and language functioning
- The shortened version of the mini-mental status examination is an accurate predictor of dementia.

Scoring

It is a reliable test, with scores of 25–30 considered normal, 18–24 indicative of mild-to-moderate, scores of 17 or less correlate with substantial impairment in activities of daily living. Social background, educational level and verbal ability can influence results and should be taken into account in their interpretation.

Components of MMSE: Orientation, registration, attention, calculation, recall and language (See Appendix 6 for MMSE format).

Neurological Examination

The purpose of neurological examination is to determine the presence or absence of disease in the nervous system. Nurses are involved in examining the neurological and physical status of the patient as a part of the total physical assessment.

Aspects of neurological examination

- Levels of consciousness
- Mental status examination
- Special cerebral functions
- Cranial nerve function
- Motor function
- Sensory function
- Cerebellar function
- Reflexes

Levels of consciousness

Assessment of levels of consciousness includes following categories:

- **Alertness:** Patient is awake, responds immediately and appropriately to all verbal stimuli.

- Lethargic:* Patient is drowsy and inattentive but arouses easily, frequently off to sleep.
- Stuporous:* He arouses with great difficulty and co-operates minimally when stimulated.
- Semi-comatose:* The patient has lost his ability to respond to verbal stimuli. There is some response to painful stimuli. Little motor function is seen.
- Comatose:* When the patient is stimulated there is no response to verbal or painful stimuli, no motor activity is seen. The Glasgow coma scale is widely used to measure the patient's level of consciousness.

A standardized method of measuring the patient's level of consciousness eliminates subjectivity and ambiguity. The Glasgow coma scale is widely used. The Glasgow coma scale is based on the assessment of eye opening, verbal response and motor response (Table 3.1).

- High score of 15 would reflect a fully alert, well-oriented person
- A score of 3 (the lowest possible score) is indicative of deep coma
- A score of 7 or less can be considered to be a generally accepted level for coma and indicates the need for a standard of nursing care conducive to the requirement of the comatose patient.

Mental status examination

The components of mental status examination include the assessment for following categories: General appearance, speech, thought process, mood, cognitive functions, attention, concentration, orientation, memory, general knowledge, abstract reasoning, judgment and insight.

Special cerebral functions

Assess for agnosia, apraxia and aphasia.

Agnosia— inability to recognize common objects through the senses.

Apraxia—patient cannot carry out skilled act in the absence of paralysis.

Aphasia— inability to communicate.

Cranial nerve examination

Cranial nerve (CN) examination provides information about the brainstem and related pathways.

- Olfactory nerve (CN I):** The function of CN I is purely sensory. Ask the patient to smell and then identify an aromatic, non-irritating odor (coffee, isopropyl alcohol, toothpaste) with each nostril separately and with the eyes closed. Test with several different odors. If the patient can perceive any one smell, consider the nerve as functioning. Other possible causes of

Table 3.1: Glasgow coma scale

Best eye opening response (Record 'C' if eyes closed by swelling)	Spontaneously To speech To pain No response	4 3 2 1
Best motor response To painful stimulus (Record best upper limb response)	Obeys verbal command Localizes pain Flexion—withdrawal Flexion—abnormal Extension—abnormal No response	6 5 4 3 2 1
Best verbal response (Record 'E' if endotracheal tube in place. 'T' if tracheostomy tube in place)	Oriented to time, place, person Conversation confused Speech inappropriate Sounds incomprehensible No response	5 4 3 2 1
Total score 15		

- anosmia are cribriform plate fracture, an olfactory bulb or a tract tumor, and previous sinus disorders or surgery
- Optic nerve (CN II): CN II has a purely sensory function. Assessment of the optic nerve involves the following steps:
 - Inspect the eye for foreign bodies, cataracts, inflammation, or other obvious abnormalities.
 - Test visual acuity: Have the patient read a newspaper, a sign (from a distance), or a Snellen's chart.
 - Test visual fields to determine whether vision is absent in one or more directions or in a portion of the visual field, such as half of the visual field, the middle portion, or both sides. Such losses may indicate various problems and may correlate with the area of the brain involved.
 - Examine the eye fundus with an ophthalmoscope. Gross inspection of the eyes and examination of the fundus can provide information about neurologic disease. Possible causes of abnormal findings include trauma to orbit or eyeball; fracture of optic foramen; diabetic retinopathy; laceration or blood clot in the brain's temporal, parietal, or occipital lobes; and increased ICP.
 - Oculomotor (CN III), trochlear (CN IV), and abducens (CN VI) nerves: CN III, CN IV, and CN VI have only motor components. CN III controls pupil constriction and elevation of the upper lid. Pupils should be equal in size and round.

Approach the pupil from the temporal side while the patient looks straight ahead. Test each pupil for both direct and consensual responses (papillary constriction) to a light. Test accommodation (eyes able to focus on both near and far objects) by having the patient look across the room (away from the light source) and then at your fingers held about 6 inches from the patient's nose.

CN III, CN IV, and CN VI co-ordinate to control eye movements in all six cardinal

directions of gaze. Test the function of these nerves by having the patient hold the head still and follow your finger or another object as it is moved in all directions of gaze. Also observe for nystagmus (involuntary eye movements), seen as fine, rhythmic eye movements that can be vertical, horizontal, or rotational. Possible causes of abnormal findings include: (1) Pressure on CN II, CN IV, or CN VI at the brain stem due to fracture of the orbit; (2) increased ICP; and (3) tumor at or trauma to the base of the brain

- Trigeminal nerve (CN V): CN V has a motor division and a sensory division. The motor division innervates the muscles of mastication. Test CN V function by asking the patient to clamp the jaws shut, open the mouth against resistance, open the mouth widely, move the jaw from side to side, and make chewing movements. A normal CN V allows all these activities. Document any asymmetry in the temporal muscles. The sensory division mediates all sensations for the entire face, scalp, cornea, and nasal and oral cavities. With the patient's eyes closed, test sensations such as pain (sharp point), touch (wisp of cotton), and temperature (hot and cold metal objects) on both sides of the face from the top of the head (vertex) to the chin.
- Test the corneal reflexes by gently touching the cornea with a sterile wisp of cotton or gently stroking the eyelash (omit this test during the screening examination). The normal response is brisk eyelid blinking. Possible causes of abnormal findings include a tumor at or trauma to the base of the brain, a fracture of the orbit, and trigeminal neuralgia
- Facial nerve (CN VII): CN VII has both motor division and a sensory division. The motor division innervates muscles controlling facial expression. Observe the face for symmetry and the ability to use facial muscles. Ask the patient to smile, frown, raise the forehead and eyebrows,

tightly close the eyes and resist attempts to open them, whistle, show the teeth, and puff out the cheeks. Test the anterior part of the tongue for taste by asking the patient to close the eyes and protrude (stick out) the tongue. Then place a taste substance on one side of the anterior tongue. Have the patient keep the tongue protruded while identifying the taste. Ask the patient to rinse the mouth or drink a small amount of water before testing the other side. Test taste on each side with sweet, salty, acidic or sour (vinegar or lemon), and bitter (coffee) substances.

Possible causes of abnormal findings are Bell's palsy, temporal bone fracture, and peripheral laceration or contusion of the parotid region

- Vestibulocochlear or acoustic nerve (CN VIII): CN VIII is a sensory nerve with two divisions: Cochlear and vestibular. The cochlear nerve permits hearing. Test auditory acuity by having the patient listen to and report on a whispered voice, rustling fingers, or a tuning fork at various distances from the ear. Test bone and air conduction with a tuning fork. The vestibular nerve helps maintain equilibrium by coordinating the muscles of the eye, neck, trunk, and extremities. Equilibrium tests include Romberg's and caloric tests (oculovestibular reflex) and electronystagmography. Possible causes of abnormal findings include Meniere's syndrome and acoustic neuroma
- Glossopharyngeal (CN IX) and vagus (CN X) nerves: CN IX and CN X have both motor and sensory components. Because of overlapping innervations of the pharynx, assess these nerves together. Ask the patient to open the mouth widely and say "Ah". Place a tongue depressor on the first third of the tongue to flatten it and enhance visualization. Observe the position and movement of the uvula and palate. The palate should rise symmetrically with the uvula at the midline. Test the gag reflex by
- gently touching each side of the pharynx with a tongue depressor, which normally elicits a brisk response. Use a small amount of water to assess the ability to swallow. Test the posterior third of the tongue for taste, as with CN VII (perform when testing CN VII). Dysfunction of CN IX includes loss of taste and sensation.
- To test the function of CN X, ask the patient to cough and to speak. Damage to CN X causes an ineffective cough and a weak, hoarse voice. Possible causes of abnormal findings include brain stem trauma or tumors, neck trauma, and stroke
- Spinal accessory nerve (CN XI): CN XI has only a motor component. It innervates the sternocleidomastoid muscle and the upper portion of the trapezius muscle. Ask the patient to (1) elevate the shoulders (with and without resistance), (2) turn (not tilt) the head to one side and then the other, (3) resist attempts to pull the chin back toward the midline, and (4) push the head forward against resistance. Disorders may produce drooping of a shoulder, muscle atrophy, weak shoulder shrug, or weak turn of the head. Possible causes of abnormal findings include neck trauma, radical neck surgery, and torticollis
- Hypoglossal nerve (CN XII): CN XII has only a motor component. This nerve innervates the tongue. Ask the patient to open the mouth widely, stick out the tongue, and rapidly move the tongue from side-to-side and in and out. Document any deviation from midline. Assess strength by having the patient push the tongue against the inside of the cheek while applying external pressure. Possible causes of abnormal findings include neck trauma associated with major blood vessel damage.

Motor function

Assessment of motor function involves assessing for muscle size, muscle strength, muscle tone, muscle co-ordination, gait and movement.

Muscle size: Inspect all major muscle groups bilaterally for symmetry, hypertrophy and atrophy.

Muscle strength: Assess the power in major muscle groups against resistance. Assess and rate muscle strength on a 5-point scale in all four extremities, comparing one side with the other, as follows:

- 5/5—Normal full strength. Muscle moves actively through the full range of motion against the effects of gravity and applied resistance.
- 4/5—Muscle moves actively through the full range of motion against the effect of gravity with weakness to applied resistance.
- 3/5—Muscle moves actively against the effect of gravity alone.
- 2/5—Muscle moves across a surface but cannot overcome gravity.
- 1/5—Muscle contraction is palpable and visible; trace or flicker movement occurs.
- 0/5—Muscle contraction or movement is undetectable.

Muscle tone: Assess muscle tone while moving each extremity through its range of passive motion. When tone is decreased (hypotonicity), the muscles are soft, flabby, or flaccid; when tone is increased (hypertonicity), the muscles are resistant to movement, rigid, or spastic. Note the presence of abnormal flexion or extension posture.

Muscle coordination: Disorders related to coordination indicate cerebellar or posterior column lesions.

Gait and station: Assess gait and station by having the patient stand still, walk and walk in tandem (one foot in front of the other in a straight line). Walking involves the functions of motor power, sensation and coordination. The ability to stand quietly with the feet together requires coordination and intact proprioception (sense of body position). If the patient has difficulty standing, assess further

to determine whether the patient is weak or unsteady. If the patient is weak, protect him from falling.

Movement: Examine the muscles for fine and gross abnormal movements. Move all the joints through a full range of passive motion. Abnormal findings include pain, joint contractures, and muscle resistance.

Sensory function

Sensory assessment involves testing for touch, pain, vibration, position (proprioception), and discrimination. A complete sensory examination is possible only on a conscious and cooperative patient. Always test sensation with the patient's eyes closed. Help the patient relax and keep warm. Conduct sensory assessment systematically. Test a particular area of the body, and then test the corresponding area on the other side.

Abnormalities of sensation

- **Dysesthesias:** Well-localized, irritating sensations, such as warmth, cold, itching, tickling, crawling, prickling, and tingling
- **Paresthesias:** Distortions of sensory stimuli (light touch may be experienced as a burning or painful sensation)
- **Anesthesia:** Absence of the sense of touch
- **Hypoesthesia:** Reduced sense of touch
- **Hyperesthesia:** Pathologic (abnormal) overperception of touch
- **Analgesia:** Absence of the sense of pain
- **Hypalgesia:** Reduced sense of pain
- **Hyperalgesia:** Increased sense of pain.

Assessment of cerebellar function

For evaluation of balance and coordination the tests used are as follows:

- **Finger-to-finger test:** It is performed by instructing the patient to place his index finger on the nurse's index finger. He is asked to repeat this for several times in succession on both sides.
- **Finger-to-nose test:** Tell the patient to extend his index finger and then touch the tip of his nose several times in rapid

succession. This test is done with patient's eyes both open and closed.

- **Romberg test:** Here the nurse instructs the patient to stand with his feet together, with arms positioned at his sides. He is told to close his eyes. This position is maintained for 10 seconds. This test is considered positive only if there is actual loss of balance.
- **Tandem walking test:** This is tested by having the patient assume a normal standing position. He is then instructed to walk over heel on a straight line. Any unsteadiness, lurching or broadening of the gait base is noted.

Throughout the cerebellar evaluation, the accuracy of the action is assessed and staggering gait, lack of co-ordination, tremors are noted as abnormal findings. Abnormalities are usually found in cerebellar diseases, such as tumor, multiple sclerosis, motor neuron diseases, etc.

Reflex activity

Reflex testing evaluates the integrity of specific sensory and motor pathways. Reflex activity assessment, always a part of neurologic assessment, provides information about the nature, location, and progression of neurologic disorders.

Normal reflexes: Two types of reflexes are normally present:

- **Superficial (cutaneous) reflexes:** Superficial (cutaneous) reflexes are elicited by stimulation of the skin or mucous membranes. The stimulus is produced by stroking a sensory zone with an object that will not cause damage. Superficial reflexes [abdominal, plantar, corneal, pharyngeal (gag), cremasteric, and anal] are absent in pyramidal tract disorders. For example, they are absent on the affected side after a stroke.
 - **Abdominal reflex:** Lightly stroking the skin on an abdominal quadrant normally contracts the abdominal muscle, moving the umbilicus towards the stimulated side.

– **Plantar reflex:** Scratching the foot's outer aspect of the plantar surface (outer sole) from the heel toward the toes normally contracts or flexes the toes in patients older than 2 years of age.

– **Corneal reflex:** Gently touching the cornea with a wisp of cotton causes reflex blinking. For example, to test the left eye, have the patient look up and to the right, and bring the cotton wisp in from the side so that the patient cannot see your hand; then very gently touch the outer edge of the cornea. In an unconscious patient, you can test the corneal reflex by holding the eyelids open and placing a drop of sterile saline on the cornea. This technique prevents inadvertent corneal abrasions.

– **Pharyngeal (gag) reflex:** Gentle stimulation with a tongue blade at the back of the throat and pharynx normally produces gagging. The corneal and pharyngeal reflexes are usually assessed with the cranial nerves, discussed earlier.

– **Cremasteric reflex:** Stroking the inner thigh of a man normally elevates the ipsilateral testicle.

– **Anal reflex:** Stimulate the perianal skin or gently insert a gloved finger into the rectum. Normal response is contraction of the rectal sphincter.

• **Deep tendon (muscle-stretch) reflexes:** Deep tendon reflexes are also called muscle-stretch, or myotactic, reflexes because reflex muscle contraction normally results from rapid stretching of the muscle. This is produced by sharply striking a muscle tendon's point of insertion with a sudden, brief blow of a reflex hammer. Reflexes commonly assessed include the biceps, triceps, brachioradialis, patella, and Achilles tendon.

– A biceps jerk (forearm flexion) is produced by tapping the biceps brachii tendon

- A triceps jerk (forearm extension) is produced by tapping the triceps brachii tendon at the elbow
- A brachioradial jerk or supinator reflex (elbow flexion, supination of forearm, and flexion of fingers and hand) is produced by tapping the styloid process of the radius about 1 to 2 inches above the wrist
- A knee jerk, quadriceps jerk, or patellar reflex (leg extension) is produced by tapping the quadriceps femoris tendon just below the patella
- An ankle jerk (plantiflexion of the foot) is produced by tapping the Achilles tendon.

Abnormal reflexes: Pathologic reflexes indicate neurologic disorders, often related to the spinal cord or higher centers. These responses include Babinski's jaw, palm-chin (palmomental), clonus, snout, rooting, sucking, glabella, grasp, and chewing reflexes.

Babinski's reflex: Test Babinski's reflex by gently scraping the sole of the foot with a blunt object. To elicit the reflex, start the stimulus at the midpoint of the heel, and move upward and laterally along the outer border of the sole to the ball of the foot. Continue the stimulus across the ball of the foot (without touching the toes) toward the medial side of the foot. Alternatively, start the stimulus at the midlateral sole and carry it down towards the heel. A normal response is plantiflexion of the toes. An abnormal response (presence of Babinski's reflex) is dorsiflexion of the great toe and, often, fanning of the other toes. In extreme circumstances, a Babinski's reflex may be accompanied by dorsiflexion of the foot at the ankle and flexion at the knee and hip (called triple flexion). When exaggerated deep reflexes are present, superficial reflexes are usually diminished or absent and pathologic reflexes (Babinski's reflex) are observed.

Other reflexes

- Jaw reflex
- Palm-chin (Palmomental) reflex

- Clonus
- Snout reflex
- Rooting reflex
- Sucking reflex
- Glabella reflex
- Grasp reflex
- Chewing reflex.

Nurses Role in Neurological Examination

- Provide a calm, suitable environment
- Collect the personal data with patient and family members
- Set the equipment needed for neurological examination
- Assess the current level of consciousness, monitor vital parameters—temperature, pulse, respiration, blood pressure, pupillary reaction, whether decerebrating or decorticating
- Thorough mental status examination should be done and recorded accurately
- Assessment of cranial nerves should be done correctly and recorded
- Assessment of motor, sensory and cerebellar functions should be done and be recorded accurately
- During the examination, she should maintain a good support with patient and family members
- She should instruct the procedure correctly and then they should be asked to do it
- Should be informed to the concerned unit doctors if there is any change.

(See Appendix 3 for Neurological Examination Format)

INVESTIGATIONS IN PSYCHIATRY

Investigations are useful to detect alteration in biologic function and to screen for medical disorders causing psychiatric symptoms.

Routine Investigations

- A complete hemogram (total and differential blood count, hemoglobin, ESR) and urinalysis are the basic routine

tests. Leucopenia and agranulocytosis are associated with certain medications (clozapine). Treatment with lithium and neuroleptic malignant syndrome are often associated with leukocytosis

- Renal function tests: Treatment with lithium
- Liver function tests: For all alcoholic patients treatment with carbamazepine, valproate and benzodiazepines
- Serum electrolytes: Dehydration, treatment with carbamazepine, antipsychotics, lithium
- Blood glucose: Routine screen above 35 years age
- Thyroid function test: Depression, treatment with lithium and carbamazepine
- Electrocardiogram (ECG): Above 35 years of age, treatment with lithium, antidepressants, ECT, antipsychotics
- HIV testing: IV drug users, suggestive sexual history, AIDS, dementia
- VDRL: Suggestive sexual history
- Serum CPK: Neuroleptic malignant syndrome (markedly increased levels)
- Chest X-ray: Before treatment with ECT
- Drug level estimation: Drug levels are indicated to test for therapeutic blood levels, for toxic blood levels and for testing drug compliance. Examples are lithium (0.6–1.6 mEq/L), carbamazepine (6–12 mg/mL), valproate (50–100 mg/mL), haloperidol (8–18 ng/mL), tricyclic antidepressants (Imipramine 200–250 ng/mL, nortriptyline 50–150 ng/mL), benzodiazepines, barbiturates.

Electrophysiological Tests

Electroencephalogram (EEG): Measures brain electrical activity, identifies dysrhythmias and asymmetries, used in the diagnosis of seizures, dementia, neoplasm, stroke, metabolic or degenerative disease.

Polysomnography/sleep studies: Used in the diagnosis of sleep disorders and seizures.

Brain Imaging Tests (Cranial)

- Computed tomography (CT) scan: Measures accuracy of brain structure to detect possible lesions, abscesses, areas of infarction or aneurysm. CT scan also identifies various anatomic differences in patients with schizophrenia, organic mental disorder and bipolar disorder
- Magnetic resonance imaging (MRI) scan: Measures the anatomic and biochemical status of various segments of the brain; detects brain edema, ischemia, infection, neoplasm, trauma and other changes such as demyelination used in the diagnosis of dementia, to detect morphological changes in schizophrenia patients
- Other tests are positron emission tomography (PET).

Neuroendocrine Tests

Commonly used neuroendocrine tests are dexamethasone suppression test, TRH stimulation test, serum prolactin levels, serum 17-hydroxycorticosteroid, serum melatonin levels.

Genetic tests

Cytogenetic work-up is advised in some cases of mental retardation.

PSYCHOLOGICAL TESTS

Psychological testing of patients is ideally conducted by a clinical psychologist who has been trained in the administration, scoring and interpretation of these procedures.

Instruments for Assessment of Symptoms

- Brief psychiatric rating scale
- Psychiatric symptom checklist
- Clinical global impression
- Anxiety self-rating scale
- Hamilton anxiety scale
- Beck's anxiety scale

- Beck's depression scale
- Hamilton depression scale
- Manic state rating scale
- Yale brown obsessive compulsive scale
- Suicide intent scale
- Nurses observation scale for inpatient evaluation (NOSIE)
- Positive and negative symptom scale (PANSS) for schizophrenia
- Extrapyramidal symptom rating scale
- Global assessment of functioning (GAF) scale
- Insight and treatment attitude questionnaire (ITAQ)
- The CAGE questionnaire
- Mini mental status examination (MMSE)
- Child behavior checklist (CBCL).

Instruments for Assessment of Personality Traits and Disorders

- Minnesota multiphasic personality inventory
- Cattell's 16 factor personality inventory
- Eysenck personality inventory.

Instruments for Assessment of Cognitive Functioning

- Wechsler adult intelligence scale (WAIS)
- Wechsler intelligence scale for children
- Binetkamath test of intelligence
- Bhatia battery test of intelligence
- NIMHANS neuropsychological battery of lobe dysfunction.

Instruments for Assessment of Psychodynamics

- Rorschach inkblot test
- Thematic apperception test

Instruments for Assessment of Environmental Stressors

- Social adjustment scale
- Marital satisfaction inventory.

Role of a Nurse in Psychological Assessment

Psychological tests have been designed to help clinicians. They help in:

- Measuring the extent of the patient's problems
- Making an accurate diagnosis
- Tracking patient progress over time
- Documenting the efficacy of treatment

Nurses should become familiar with the many standardized psychological tests that are available to enhance each stage of the nursing process. These tests help in providing care and measurable indicators for treatment outcome. For example, if the nurse is caring for a patient with depression, it would be helpful to use one of the depression rating scales with the patient at the beginning of care/treatment to establish a baseline profile of the patient's symptoms and help confirm the diagnosis. The nurse might then administer the same scale at various times during the course of treatment to measure the patient's progress.

A nurse should have knowledge about all the psychological tests, which will enable her to clarify the patient's and relative's doubts regarding the psychological tests they have to undergo.

The nurse should reassure the patient about the safety of the tests and confidentiality of the observations of the psychologist. Psychological tests are another source of data for the nurse to use in planning care for the patient.

REVIEW QUESTIONS

Long Essay

1. Describe in detail about nursing process in psychiatric nursing.

Short Essays

1. Mental status examination.
2. Describe various methods of assessment in psychiatry.

3. Commonly used psychological tests in psychiatry—role of a nurse.
4. Commonly used investigations in psychiatry.

Short Answers

1. Components of MSE
2. MMSE.

MULTIPLE CHOICE QUESTIONS

- 1. Nurse asks a patient to remember three words: House, garden and rain. About 10 minutes later, she asks the patient to repeat those words. Which aspect of memory is the nurse testing?**
 - a. Immediate memory
 - b. Recent memory
 - c. Remote memory
 - d. Delayed memory
- 2. Which of the tools does a nurse use to assess a patient's orientation and recall?**
 - a. Beck depression inventory
 - b. Thematic apperception test
 - c. Mini-mental status examination
 - d. Beck anxiety scale
- 3. Identifying the patient problem is a part of:**
 - a. Nursing assessment
 - b. Nursing diagnosis
 - c. Planning
 - d. Implementation
- 4. Which of the following is the first step of nursing process?**
 - a. Nursing assessment
 - b. Nursing diagnosis
 - c. Planning
 - d. Implementation
- 5. Which of the following test is used to assess cognitive impairment?**
 - a. History taking
 - b. Mental status examination
 - c. Mini-mental status examination
 - d. Glasgow coma scale
- 6. All of the following are components of MSE, except:**
 - a. General appearance and behavior
 - b. Speech
 - c. Mood
 - d. Language
- 7. Which of the following tool is used to assess cognitive function?**
 - a. Wechsler adult intelligence scale
 - b. Child behavioral checklist
 - c. CAGE questionnaire
 - d. Rorschach inkblot test
- 8. Cytogenetic tests are advised in which of the following condition:**
 - a. Schizophrenia
 - b. Mania
 - c. Autism
 - d. Mental retardation
- 9. Which of the following is an electro-physiological test?**
 - a. Positron emission tomography
 - b. Magnetic resonance imaging
 - c. Polysomnography
 - d. Computed tomography
- 10. Nursing process is a method of:**
 - a. Documenting the patient problems
 - b. Data collection from the patient
 - c. A systematic organization and implementation of patient care
 - d. Differentiating the roles of a nurse and a physician

KEY

1. b
2. c
3. a
4. a
5. c
6. d
7. a
8. d
9. c
10. c

Chapter 4

Therapeutic Communication and Nurse–Patient Relationship

COMMUNICATION—ELEMENTS AND TYPES

Communication refers to the giving and receiving of information. Communication is the means by which people influence the behavior of another, leading to the successful outcome of nursing intervention. Communication is the relationship itself because without it, a therapeutic nurse-patient relationship is impossible.

It is the vehicle used to establish a therapeutic relationship involving three elements: The sender, the message and the receiver. The sender prepares or creates a message when a need occurs and sends the message to a receiver or listener, who then decodes it. The receiver may then return a message or feedback to the initiator of the message (Fig. 4.1).

Types of Communication

Communication takes place on two levels: Verbal and nonverbal.

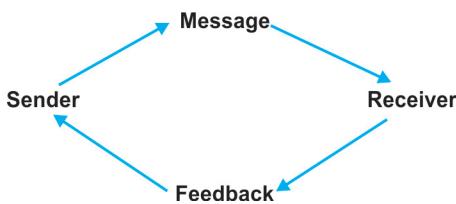


Fig. 4.1: Communication process

Verbal communication occurs through words, spoken or written. Nonverbal communication occurs through gestures or behaviors that do not involve the spoken or written words. The types of nonverbal communication include vocal cues, gestures, physical appearance, space, posture, touch and facial expression. Nonverbal communication may more accurately reveal the patient feelings than verbal communication.

THERAPEUTIC COMMUNICATION

Therapeutic communication is an interpersonal interaction between the nurse and the patient during which the nurse focuses on the patient's specific needs to promote an effective exchange of information. All nurses need skills in therapeutic communication to effectively apply the nursing process and to meet standards of care for their patients.

Therapeutic communication can help nurses to accomplish many goals:

- 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.

To have an effective therapeutic communication, the nurse must consider privacy and respect of boundaries, use of touch, and active listening and observation.

Principles or Characteristics of 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 and only when it has a therapeutic purpose
- Avoid social relationship with patients
- Maintain patient confidentiality
- Assess the patient's intellectual competence to determine the level of understanding
- Implement interventions from a theoretic base
- Maintain a nonjudgmental attitude. Avoid making judgments about patient's behavior
- Avoid giving advice
- Guide the patient to reinterpret his or her experiences rationally.

Therapeutic Communication Techniques

1. **Listening:** It is an active process of receiving information. Responses on the part of the nurse, such as maintaining eye-to-eye contact, nodding, gesturing and other forms of receptive nonverbal communication convey to the patient that he is being listened to and understood.
Therapeutic value: Nonverbally communicates to the patient the nurse's interest and acceptance.
2. **Broad openings:** Encouraging the patient to select topics for discussion. For example, "What are you thinking about?"
Therapeutic value: Indicates acceptance by the nurse and the value of patient's initiative.
3. **Restating:** Repeating the main thought expressed by the patient. For example,

"You say that your mother left you when you were 5-year-old."

Therapeutic value: Indicates that the nurse is listening and validates, reinforces or calls attention to something important that has been said.

4. **Clarification:** Attempting to put vague ideas or unclear thoughts of the patient into words to enhance the nurse's understanding or asking the patient to explain what he means. For example, "I am not sure what you mean. Could you tell me about that again?"
Therapeutic value: It helps to clarify feelings, ideas and perceptions of the patient and provides an explicit correlation between them and the patient's actions.
5. **Reflection:** Directing back the patient's ideas, feelings, questions and content. For example, "You are feeling tense and anxious and it is related to a conversation you had with your husband last night."
Therapeutic value: Validates the nurse's understanding of what the patient is saying and signifies empathy, interest and respect for the patient.
6. **Humor:** The discharge of energy through comic enjoyment of the imperfect. For example, "That gives a whole new meaning to the word 'nervous' ", said with shared kidding between the nurse and the patient.
Therapeutic value: Can promote insight by making repressed material conscious, resolving paradoxes, tempering aggression and revealing new options, and is a socially acceptable form of sublimation.
7. **Informing:** The skill of information giving. For example, "I think you need to know more about your medications."
Therapeutic value: Helpful in health teaching or patient education about relevant aspects of patient's well-being and self-care.
8. **Focusing:** Questions or statements that help the patient expand on a topic of importance. For example, "I think that we should talk more about your relationship with your father."
Therapeutic value: Allows the patient to discuss central issues and keeps the communication process goal-directed.

9. **Sharing perceptions:** Asking the patient to verify the nurses understanding of what the patient is thinking or feeling. For example, "You are smiling, but I sense that you are really very angry with me."

Therapeutic value: Conveys the nurse's understanding to the patient and has the potential for clearing up confusing communication.

10. **Theme identification:** This involves identification of underlying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship. For example, "I noticed that you said, you have been hurt or rejected by the man. Do you think this is an underlying issue?"

Therapeutic value: It allows the nurse to promote the patient's exploration and understanding of important problems.

11. **Silence:** Lack of verbal communication for a therapeutic reason. For example, sitting with a patient and nonverbally communicating interest and involvement.

Therapeutic value: Allows the patient time to think and gain insight, slows the pace of the interaction and encourages the patient to initiate conversation while enjoying the nurse's support, understanding and acceptance.

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

Therapeutic value: Increases the patient's perceived notions or choices.

a preoccupation of impaired thought process and changing of the subject if one becomes uncomfortable with the topic being discussed.

THERAPEUTIC NURSE-PATIENT RELATIONSHIP

A relationship is defined as a state of being related or a state of affinity between two individuals. The nurse and patient interact with each other in the health care system with the goal of assisting the patient to use personal resources to meet his or her unique needs.

In a therapeutic relationship, the nurse and patient work together towards the goal of assisting the patient to regain the inner resources to meet life challenges and facilitate growth. The interaction is purposefully established, maintained and carried out with the anticipated outcome of helping the patient gain new coping and adaptation skills.

Types of Relationships

- Social relationships
- Intimate relationships
- Therapeutic relationships.

Social Relationships

A social relationship can be defined as a relationship that is primarily initiated with the purpose of friendship, socialization, enjoyment or accomplishing a task. Mutual needs are met during social interaction. For example, participants share ideas, feelings and experiences.

Intimate Relationships

An intimate relationship occurs between two individuals who have an emotional commitment to each other. Those in an intimate relationship usually react naturally with each other. Often, the relationship is a partnership wherein each member cares about the other's need for growth and satisfaction.

Ineffective/Non-therapeutic Communication

These include failure to listen, conflicting verbal or non-verbal messages, a judgmental attitude, false reassurance, giving of advice, the inability to receive information because of

Therapeutic Relationships

The therapeutic relationship between nurse and the patient differs from both a social and an intimate relationship in that the nurse maximizes inner communication skills, understanding of human behavior and personal strengths, in order to enhance the patient's growth. The focus of the relationship is on the patient's ideas, experiences and feelings (Box 4.1).

Components of Therapeutic Nurse–Patient Relationship

Rapport

Rapport is a relationship or communication, especially when useful and harmonious. It is the crux of a therapeutic relationship between the nurse and the patient. It is:

- A willingness to become involved with another person
- Growth towards mutual acceptance and understanding of individuality
- The end result of one's care and concern for another.

The nurse establishes rapport through demonstration of understanding, warmth and nonjudgmental attitude. A skilled nurse will be able to establish rapport that will alleviate the patient's problems. When rapport develops, the patient feels comfortable with the nurse and finds it easier to self-disclose. The nurse also feels comfortable and recognizes that an interpersonal bond or alliance is developing.

Box 4.1: Goals of therapeutic relationship

- » Facilitating communication of distressing thoughts and feelings
- » Assisting the patient with problem-solving
- » Helping patients examine self-defeating behaviors and test alternatives
- » Promoting self-care and independence

Empathy

Empathy is an ability to feel with the patient while retaining the ability to critically analyze the situation. It is the ability to put oneself in another person's circumstances and feelings. The nurse need not necessarily have to experience it, but has to be able to imagine the feelings associated with the experience.

In empathy process, the nurse receives information from the patient with an open, nonjudgmental acceptance, and communicates this understanding of the experience and feelings so that the patient feels understood. This serves as a basis for the relationship.

Sympathy is often confused with empathy. In sympathy, the nurse actually feels what the patient feels but in the process objectivity is lost, and the nurse becomes focused on relief of personal distress rather than on assisting the patient to resolve the problem. With empathy while understanding the patient's thoughts and feelings, the nurse is able to maintain sufficient objectivity to allow the patient to achieve problem resolution with minimal assistance.

Warmth

Warmth is the ability to help the patient feel cared for and comfortable. It shows acceptance of the patient as a unique individual. It involves a nonpossessive caring for the patient as a person and a willingness to share the patient's joys and sorrows.

Genuineness

Genuineness involves being one's own self. This implies that the nurse is aware of her thoughts, feelings, values and their relevance in the immediate interaction with a patient. The nurse's response to the patient is sincere and reflects her internal response. It is also important that the nurse's verbal and nonverbal communication corresponds with each other.

Characteristics of Therapeutic Nurse–Patient Relationship

- The therapeutic relationship is the cornerstone of psychiatric-mental health nursing, where observation and understanding of behavior and communication are of great importance. It is a mutual learning experience and a corrective emotional experience for the patient
- The nature of the therapeutic relationship is characterized by the mutual growth of individuals who “dare” to become related to discover love, growth and freedom
- The therapeutic relationship is based on the belief that the patient has potential, and as a result of the relationship, “will grow to his fullest potential”
- In a therapeutic relationship, the nurse and patient work together towards the goal or assisting the patient to regain the inner resources in order to meet life challenges and facilitate growth. The interaction is purposefully established, maintained and carried out with the anticipated outcome of helping the patient to gain new coping and adaptation skills.

Ethics and Responsibilities

Ethics has been defined as a branch of philosophy that refers to the study of values that conform to the moral standards of a profession. The American Nurses Association has identified four primary principles to guide ethical decisions. Governing the relationship between the nurse and the patients, these principles include the patient’s right to autonomy (making decisions for oneself), the patient’s right to beneficence (doing good by the nurse), the patient’s right to justice or fair treatment, and the patient’s right to veracity (honest) and truth by the nurse regarding the patient’s condition and treatment.

Nurses’ respect for the patient’s dignity, autonomy, cultural beliefs, and privacy is of particular concern in psychiatric-

mental health nursing practice. The nurse serves as an advocate for the patient and is obliged to demonstrate nonjudgmental and nondiscriminatory attitudes and behaviors that are sensitive to patient diversity. An essential aspect of the patient’s response is the right to exercise personal choice about participation in proposed treatments. The responsible use of the nurse’s authority respects the patient’s freedom to choose among existing alternatives and facilitates awareness of resources available to assist with decision making.

Nurses working with psychiatric-mental health patients are prepared to recognize the special nature of the provider-patient relationship and take steps to assure therapeutic relationships are conducted in a manner that adheres to the mandates stipulated in the ANA Code for Nurses (ANA 1985). Unethical behavior (e.g. omission of informed consent, breach of confidentiality, undue coercion, boundary infringement) and illegal acts can increase the patient’s vulnerability and demand special vigilance on the part of the psychiatric-mental health nurse.

Dynamics of Therapeutic Nurse–Patient Relationship

Dynamics are the forces that change or produce the social or psychological system in a relationship. It is the nurse’s professional responsibility to understand the dynamics of the therapeutic relationship, to establish the relationship and to maintain the relationship within therapeutic boundaries.

Forces that change the nurse-patient relationship:

1. Therapeutic use of self
2. Gaining self-awareness
3. Power
4. Trust
5. Intimacy
6. Respect

The **therapeutic use of self** is defined as, “the ability to use one’s personality consciously

and in full awareness in an attempt to establish relatedness and to structure nursing interventions.” Peplau (1952) described that nurses must clearly understand themselves to promote patient’s growth, change and heal.

Self-awareness is the process of understanding one’s own beliefs, thoughts, motivations, biases and limitations and recognizing how they affect others. Without self-awareness, nurses will find it impossible to establish and maintain therapeutic relationships with patients. The Johari window is a representation of the self and a tool that can be used to increase self-awareness. The **Johari window** is divided into four quadrants (Fig. 4.2).

The goal of increasing self-awareness by using the Johari window is to increase the size of the quadrant that represents the open or public self. The individual who is open to self and others has the ability to be spontaneous and share emotions and experiences with others. Increased self-awareness allows an individual to interact with others comfortably, to accept the differences in others and to observe each person’s right to respect and dignity.

In creating a Johari window, the first step for the nurse is to appraise her own qualities by creating a list of them: Values, attitudes, feelings, strengths, behaviors, accomplishments, needs, desires and thoughts. The

second step is to find out the perceptions of others by interviewing them and asking them to identify qualities, both positive and negative, they see in the nurse. To learn from this exercise, the opinions given must be honest. The third step is to compare lists and assign qualities to the appropriate quadrant. If quadrant 1 is the longest list, this indicates that the nurse is open to others; a smaller quadrant 1 means that the nurse shares little about herself with others. If quadrants 1 and 3 are both small, the person demonstrates little insight. Any change in one quadrant is reflected by changes in other quadrants. The goal is to work towards moving qualities from 2, 3 and 4 into quadrant 1 (qualities known to self and others). Doing so indicates that the nurse is gaining self-knowledge and awareness.

The appropriate use of **power** in a caring manner enables the nurse to work with the patient towards the patient’s goals and to ensure that the patient’s vulnerable position in the nurse–patient relationship is not taken advantage of.

To maintain **trust** in the relationship, it is important that the nurse keeps promises to patients. If trust is breached, then it becomes very difficult to re-establish it.

In this context, **intimacy** relates to the kind of activities nurses perform for the patients that create personal and private closeness

	Known to self Open or public self	Unknown to self Blind/Unaware of self
Known to others	1	2
	Behaviors, feelings and thoughts known to the individual and others	Things that others know but the individual does not know
Unknown to others	3	4
	Private/Hidden self Things about self-known only to self	Unknown self Aspects of the self that are unknown to the individual and to others

Fig. 4.2: Johari window

on many levels. This can involve physical, psychological, spiritual and social elements.

Respect for the dignity and worth of the patient is fundamental to the relationship. The nurse needs to know and understand the culture and other aspects of the patient's individuality and to take these into account when providing service.

Phases and Tasks of Therapeutic Relationship

Four phases of relationship process have been identified:

1. Pre-interaction phase.
2. Introductory or orientation phase.
3. Working phase.
4. Termination phase.

Pre-interaction Phase

This phase begins when the nurse is assigned to initiate a therapeutic relationship and includes all that the nurse thinks, feels or does immediately prior to the first interaction with the patient. The nurse's initial task is one of self-exploration. The nurse may have misconceptions and prejudices about psychiatric patients and may have feelings and fears common to all novices. Many nurses express feelings of inadequacy and fear of hurting or exploiting the patient. Another common fear of nurses is related to the stereotyped psychiatric patients' abusive and violent behavior.

The nurse should also explore feelings of inferiority, insecurity, approval-seeking behaviors, etc. This self-analysis is a necessary task because, to be effective, she should have a reasonably stable self-concept and an adequate amount of self-esteem.

Nurse's tasks in the pre-interaction phase

- Explore own feelings, fantasies and fears
- Analyze own professional strengths and limitations
- Gather data about patient whenever possible
- Plan for first meeting with patient

Problems encountered

- *Difficulty in self-analysis and self-acceptance:* Promoting a patient's self-realization and self-acceptance is facilitated by the nurse's acceptance of herself and behaving in ways congruent with her own personality. Also, the nurse should have enough sources of satisfaction and security in her nonprofessional life to avoid the temptations or using her patient for the pursuit of her personal satisfaction or security. If she does not have sufficient personal fulfillment she should realize it and the source of dissatisfaction clarified, so that it does not interfere with the success of the therapeutic relationship
- *Anxiety:* Quite frequently, the nurse may experience anxiety of varying intensity during the pre-interaction phase due to role threat, feelings of incompetence, fear of being hurt or of causing distress, fear of losing control and fear of rejection. The nurse needs to become aware of what is being experienced, identify the threat, and decide what needs to be done about it. This is important, so that the patient is not unduly affected by the nurse's anxiety
- Apart from anxiety, the nurse may also experience boredom, anger, indifference, and depression. The cause of such feelings must be identified, which is the first step in devising ways to cope with them.

Ways to overcome

- The nurse needs help from her supervisor and peers in self-analysis and facing reality in order to help patients do likewise. This provides an opportunity to explore feelings and fears and develop useful insight into one's professional role
- It is also helpful to conceptualize in advance what she wishes to accomplish during the relationship. The nurse may, in consultation with her supervisor, identify in writing goals for the initial interaction, and decide the methods to be used in achieving the goals

- The nurse also needs to be consciously aware of the reasons for choosing a particular patient. She may also attempt to assess the patient's anxiety level as well as her own. The nurse who is able to analyze herself and recognize her assets and limitations, is able to use this information in relating to patients in a natural, congruent and relaxed manner.

Introductory or Orientation Phase

It is during the introductory phase that the nurse and the patient meet for the first time. One of the nurse's primary concerns is to find out why the patient sought help. This forms the basis of the nursing assessment and helps the nurse to focus on the patient's problem and to determine patient's level of motivation.

Nurse's tasks in the orientation phase

- Establish rapport, trust and acceptance
- Establish communication; assist in the verbal expression of thoughts and feelings
- Gather data, including the patient's feelings, strengths and weaknesses
- Define patient's problems; set priorities for nursing intervention
- Mutually set goals.

Problems encountered

- The major problem encountered during this phase is related to the manner in which the nurse and patient perceive each other. A nurse may react to a patient not in terms of his uniqueness, but in terms of the nurse's stereotyped view of a 'psychiatric patient' or she may, because of her theoretical background, read in terms of diagnostic categories. Sometimes, the nurse may relate to a patient as if he were a significant individual from the past. The nurse may then displace to the patient the feelings she has for the significant individual. Since, interaction is a reciprocal process, the patient also perceives the nurse in his own idiosyncratic manner.

Thus, perception of each other as unique individuals may not take place

- Problems related to establishing an agreement or pact between the nurse and patient: The patient may feel that since the nurse is here only for a few weeks much help cannot be expected from her in the short span of time. The same feelings may be experienced by the nurse, in that she feels she cannot do much for the patient during his stay in the hospital due to factors like limited time, overwork or the nurse's opinion that the patient is suffering from a 'major psychiatric problem'. Because the establishment of an agreement or pact to work together is a mutual process, such misperceptions can greatly hinder it.

Ways to overcome

- The nurse must be willing to relate honestly to her perceptions, thoughts and feelings, and to share the data collected during the nurse-patient interaction with her supervisors. The supervisor must provide an atmosphere in which the nurse feels free to reveal self without any fear of criticism
- Difficulties may be faced in assisting a nurse who perceives a patient as if he were someone from her past life. She is usually not aware of doing so, since most of this behavior is unconsciously determined. An alert supervisor can usually detect that the nurse is distorting the patient by viewing him as someone else. It may be necessary to bring the problem to the nurse's attention so that she can examine her behavior. Gradually, with assistance the nurse is able to audit her behavior, and then change it.

Formulating a contract

Formulating a contract is a mutual process. It begins with the introduction of the nurse and patient, exchange names, and explanation of roles. An explanation of roles includes the responsibilities and expectations of the patient

and nurse, with a description of what the nurse can and cannot do. The nurse is responsible for providing guidance throughout the therapeutic relationships protecting confidential information, and maintaining professional boundaries. The patient is responsible for attending agreed upon sessions, interacting during the sessions and participating in the nurse-patient relationship. This is followed by a discussion of the purpose of the relationship, in which the nurse emphasizes that the focus of it will be the patient and the patient's life experiences and areas of conflict.

Discuss the contract dates, time and place of meetings, duration of each meeting, when meetings will terminate, who will be involved in the treatment plan. Nurse should maintain confidentiality at all times, evaluate progress with patient, and document sessions. At the outset, both nurse and patient should agree on these responsibilities in an informal or verbal contract. In some instances, a formal or written contract may be appropriate (Box 4.2).

Working Phase

Most of the therapeutic work is carried out during the working phase. The nurse and the patient explore relevant stressors and promote the development of insight in the patient. By linking perceptions, thoughts, feelings and actions, the nurse helps the patient to master anxieties, increase independence and coping mechanisms. Actual behavioral change is the

Box 4.2: Elements of a nurse–patient contract

- » Exchanging names of nurse and patient
- » Explanation of roles of nurse and patient
- » Explanation of responsibilities of nurse and patient
- » Discussion of purpose
- » Discussion of date, time and place
- » Description of meeting conditions for termination
- » Confidentiality

focus of attention in this phase of the relationship.

Nurse's tasks in the working phase

- Gather further data; explore relevant stressors
- Promote patient's development of insight and use of constructive coping mechanisms
- Facilitate behavioral change; encourage him to evaluate the results of his behavior
- Provide him with opportunities for independent functioning
- Evaluate problems and goals and redefine as necessary.

Problems encountered

- *Testing of the nurse by the patient:* The patient may test the nurse in a number of ways, and for a number of reasons. For example, he may wish to check her ability to set limits and abide by them. A patient with problems related to aggression may deliberately attempt to provoke the nurse to determine whether or not she will become punitive
- *Progress of the patient:* Another barrier is the nurse's unrealistic assumption as to the progress the patient should be making. It is common for the patient to show desirable behavioral changes in the beginning, and then remain fixed, neither progressing nor regressing. A nurse who was enthusiastic about the patient's improvement may then become discouraged when he does not progress at a steady state
- *The nurse's fear of closeness:* If the nurse fears closeness too much, she may react by being indifferent, rejecting or being cold towards the patient. She must learn to interact with kindness and concern, but with objectivity and professional interest
- *Life stresses of the nurse:* A nurse who has difficulty in coping with her own life problems cannot help a patient in making appropriate behavioral changes

- **Resistance behaviors:** Resistance is the patient's attempt to remain unaware of anxiety-producing aspects within him. Resistance may take different forms and some of them were identified by Wolfberg as follows:
 - Suppression and repression of relevant information
 - Intensification of symptoms
 - A helpless outlook on the future
 - Breaking appointments, coming late to his sessions, being forgetful, silent and sleepy during the interactions
 - Acting out or irrational behavior
 - Expressing an excessive liking for the nurse and claiming that nobody can replace her
 - Reporting physical symptoms which may occur only during the time the patient is with the nurse
 - Hostility, dependence, provocative remarks, sexual interest in the nurse
 - **Transference and counter transference reactions:** These are, in fact, a form of resistance behavior. Transference is the unconscious transfer of qualities or attributes originally associated with another individual by the patient. Transference occurs because the patient brings frustrations, conflicts and feelings of dependence from a past relationship into the therapeutic relationship. The patient may express feelings of aggression, rejection or hostility that are too intense for the current situation. These responses are often not appropriate for the nurse–patient relationship.
Counter transference is the reverse of transference. The nurse may have unresolved problems from an earlier relationship. She may unconsciously transfer inappropriate attributes to a patient that was experienced in that earlier relationship. The patient's transference provokes the nurse's counter transference reactions.
- Ways to overcome**
- Conferences with the supervisors and group discussions with other members of the staff are the ways in which the nurse can best be assisted to overcome the barriers encountered during the working phase. It is during this phase that the supervisor helps the nurse to increase her ability to collect and interpret data, apply concepts and synthesize the data obtained
 - There will be times when the nurse believes she is making little or no progress, either in helping the patient or in gaining knowledge. It is at such times that emotional support is needed, and it is the task of the supervisor to encourage the nurse to persevere
 - At one time or another, most nurses may exhibit a reluctance to write and analyze process records or to engage in a discussion with the supervisor about the content of records, due to many reasons. For instance fatigue, boredom, discouragement or an apparent impasse in interacting with a patient may cause reluctance. A discussion of the meaning of behavior and of ways to overcome it is essential
 - Handling resistances: The nurse may find the experience of transference and counter transference particularly difficult. The relationship can become stalled and nonbeneficial if the nurse is not prepared for the patient's expression of feelings or is so preoccupied by her own needs and problems that she cannot clearly perceive what is happening.
 - The first thing the nurse must do in handling resistance is to listen. When she recognizes the resistance, she then uses clarification and reflection of feelings; clarification helps to give the nurse a more focused idea of what is happening, while reflection of content helps the patient to become aware of what has been going on in his own mind
 - It is not sufficient to merely identify that resistance is occurring; the behavior must be explored and possible reasons for its occurrence analyzed. Ignoring transference can perpetuate the pattern.

Also, being overly critical of the patient, withholding information or being over involved in making decisions for the patient can encourage the dysfunctional behavioral pattern. It is important that the nurse maintains open communication with her supervisor, who can then guide her in making adequate progress in handling such resistance reactions.

Termination Phase

This is the most difficult, but most important phase of the therapeutic nurse-patient relationship. The goal of this phase is to bring a therapeutic end to the relationship.

Criteria for determining patient's readiness for termination

- Patient experiences relief from presenting problems
- Patient's social function has improved and isolation has decreased
- Patient's ego functions are strengthened and he has attained a sense of identity
- Patient employs more effective and productive defense mechanisms
- Patient has achieved the planned treatment goals.

Nurse's tasks in the termination phase

- Establish reality of separation
- Mutually explore feelings of rejection, loss, sadness, anger and related behavior
- Review progress of therapy and attainment of goals
- Formulate plans for meeting future therapy needs.

Problems encountered

- It is the task of the nurse to prepare the patient for termination of the relationship. However, patients differ in their reactions to the nurse's attempts to prepare them for termination. An ill person who has experienced trust, support and the warmth of caring may be reluctant to discontinue the nurse-patient contact.

Some behaviors exhibited in this regard can be:

- Patients may perceive termination as desertion and may demonstrate angry behavior
- Some patients attempt to punish the nurse for this desertion by not talking during the last few interactions or by ignoring termination completely; they may act as if nothing has changed and the interactions will go on as before
- Other patients react to the threatened loss by becoming depressed or assuming an attitude of not caring
- Fault-finding is another behavior; the patient may state that the therapy is not beneficial or not working; he may refuse to follow through on something that has been agreed upon before
- Resistance often comes in the form of "flight to health," which is exhibited by a patient who suddenly declares that there is no need for therapy; he claims to be all right and wants to discontinue the therapeutic relationship; this may be a form of denial or fear of the anticipated grief over separation
- "Flight to illness" occurs when a patient exhibits sudden return of symptoms; this is an unconscious effort to show that termination is inappropriate and that the nurse is still needed; the patient may disclose new information about him or more problems or even threaten to commit suicide in an attempt to delay parting
- The barriers to goal accomplishment during this phase also seem to be related to the nurse's inability or unwillingness to make specific plans and implement them. Plans for termination are essential and the nurse needs to conceptualize these plans in advance. A nurse who does not discuss frankly the reasons for termination or elicit from the patient his thoughts and feelings about the impending termination cannot help to prepare him psychologically.

Similarly, a nurse who cannot explore her own thoughts and feelings about separation from the patient is also unable to accomplish the goals related to termination.

Ways to overcome

- The nurse should be aware of the patient's feelings and be able to deal with them appropriately. The nurse can assist the patient by openly eliciting his thoughts and feelings about termination. For some patients, termination is a critical experience, because many of their past relationships were terminated in a negative way that left them with unresolved feelings of abandonment, rejection, hurt and anger. Learning to bear the sorrow of the loss while incorporating positive aspects of the relationship into one's life is the goal of termination in the therapeutic nurse-patient relationship.
- During this phase, the supervisor may notice that the nurse is showing less interest in the patient than shown earlier and may be disengaging self from the patient several days before the final interaction. This may be a psychological defense mechanism by which she tries to decrease or delay the anxiety she is experiencing as a result of the impending termination of relationship. The task of the supervisor is to discuss frankly with the nurse the meaning of the behavior. The supervisor then initiates action to assist the nurse to persevere and intensify her efforts to prepare both self and patient for his eventual release from the hospital.

Therapeutic Impasses

Therapeutic impasses are blocks in the progress of the nurse–patient relationship. Impasses provoke intense feelings in both the nurse and the patient, which may range from anxiety and apprehension to frustration, love or intense anger.

- **Resistance:** Resistance is the patient's attempt to remain unaware of anxiety producing aspects within the self. Page 113 lists form of resistance displayed by patients.
- **Transference:** Transference is an unconscious response in which the patient experiences feelings and attitudes toward the nurse that were originally associated with significant figures in the patient's early life. For example, a patient perceives the nurse as acting the way that his mother did, regardless of how the nurse is truly acting. Transference can be positive if patients view the nurse as helpful and caring. Negative transference is more difficult because of unpleasant emotions that interfere with treatment, such as anger and fear.
- **Countertransference:** It refers to a specific emotional response by the nurse toward the patient that is inappropriate to the content and context of the therapeutic relationship or inappropriate in its emotional intensity. Countertransference reactions are usually of three types: Reactions of intense love or caring, reactions of intense hostility or hatred and reactions of intense anxiety often in response to a patient's resistance (Box 4.3).

Box 4.3: Forms of countertransference displayed by nurses

- » Difficulty in empathizing with patient in certain problem areas
- » Recurrent anxiety, unease, or guilt related to patient
- » Personal or social relationship with patient
- » Encouraging patient's dependency, praise or affection
- » Sexual or aggressive fantasies towards patient
- » Arguing with patient or tendency to "push" patient before he is ready
- » Feeling angry or impatient because of patient's unwillingness to change

Box 4.4: Possible boundary violations

- » Nurse accepts free gifts from patient
- » Having personal or social relationship with patient
- » Nurse attends a social function of patient
- » Nurse regularly reveals personal information to patient
- » Nurse routinely hugs or has physical contact with patient
- » Nurse does business with or purchases services from patient

- **Boundary violation:** Occurs when a nurse goes outside the boundaries of the therapeutic relationship and establishes a social, economic or personal relationship with a patient (Box 4.4).

Interventions to Overcome Therapeutic Impasses

- Nurse must have knowledge of the impasses and recognize behaviors that indicate their existence
- Nurse must reflect on feelings, explore reasons behind such behavior
- Co-workers are more likely than others to recognize the phenomenon initially and give feedback to the nurse about it
- Nurses must examine their strengths, weaknesses, prejudices, and values before they can interact more appropriately with patients
- The transference reactions of patients must also be examined, gently but directly
- Nurses must be open and clear about their genuine reactions when patients misperceive behavior
- Nurses should also state actions that they can and cannot take to meet patient's needs
- Limit setting is useful when patients act inappropriately towards the nurse
- Maintain open communication with her supervisor, who can then guide her in

making adequate progress in handling such resistance reactions.

PROCESS RECORDING

Recording is an important and necessary function of any organization, whether it is an industry, a business enterprise, a hospital or for that matter even farming. Recording is done in different ways in different organizations and situations. Process recording is the method of recording used in psychiatric wards by nurses.

Definition: Process recording is a written account or verbatim recording of all that transpired, during and immediately following the nurse-patient interaction. In other words, it is the recording of the conversation during the interaction or the interview between the nurse and the patient in the psychiatric setup with the nurse's inference. It may be written during the interaction or immediately after the one-to-one interaction.

Purpose and Uses

The aim of process recording is to improve the quality of the interaction for better effect to the patient and as a learning experience for the nurse to continuously improve her clinical interaction pattern. When correctly used, it—

- Assists the nurse or student to plan, structure and evaluate the interaction on a conscious rather than an intuitive level
- Assists her to gain competency in interpreting and synthesizing raw data under supervision
- Helps to consciously apply theory to practice
- Helps her to develop an increased awareness of her habitual, verbal and non-verbal communication pattern and the effect of those patterns on others
- Helps the nurse to learn to identify thoughts and feelings in relation to self and others

- Helps to increase observational skills, as there is a conscious process involved in thinking, sorting and classifying the interaction under the various headings
- Helps to increase the ability to identify problems and gain skills in solving them.

After a few exercises, these skills will become so in-built that she will keep using them automatically even when it is not specifically required or when she does not have the time to do it. Thus, process recording is a/an—

- Educative tool
- Teaching tool
- Diagnostic tool
- Therapeutic tool, and a prerequisite for nursing process.

Prerequisites for Process Recording

- Physical setting
- Getting consent of the patient for the possibility of cassette recording
- Confidentiality.

Suggested Outlines for Process Recording

Introductory Material

This should include a short description of the patient, his name, age, educational level, health problems and length of stay in the hospital. The date, time, place of interaction and a short description of the milieu of the ward immediately prior to the interaction will be helpful in understanding the thoughts and feelings of the patient. It is also helpful to record the thoughts and feelings of the nurse just before the interaction. Reason for choosing the patient and the duration of the nurse–patient relationship should also be included. To understand the patient in a better way, process recording also includes personal history, family history, socioeconomic history, medical history, present complaints, past psychiatric history if any, and provisional diagnosis.

Objectives

Objectives should be formulated prior to meeting. They should be specific, readily measure change in the patient behavior and function as a guide for interaction. They can be different on different days of the interview. For example, in the beginning, setting short-term goals may be more appropriate. In the second stage (working phase), the objectives can be more long-term in nature, focusing on corrective psychodynamics, including rehabilitation, follow-up and preparing the family for future plans.

Context of the Interaction

Describe where the interaction took place, activities involving the patient that occurred before the interaction, the patient's physical appearance and how the interaction began, i.e. whether the patient approached you or you initiated the interaction.

Record of Interaction between Nurse and the Patient

This should include truthful recording of what the nurse said and did and what the patient said and did, including any nonverbal behavior of the patient, such as changing the position, looking at various things, eye contact, biting the nails, pacing, tone of voice, rate of speech and changes in facial expressions. What the nurse did also includes her nonverbal behavior. The nurse's thoughts and feelings also should be recorded so that a self-evaluation can be made as to how these influence her behavior. Periods of silence are also important to record.

Analysis of the Interaction

An analysis of the interaction should include the interpretation of the verbal and nonverbal behavior and patient's thoughts and feelings as evident from the process. The communication techniques used by the nurse

and evaluation of the technique in terms of its effect on the patient and in terms of the planned objectives also should be included. The nurse's thoughts and feelings at the end of the interaction and the plans made for further interactions should be stated.

Process recording can be written as short notes during the interaction and rewritten immediately after it. Total time spent on the recording can be around 30 minutes. The active time can be 20 minutes, with 10 minutes for conclusion and recording. Although video or tape recorders give more accurate recording, the impact of this equipment on the interaction will make an unnatural influence.

Summary

The recording process should end with a brief summary to evaluate whether initial objectives for the interaction were met. If the objectives were not met, provide a brief analysis of the reasons thereof. This provides an opportunity to modify the conversation. (See Appendix 5 for Process Recording Format)

REVIEW QUESTIONS

Long Essays

1. Explain in detail about therapeutic communication techniques.
2. Define therapeutic nurse-patient relationship. Explain the various phases and tasks of therapeutic relationship.
3. Explain in detail about therapeutic impasses and its intervention.

Short Essays

1. Characteristics of therapeutic communication.
2. Components of therapeutic relationship.
3. Dynamics of therapeutic nurse-patient relationship.
4. Process recording.
5. Working phase.

Short Answers

1. Types of communication.
2. Types of relationship.
3. Differences between therapeutic and social relationship.
4. Goals of therapeutic relationship.
5. Nurse-patient relationship.
6. Counter transference.
7. Rapport and resistance.
8. Empathy and sympathy.

MULTIPLE CHOICE QUESTIONS

- 1. The following are elements of communication, except:**
 - a. Sender
 - b. Message
 - c. Receiver
 - d. Patient
- 2. The nurse should pay close attention to the patient's nonverbal communication because:**
 - a. Patients do not inform the nurse what is expected
 - b. It may more accurately reveal the patient's feelings
 - c. It will provide the nurse with complete assessment
 - d. All the symptoms may not be expressed verbally
- 3. Which of the following is a goal of therapeutic communication?**
 - a. Identify important needs of patient
 - b. Facilitate the patient's expression of emotions
 - c. Implement the interventions
 - d. All of the above
- 4. What is the meaning of restating?**
 - a. Repeating the main thoughts expressed by the patient
 - b. Directing back the patient's ideas
 - c. Asking the patient to verify the nurse's understanding
 - d. All of the following

- 5. Which of the following is a barrier to therapeutic communication?**
- Focusing
 - Giving advice
 - Restating
 - Listening
- 6. Which of the following is an ineffective/nontherapeutic communication?**
- Judgmental attitude
 - Silence
 - Focusing
 - Informing
- 7. A relationship that occurs between two individuals who have an emotional commitment to each other is:**
- Social relationship
 - Intimate relationship
 - Therapeutic relationship
 - Distant relationship
- 8. Empathy means:**
- An ability to feel with the patient
 - An ability to put oneself in patient situation
 - An ability to imagine the feelings associated with the experience
 - All of the above
- 9. For a nurse to be able to develop effective communication skills, she should:**
- Be able to communicate effectively with all patients
 - Identify her own beliefs, thoughts and motivations
 - Understand causes of mental disorders
 - Have knowledge of various treatment modalities
- 10. The following is a task of the initial phase in nurse–patient relationship:**
- Encouraging verbalization of feelings
 - Exploring alternate behavior
 - Implementing various interventions
 - Evaluating the plan of action
- 11. In which of the following phases of therapeutic nurse–patient relationship, patient problems are noted and coping skills are identified?**
- PreIntroductory phase
 - Introductory phase
 - Working phase
 - Termination phase
- 12. Unconscious transfer of qualities originally associated with another individual by the patient is called:**
- Transference
 - Countertransference
 - Rapport
 - Empathy
- 13. Unconscious transfer of inappropriate attributes originally associated with another individual by the nurse is called:**
- Transference
 - Countertransference
 - Rapport
 - Empathy
- 14. During interview _____ are used:**
- Close-ended questions
 - Open-ended questions
 - Derogatory questions
 - Critical questions
- 15. Process recording is:**
- A written documentation of patient education
 - A written documentation of patient care
 - A written documentation of verbal interaction with the patient
 - A written documentation of abnormal patient behavior.

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|------|------|------|------|-------|
| 1. d | 2. b | 3. d | 4. a | 5. b | 6. a | 7. b | 8. d | 9. b | 10. a |
| 11. b | 12. a | 13. b | 14. b | 15. c | | | | | |

Chapter 5

Therapeutic Modalities and Therapies used in Mental Disorders

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

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

PHYSICAL THERAPIES

Physical therapies are treatment approaches that use physiologic or physical interventions to effect behavioral change. The most common form of physical therapies are: Psychopharmacology, electroconvulsive therapy, light therapy, repetitive transcranial magnetic stimulation.

PSYCHOPHARMACOLOGY

Psychopharmacology is the study of drugs used to treat psychiatric disorders. It discusses many psychoactive medications that alter synaptic transmission in the brain in certain

and specific ways. Medications that affect psychic function, behavior or experience are called psychotropic medications. They have significant effect on higher mental functions. Psychopharmacological agents are first-line treatment for almost all psychiatric ailments nowadays. With the growing availability of a wide range of drugs to treat mental illness, the nurse practicing in modern psychiatric settings needs to have a sound knowledge of the pharmacokinetics involved, the benefits and potential risks of pharmacotherapy, as well as her own role and responsibility.

Several terms used in discussions of drugs and drug therapy are important for nurses to know.

Efficacy refers to the maximal therapeutic effect that a drug can achieve. **Potency** describes the amount of the drug needed to achieve that maximum effect; low-potency drugs require higher dosages to achieve efficacy, whereas high-potency drugs achieve efficacy at lower dosages.

Half-life is the time it takes for half of the drug to be removed from the bloodstream. Drugs with a shorter half-life may need to be given once a day. Drugs that activate receptors are termed **agonist**, and those that block are termed **antagonists**.

Core Concept

Neurotransmitters are the chemical messengers that travel from one brain cell to

another and are synthesized by enzymes from certain dietary amino acids or precursors. These are stored in the axon terminals of the presynaptic neuron. An electrical impulse through the neuron stimulates the release of the neurotransmitter into the synaptic cleft, which in turn determines whether another electrical impulse is generated (Fig. 5.1).

Receptors are molecules situated on the cell membrane that are binding sites for neurotransmitters. The synapse separates the two neurons (pre- and postsynaptic cells). These neurotransmitters are stored in the vesicles waiting to be released into the synapse. After neurotransmission, they are either reabsorbed (reuptake) and stored by the presynaptic cell for later use or are metabolized (broken down) by enzymes, such as monoamino oxidase (MAO) and cholinesterase (ChE). During neurotransmission, the chemical neurotransmitter released from a storage vesicle in the presynaptic cell crosses the synapse and is recognized by the receptor on

the postsynaptic cell membrane termed as binding (Box 5.1 and Fig. 5.2).

Box 5.1: Drugs affect neurotransmission in several ways

- » Release: More neurotransmitters are released into the synapse from the storage vesicles in presynaptic cell
- » Blockade: The neurotransmitters are prevented from binding to the postsynaptic receptors
- » Receptor sensitivity changes: The receptor becomes more or less responsive to the neurotransmitter
- » Blocked reuptake: As the presynaptic cell does not reabsorb the neurotransmitter, it is retained in the synapse, and therefore, enhances or prolongs the action
- » Interference with storage vesicles: Either released more or less
- » Precursor chain interference: The process that 'makes' the neurotransmitter is either synthesized more or less

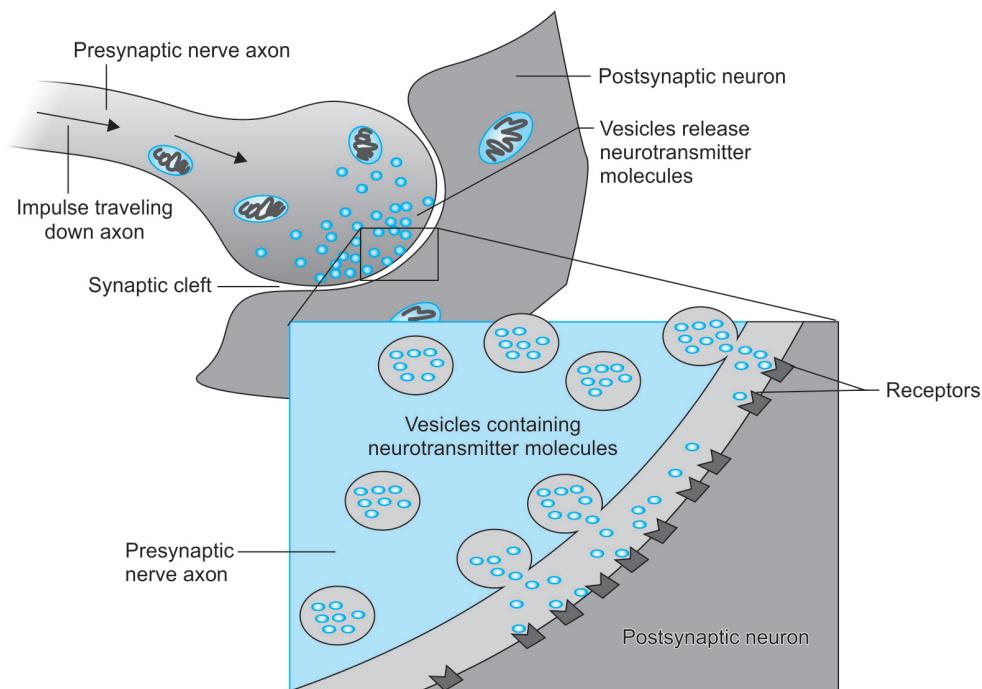


Fig. 5.1: Synapse

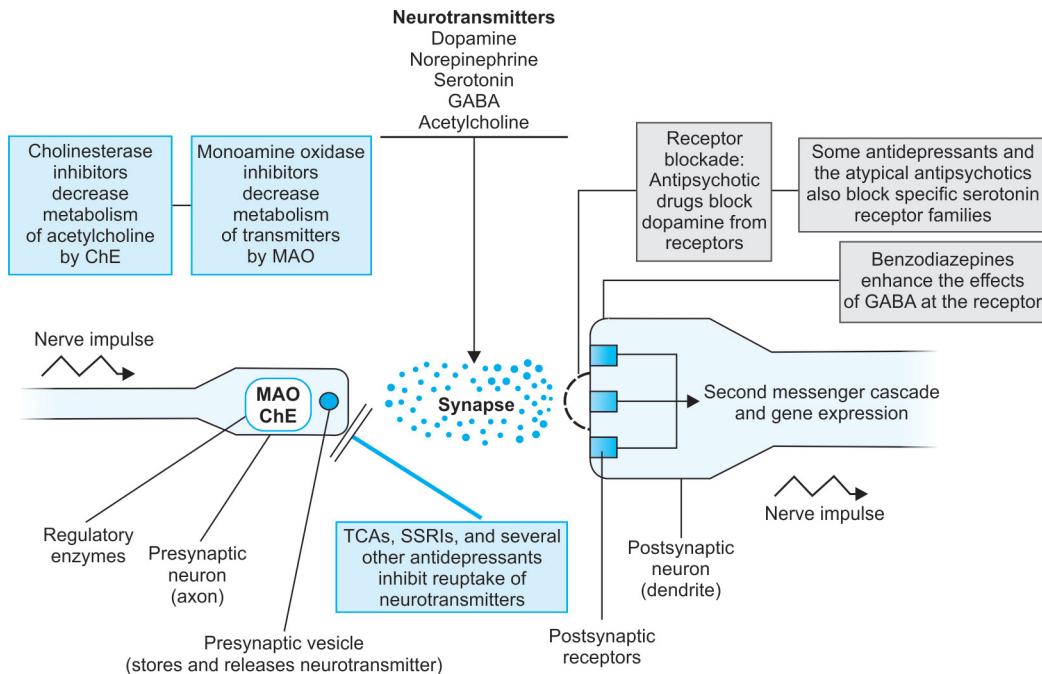


Fig. 5.2: Neurotransmission and drug effects at the synapse

Psychotropic drugs alter synaptic activity by:

- Modifying the reuptake of a neurotransmitter into the presynaptic neuron
- Activating or inhibiting postsynaptic receptors
- Inhibition of enzyme activity.

Biological theories suggest that:

- Many of the psychiatric disorders are caused by dysregulation (imbalance) in the complex process of brain structures communicating with each other through neurotransmission
- Psychosis involves excessive dopamine and serotonin dysregulation. Antipsychotic drugs block dopamine from the receptor site
- Mood disorders result from disruption of normal patterns of neurotransmission of norepinephrine, serotonin and other transmitters. Antidepressants block the

reuptake of norepinephrine or serotonin and regulate the areas of the brain that manufacture these chemicals. Some antidepressants and atypical antipsychotics block specific subtypes of serotonin receptors, thereby enhancing serotonin transmission at serotonin receptors implicated in depression. MAOIs decrease enzymatic metabolism of norepinephrine and serotonin. Cholinesterase inhibitors decrease the metabolism of acetylcholine

- Anxiety to be a dysregulation of GABA and other neurotransmitters. Benzodiazepines enhance the effects of GABA.

General Guidelines regarding Drug Administration in Psychiatry

- The nurse should not administer any drug unless there is a written order. Do

not hesitate to consult the doctor when in doubt about any medication

- All medications given must be charted on the patient's case record sheet
- While giving medication:
 - Always address the patient by name and make certain of his identification
 - Do not leave the patient until the drug is swallowed
 - Do not permit the patient to go to the bathroom to take the medication
 - Do not allow one patient to carry medicine to another.
- If it is necessary to leave the patient to get water, do not leave the tray within the reach of the patient
- Do not force oral medication because of the danger of aspiration. This is especially important in stuporous patients
- Check drugs daily for any change in color, odor and number
- Bottles should be tightly closed and labeled. Labels should be written legibly and in bold lettering. Poison drugs are to be legibly labeled and kept in separate cupboard
- Make sure that an adequate supply of drugs is on hand, but do not overstock
- Make sure no patient has access to the drug cupboard
- Drug cupboards should always be kept locked when not in use. Never allow a patient or worker to clean the drug cupboard. The drug cupboard keys should not be given to patients.

Patient Education related to Psychopharmacology

Nurses assess for drug side effects, evaluate desired effects, and make decisions about prn (pro re nata) medication. Thus, nurses must understand general principles of psychopharmacology and have specific knowledge related to psychotropic drugs.

Teaching patients can decrease the incidence of side effects while increasing compliance with the drug regimen.

Specific areas of education include the following:

- *Discussion of side effects:* Side effects can directly affect the patient's willingness to adhere to the drug regimen. The nurse should always inquire about the patient's response to a drug, both therapeutic responses and adverse responses.
- *Discussion of safety issues:* Because some drugs, such as tricyclic antidepressants, have a narrow therapeutic index, thoughts of self harm must be discussed.
 - Discuss on abruptly discontinued effects
 - Many psychotropic drugs cause sedation or drowsiness, discussions concerning use of hazardous machinery, driving must be reviewed.
- *Drug interactions:* Patients and families must be taught to discuss the effects of the addition of over-the-counter drugs, alcohol and illegal drugs to currently prescribed drugs.
- *Instructions for older adult patients:* Because older individuals have a different pharmacokinetic profile than younger adults, special instructions concerning side effects and drug-drug interactions should be explained.
- *Instructions for pregnant or breastfeeding patients:* As pregnant or breastfeeding patients have special risks associated with psychotropic drug therapy, special instructions should be tailored for these individuals. Teaching patients about their medications enables them to be mature participants in their own care and decreases undesirable side effects. Furthermore, effective teaching can reduce noncompliance (Box 5.2).

Box 5.2: Common reasons for patients not taking medication as prescribed

- » Side effects
- » Emotional dulling
- » Cognitive slowing
- » Sexual dysfunction
- » Denial of need
- » Fear of becoming addicted
- » Interference with work
- » Illness (suspiciousness)
- » Inability to use alcohol or other recreational drugs
- » Busy lifestyle
- » Duration of treatment

Classification of Psychotropic Drugs

1. Antipsychotics
2. Antidepressants
3. Mood stabilizing drugs
4. Anxiolytics and hypnotics
5. Antiepileptic drugs
6. Antiparkinsonian drugs
7. Miscellaneous drugs which include stimulants, drugs used in eating disorders, drugs used in de-addiction, drugs used in child psychiatry, vitamins, calcium channel blockers, etc.

ANTIPSYCHOTICS

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

Antipsychotic medications cannot 'cure' the illness, but they can take away many of the symptoms or make them milder. In some cases, they can shorten the course of an episode of the illness as well.

The first antipsychotic medications were introduced in the 1950s. Antipsychotic medications have helped many patients with

psychosis lead a more normal and fulfilling life by alleviating psychotic symptoms. The early antipsychotic medications often have unpleasant side effects such as muscle stiffness, tremor and abnormal movements, leading researchers to continue their search for better drugs. The 1990s saw the development of several new drugs for schizophrenia, called "atypical antipsychotics." Because they have fewer side-effects than the older drugs, today they are often used as a first-line treatment.

In clinical trials, atypical antipsychotics were found to be more effective than conventional or "typical" antipsychotic medications in individuals with treatment-resistant schizophrenia (schizophrenia that has not responded to other drugs), and the risk of tardive dyskinesia (a movement disorder) was lower. Commonly used atypical antipsychotics are clozapine, risperidone, aripiprazole, olanzapine, quetiapine, ziprasidone, amisulpride and paliperidone. Each has a unique side effect profile, but in general, these medications are better tolerated than the earlier drugs.

Classification

See Table 5.1.

Indications

- **Organic psychiatric disorders**
 - Delirium
 - Dementia
 - Delirium tremens
 - Drug-induced psychosis and other organic mental disorders.
- **Functional disorders**
 - Schizophrenia
 - Schizoaffective disorders
 - Paranoid disorders.
- **Mood disorders**
 - Mania
 - Major depression with psychotic symptoms.

Table 5.1: Classification of antipsychotic drugs

Class	Examples of drugs	Trade name	Oral dose mg/day	Parenteral dose (mg)
Phenothiazines	Chlorpromazine	Megatil	300–1500	50–100
		Largactil		IM only
		Tranchlor		
	Triflupromazine	Siquil	100–400	30–60 IM only
	Thioridazine	Thioril, Melleril	300–800	-
		Ridazin		
	Trifluoperazine	Espazine	15–60	1–5 IM
	Fluphenazine decanoate	Prolinate	-	25–50 IM every 1–3 weeks
Thioxanthenes	Flupenthixol	Fluanxol	3–40	
Butyrophenones	Haloperidol	Senorm, Serenace	5–100	5–20 IM
		Relinace		-
Diphenylbutyl	Pimozide	Orap	4–20	
Piperidines	Penfluridol	Flumap	20–60 weekly	-
Indolic derivatives	Molindone	Mobam	50–225	-
Dibenzoxazepines	Loxapine	Loxapac	25–100	-
Atypical antipsychotics	Clozapine	Sizopin, Lozapin	50–450	-
	Risperidone	Sizodon, Sizomax	2–10	-
	Olanzapine	Oleanz	10–20 mg	-
	Quetiapine	Qutan	150–750 mg	-
	Ziprasidone	Zisper	20–80 mg	-
Others	Reserpine	Serpasil	0.5–50	-

- **Childhood disorders**

- Attention-deficit hyperactivity disorder
- Autism
- Enuresis
- Conduct disorder.

- **Neurotic and other psychiatric disorders**

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

- **Medical disorders**

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

Pharmacokinetics

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

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

Mechanism of Action

Antipsychotic drugs block D2 receptors in the mesolimbic and mesofrontal systems (concerned with emotional reactions). Sedation is caused by alpha-adrenergic blockade. Antidopaminergic actions on basal ganglia are responsible for causing EPS (Extrapyramidal Symptoms) (Fig. 5.3).

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

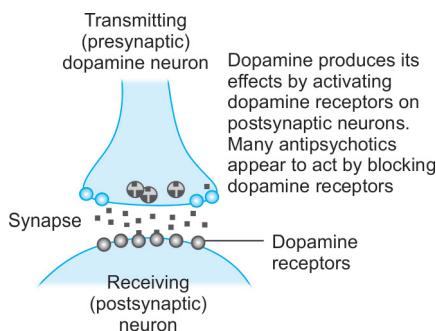


Fig. 5.3: Dopamine neurotransmission and drug effects at the synapse

Adverse Effects of Antipsychotic Drugs

- **Extrapyramidal symptoms (EPS):** These are serious neurologic symptoms and major side effects of antipsychotic drugs. Blockade of D2 receptors in the midbrain region of the brain stem is responsible for the development of EPS. Conventional antipsychotic drugs cause a greater incidence of EPS than do atypical antipsychotic drugs.

- *Neuroleptic-induced parkinsonism:* Symptoms include rigidity, tremors, bradykinesia, stooped posture, drooling, akinesia, ataxia, etc. The disorder can be treated with anticholinergic agents.
- *Acute dystonia:* Dystonic movements result from a slow sustained muscular spasm that lead to an involuntary movement. Dystonia can involve the neck, jaw, tongue and the entire body (opisthotonus). There is also involvement of eyes leading to upward lateral movement of the eye known as oculogyric crisis. Dystonias can be prevented by anticholinergics, antihistaminergics, dopamine agonists, beta-adrenergic antagonists, benzodiazepines, etc.
- *Akathisia:* Akathisia is a subjective feeling of muscular discomfort that can cause patients to be agitated, restless and feel, generally, dysphoric. Akathisia can be treated with propranolol, benzodiazepines and clonidine.
- *Tardive dyskinesia:* It is a delayed adverse effect of antipsychotics. It consists of abnormal, irregular choreoathetoid movements of the muscles of the head, limbs and trunk. It is characterized by chewing, sucking, grimacing and perioral movements.
- *Neuroleptic malignant syndrome:* This is a rare but serious disorder occurring in a small minority of patients taking neuroleptics, especially high-potency compounds.

The onset is often, but not invariably in the first 10 days of treatment. The clinical picture includes the rapid onset (usually over 24–72 hours) of severe motor, mental and autonomic disorders. The prominent motor symptom is generalized muscular hypertonicity. Stiffness of the muscles in the throat and chest may cause dysphasia, and dyspnea. The mental symptoms include akineticmutism, stupor or impaired consciousness. Hyperpyrexia develops with evidence of autonomic disturbances in the form of unstable blood pressure, tachycardia, excessive sweating, salivation, and urinary incontinence. In the blood, creatine phosphokinase (CPK) levels may be raised to very high levels, and the white cell count may be increased. Secondary features may include pneumonia, thromboembolism, cardiovascular collapse, and renal failure. The syndrome lasts for one to two weeks after stopping the drug.

(Refer Chapter 13, Page 322 for management of Neuroleptic Malignant Syndrome)

- **Autonomic side-effects:** Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence and impaired ejaculation.

- **Seizures**

- **Sedation**

- **Other effects**

- Agranulocytosis (especially for clozapine)
- Sialorrhea or increased salivation (especially for clozapine)
- Weight gain
- Jaundice
- Dermatological effects (contact dermatitis, photosensitive reaction)

Side Effects of Atypical Antipsychotics

Atypical antipsychotics have lower incidence of tardive dyskinesia, increase the risk of cardiovascular disease, hyperglycemia and diabetes; sexual side effects are impaired sexual performance with the main difficulties

being failure to ejaculate. In females, there may be abnormal menstrual cycles and infertility. In both, males and females, the breast may become enlarged and a fluid sometimes oozes from the nipples. Risperidone and paliperidone cause a high increase in prolactin levels.

Nurse's Responsibility for a Patient Receiving Antipsychotics

- Instruct the patient to take sips of water frequently to relieve dryness of mouth. Frequent mouth washes, use of chewing gum, applying glycerine on the lips are also helpful.
- A high-fiber diet, increased fluid intake and laxatives, if needed, help to reduce constipation.
- Advise the patient to get up from the bed or chair very slowly. Patient should sit on the edge of the bed for one full minute dangling his feet, before standing up. Check BP before and after medication is given. This is an important measure to prevent falls and other complications resulting from orthostatic hypotension.
- Differentiate between akathisia and agitation and inform the physician. A change of drug may be necessary if side-effects are severe. Administer antiparkinsonian drugs as prescribed.
- Observe the patient regularly for abnormal movements.
- Take all seizure precautions.
- Patient should be warned about driving a car or operating machinery when first treated with antipsychotics. Giving the entire dose at bedtime usually eliminates any problem from sedation.
- Advise the patient to use sunscreen measures (use of full sleeves, dark glasses, etc.) for photosensitive reactions.
- Teach the importance of drug compliance, side-effects of drugs and reporting if too severe, regular follow-ups. Give reassurance and reduce unfounded fears and anxieties.

- A patient receiving clozapine is at risk for developing agranulocytosis. Monitor TC, DC essentially in the first few weeks of treatment. Stop the drug if the WBC count drops to less than 3000/mm³ of blood. The patient should also be told to report if sore throat or fever develop, which might indicate infection.
- Seizure precautions should also be taken as clozapine reduces seizure threshold. The dose should be regulated carefully and the patient may also be put on anticonvulsants, such as eptoin. (See Appendix 21 for Drug Guide).

ANTIDEPRESSANTS

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

Classification

See Table 5.2.

Indications

- Depression**
 - Depressive episode
 - Dysthymia
 - Reactive depression
 - Secondary depression
 - Abnormal grief reaction.
- Childhood Psychiatric Disorders**
 - Enuresis
 - Separation anxiety disorder
 - Somnambulism
 - School phobia
 - Night terrors.
- Other Psychiatric Disorders**
 - Panic attack
 - Generalized anxiety disorder
 - Agoraphobia, social phobia
 - OCD with or without depression
 - Eating disorder
 - Borderline personality disorder
 - Post-traumatic stress disorder
 - Depersonalization syndrome

Table 5.2: Classification of antidepressants

Class	Examples of drugs	Trade names	Oral dosage (mg/day)
Tricyclic antidepressants (TCAs)	Imipramine	Antidep	75–300
	Amitriptyline	Tryptomer	75–300
	Clomipramine	Anafranil	75–300
	Dothiepin	Prothiaden	75–300
	Mianserin	Depnon	30–120
Selective serotonin reuptake inhibitors (SSRIs)	Fluoxetine	Fludac	10–80
	Sertraline	Serenata	50–200
Dopaminergic antidepressants	Fluvoxamine	Faverin	50–300
Atypical antidepressants	Amineptine	Survector	100–400
Monoamine oxidase inhibitors (MAOIs)	Trazodone	Trazalon	150–600
	Isocarboxazid	Marplan	10–30

- Medical Disorders
 - Chronic pain
 - Migraine
 - Peptic ulcer disease.

Pharmacokinetics

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

Mechanism of Action

The exact mechanism is unknown. The predominant action is by increasing catecholamine levels in the brain. TCAs are also called as mono amine reuptake inhibitors (MARIs). The main mode of action is by blocking the reuptake of norepinephrine (NE) and/or serotonin (5-HT) at the nerve terminals, thus increasing the NE and 5-HT levels at the receptor site.

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

SSRIs act by inhibiting the re-uptake of serotonin and increasing its levels at the receptor site (Fig. 5.4).

Side Effects

- Autonomic side effects:** Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence, impaired ejaculation, delirium and aggravation of glaucoma.
- CNS effects:** Sedation, tremor and other extrapyramidal symptoms, withdrawal syndrome, seizures, jitteriness syndrome, precipitation of mania.

- Cardiac side effects:** Tachycardia, ECG changes, arrhythmias, direct myocardial depression, quinidine-like action (decreased conduction time).
- Allergic side effects:** Agranulocytosis, cholestatic jaundice, skin rashes, systemic vasculitis.
- Metabolic and endocrine side effects:** Weight gain.
- Special effects of MAOI drugs:** Hypertensive crisis, severe hepatic necrosis, hyperpyrexia.

Nurse's Responsibility for a Patient Receiving Antidepressants

Most of the nurse's responsibilities for a patient on antidepressants are the same as for a patient receiving antipsychotics (See page 127). In addition:

- Patients on MAOIs should be warned against the danger of ingesting tyramine-rich foods which can result in hypertensive crisis. Some of these foods are beef liver, chicken liver, fermented sausages, dried fish, overripe fruits, chocolate and beverages like wine, beer and coffee

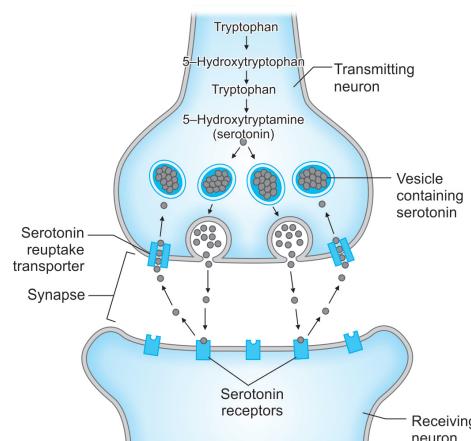


Fig. 5.4: Serotonin neurotransmission and drug effects at the synapse

- Report promptly if occipital headache, nausea, vomiting, chest pain or other unusual symptoms occur; these can herald the onset of hypertensive crisis
- Instruct the patient not to take any medication without prescription
- Caution the patient to change his position slowly to minimize orthostatic hypotension
- Strict monitoring of vitals, especially blood pressure is essential
(See Appendix 21 for Drug Guide).

LITHIUM AND OTHER MOOD STABILIZING DRUGS

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

- Lithium
- Carbamazepine
- Sodium valproate.

Lithium

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

Indications

- Acute mania
- Prophylaxis for bipolar and unipolar mood disorder
- Schizoaffective disorder
- Cyclothymia
- Impulsivity and aggression
- Other disorders:
 - Premenstrual dysphoric disorder
 - Bulimia nervosa
 - Borderline personality disorder
 - Episodes of binge drinking
 - Trichotillomania
 - Cluster headaches

Pharmacokinetics

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

Mechanism of Action

The probable mechanisms of action can be:

- Accelerates presynaptic reuptake and destruction of catecholamines, like norepinephrine
- Inhibits the release of catecholamines at the synapse
- Decreases postsynaptic serotonin receptor sensitivity

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

Dosage

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

- Lithium carbonate: 300 mg tablets (e.g. Licab); 400 mg sustained release tablets (e.g. Lithosun-SR)
- Lithium citrate: 300 mg/5 mL liquid
The usual range of dose per day in acute mania is 900–2100 mg given in 2–3 divided doses. The treatment is started after serial lithium estimation is done after a loading dose of 600 mg or 900 mg of lithium to determine the pharmacokinetics.

Blood Lithium Levels

- Therapeutic levels = 0.8–1.2 mEq/L (for treatment of acute mania)

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

Side Effects

1. **Neurological:** Tremors, motor hyperactivity, muscular weakness, cogwheel rigidity, seizures, neurotoxicity (delirium, abnormal involuntary movements, seizures, coma).
2. **Renal:** Polydipsia, polyuria, tubular enlargement, nephrotic syndrome.
3. **Cardiovascular:** T-wave depression.
4. **Gastrointestinal:** Nausea, vomiting, diarrhea, abdominal pain and metallic taste.
5. **Endocrine:** Abnormal thyroid function, goiter and weight gain.
6. **Dermatological:** Acneiform eruptions, papular eruptions and exacerbation of psoriasis.
7. **Side-effects during pregnancy and lactation:** Teratogenic possibility, increased incidence of Ebstein's anomaly (distortion and downward displacement of tricuspid valve in right ventricle) when taken in first trimester. Secreted in milk and can cause toxicity in infant.
8. **Lithium toxicity:** Toxicity occurs when serum lithium level >2.0 mEq/L (Box 5.3).

Box 5.3: Signs and symptoms of lithium toxicity (serum lithium level >2.0 mEq/L)

- » Ataxia
- » Coarse tremor (hand)
- » Nausea and vomiting
- » Impaired memory
- » Impaired concentration
- » Nephrotoxicity
- » Muscle weakness
- » Convulsions
- » Muscle twitching
- » Dysarthria
- » Lethargy
- » Confusion
- » Coma
- » Hyper-reflexia
- » Nystagmus

Management of Lithium Toxicity

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

Contraindications of Lithium Use

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

Nurse's Responsibilities for a Patient Receiving Lithium

The pre-lithium work up: A complete physical history, ECG, blood studies (TC, DC, FBS, BUN, creatinine, electrolytes) and urine examination (routine and microscopic) must be carried out. It is important to assess renal function as renal side effects are common and the drug can be dangerous in an individual with compromised kidney function. Thyroid functions should also be assessed, as the drug is known to depress the thyroid gland.

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

- Lithium must be taken on a regular basis, preferably at the same time daily (for

example, a patient taking lithium on TID schedule, who forgets a dose should wait until the next scheduled time to take lithium and not take twice the amount at one time as it can lead to lithium toxicity)

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

six months, blood sample should be taken for estimation of electrolytes, urea, creatinine, a full blood count, and thyroid function test.

Carbamazepine

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

Indications

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

Dosage

The average daily dose is 600–1800 mg orally, in divided doses. The therapeutic blood levels are 6–12 µg/mL. Toxic blood levels are attained at more than 15 µg/mL.

Mechanism of Action

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

Side Effects

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

Nurse's Responsibilities

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

Sodium Valproate (Encorate Chrono, Valparin, Epilex, Epival)

Indications

- Acute mania, prophylactic treatment of bipolar I disorder, rapid cycling bipolar disorder
- Schizoaffective disorder
- Seizures
- Other disorders like bulimia nervosa, obsessive-compulsive disorder, agitation and PTSD.

Mechanism of Action

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

Dosage

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

Side Effects

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

Nurse's Responsibilities

- Advise the patient to take the drug immediately after food to reduce GI irritation

- Advise regular follow-up and periodic examination of blood count, hepatic function and thyroid function. Therapeutic serum level of valproic acid is 50–100 micrograms/mL.

ANXIOLYTICS (ANTI-ANXIETY DRUGS) AND HYPNOSEDATIVES

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

Classification

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

Indications for Benzodiazepines

- Anxiety disorders
- Insomnia
- Depression
- Panic disorder and social phobia
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Bipolar I disorder

- Other psychiatric indications include alcohol withdrawal, substance-induced and psychotic agitation.

Dosage (mg/day)

- Alprazolam: 0.5–6 PO
- Oxazepam: 15–120 PO
- Lorazepam: 2–6 PO/IV/IM
- Diazepam: 2–10 PO/IM/ slow IV
- Clonazepam: 0.5–20 PO/IM
- Chlordiazepoxide: 15–100 PO; 50–100 slow IV
- Nitrazepam: 5–20 PO.

Mechanism of Action

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

Side Effects

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

Nurse's Responsibility in the Administration of Benzodiazepines

- Administer with food to minimize gastric irritation
- Advise the patient to take medication exactly as directed. Abrupt withdrawal may cause insomnia, irritability and sometimes even seizures
- Explain about adverse effects and advise him to avoid activities that require alertness
- Caution the patient to avoid alcohol or any other CNS depressants along with benzodiazepines; also instruct him not to take any over-the-counter (OTC) medications

- If IM administration is preferred give deep IM
- For IV administration do not mix with any other drug. Give slow IV as respiratory or cardiac arrest can occur; monitor vital signs during IV administration. Prevent extravasations, since it can cause phlebitis and venous thrombosis.
(See Appendix 21 for Drug Guide)

ANTIPARKINSONIAN AGENTS

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

Anticholinergics

- Trihexyphenidyl
- Benztropine
- Biperiden.

Dopaminergic Agents

- Bromocriptine
- Carbidopa/Levodopa.

Monoamine Oxidase Type B Inhibitors

- Selegiline.

Trihexyphenidyl (Artane, Trihexane, Trihexy, Pacitane)

Indications

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

Mechanism of Action

It acts by increasing the release of dopamine from presynaptic vesicles, blocking the

reuptake of dopamine into presynaptic nerve terminals or by exerting an agonist effect on postsynaptic dopamine receptors. Trihexyphenidyl reaches peak plasma concentrations in 2–3 hours after oral administration and has duration of action up to 12 hours.

Dosage

1–2 mg/day orally initially, maximum dose up to 15 mg/day in divided doses.

Side Effects

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

Nurse's Responsibilities

- Assess parkinsonian and extrapyramidal symptoms. Medication should be tapered gradually
- Caution patient to make position changes slowly to minimize orthostatic hypotension
- Instruct the patient about frequent rinsing of mouth and good oral hygiene
- Caution patient that this medication decreases perspiration, and over-heating may occur during hot weather.

ANTABUSE DRUGS

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

(Refer Chapter 9, Page 247 for a detailed description on disulfiram).

ANTI-CRAVING DRUGS

Through detoxification process the withdrawal symptoms of a particular type of drug or chemical are managed as the toxins from the

drug are removed from the body. The removal of the drug from the body is accompanied by cravings—physical, psychological and emotional. A number of stimuli can put off a craving response within the brain. Anti-craving drugs seem to work by blocking the receptors associated with cues that set off relapse. Several different addictions (alcoholism, opiate addiction, nicotine addiction and cocaine addiction) are being treated with use of anti-craving medications after detoxification. These drugs are used to help prevent relapse both during the detox phase and in early recovery phase. Commonly used anti-craving drugs are Naltrexone, Naloxone, Subutex, Topiramate, Baclofen, Acamprosate, Methadone, Neurontin, etc.

DRUGS USED IN CHILD PSYCHIATRY

Clonidine

Indications

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

Mechanism of Action

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

Dosage

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

Side Effects

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

Nurse's Responsibility

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

Methylphenidate (Ritalin)

Methylphenidate, dextroamphetamine and pemoline are sympathomimetics.

Indications

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

Mechanism of Action

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

Dosage

Starting dose is 5–10 mg/day orally, maximum daily dose is 80 mg/day.

Side Effects

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

Nurse's Responsibilities

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

GERIATRIC CONSIDERATIONS

Elderly are more sensitive to drugs due to age-related changes in the brain. These are

changes in the receptor availability (due to neuronal death) and sensitivity and changes in neural membrane properties. Further, pharmacokinetics are also altered due to changes in absorption (high gastric pH, reduced absorptive surface, reduced intestinal motility) and distribution (blood flow, alterations, decreased total body water, metabolism and excretion). High potency neuroleptics are preferred in small doses. Antidepressants are safer to start in small doses and maintain on low doses.

ELECTROCONVULSIVE THERAPY

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

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

Parameters of Electrical Current Applied

Standard dose according to American Psychiatric Association, 1978:

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

Type of Seizure Produced

- Grandmal seizure—tonic phase lasting for 10–15 seconds
- Clonic phase lasting for 30–60 seconds.

Mechanism of Action

The exact mechanism of action is not known. One hypothesis states that ECT possibly

affects the catecholamine pathways between diencephalon (from where seizure generalization occurs) and limbic system (which may be responsible for mood disorders), also involving the hypothalamus.

Types of ECT

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

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

Frequency and Total Number of ECT

Frequency: Three times per week or as indicated.

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

Application of Electrodes

Bilateral ECT: Each electrode is placed 2.5–4 cm (1–1½ inch) above the midpoint, on a line joining the tragus of the ear and the lateral canthus of the eye.

Unilateral ECT: Electrodes are placed only on one side of head, usually non-dominant side (right side of head in a right-handed individual) (Fig. 5.5).

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

Indications

- **Major depression:** With suicidal risk; stupor; poor intake of food and fluids; melancholia with psychotic features; unsatisfactory response to drugs or where drugs are contraindicated or have serious side effects.
- **Severe catatonia (functional):** With stupor; poor intake of food and fluids;

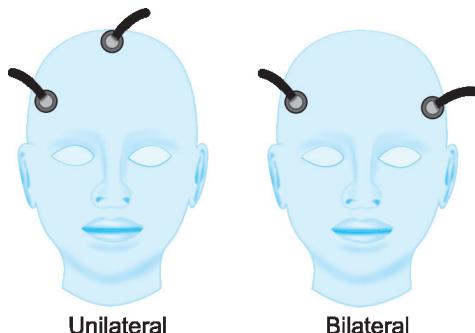


Fig. 5.5: Application of ECT electrodes

unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side effects.

- **Severe psychosis (schizophrenia or mania):** With risk of suicide, homicide or danger of physical assault; depressive features; unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side effects.
- **Organic mental disorders:**
 - Organic mood disorders
 - Organic psychosis
- **Other indications:** ECT is preferred to antidepressant therapy in some cases, such as for patients with cardiac disease; when tricyclics are contraindicated because of the potential for dysrhythmias and congestive heart failure; and for pregnant women, in whom antidepressants place the fetus at risk for congenital defects.

Contraindications

- Absolute
 - Raised ICP (intracranial pressure)
- Relative
 - Cerebral aneurysm
 - Cerebral hemorrhage
 - Brain tumor
 - Acute myocardial infarction
 - Congestive heart failure

- Pneumonia or aortic aneurysm
- Retinal detachment.

Complications of ECT

Life-threatening complications of ECT are rare. ECT does not cause any brain damage. Fractures can sometimes occur in elderly patients with osteoporosis. In patients with a history of heart disease, dysrhythmias and respiratory arrest may occur.

Side Effects of ECT

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

ECT Team

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

Treatment Facilities

There should be a suite of three rooms:

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

Role of the Nurse

Pre-treatment Evaluation

- Detailed medical and psychiatric history, including history of allergies
- Assessment of patients' and families knowledge of indications, side-effects, therapeutic effects and risks associated with ECT
- An informed consent should be taken. Allay any unfounded fears and anxieties regarding the procedure
- Assess baseline vital signs
- Patient should be on empty stomach for 4–6 hours prior to ECT
- Withhold night doses of drugs which increase seizure threshold like diazepam, barbiturates and anticonvulsants
- Withhold oral medications in the morning
- Head shampooing in the morning since oil causes impedance of passage of electricity to brain
- Any jewellery, prosthesis, dentures, contact lens, metallic objects and tight clothing should be removed from the patient's body
- Empty bladder and bowel just before ECT
- Administration of 0.6 mg atropine IM or SC 30 minutes before ECT, or IV just before ECT.

Intra-procedure Care

- Place the patient comfortably on the ECT table in supine position
- Stay with the patient to allay anxiety and fear
- Assist in administering the anesthetic agent (thiopental sodium 3–5 mg/kg body weight) and muscle relaxant (1 mg/kg body weight of succinylcholine)
- Since the muscle relaxant paralyzes all muscles including respiratory muscles, patent airway should be ensured and ventilatory support should be started
- Mouth gag should be inserted to prevent possible tongue bite

- The place(s) of electrode placement should be cleaned with normal saline or 25% bicarbonate solution, or a conducting gel applied
- Monitor voltage, intensity and duration of electrical stimulus given.
- Monitor seizure activity using cuff method
- 100 percent oxygen should be provided.
- During seizure monitor vital signs, ECG, oxygen saturation, EEG, etc.
- Record the findings and medicines given in the patient's chart.

Post-procedure Care

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

LIGHT THERAPY

Light therapy, sometimes called phototherapy, involves exposing the patient to an artificial light source during winter months to relieve seasonal depression. The light source must be very bright, full-spectrum light, usually 2,500 lux.

Indications

- Bulimia
- Sleep maintenance insomnia
- Seasonal depression.

Adverse Effects

- Nausea
- Eye irritation
- Headache.

Contraindications

- Glaucoma
- Cataract
- Use of photosensitizing medications.

Nurse's Role

The patient is instructed to sit in front of the light at a distance of about 3 feet, engaging in a variety of other activities, but glancing directly into the light every few minutes. The duration of administration is 1–2 hours daily.

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION

Transcranial Magnetic Stimulation (TMS) or Repetitive Transcranial Magnetic Stimulation (RTMS) produces a magnetic field over the brain, influencing brain activity. Apparently, TMS increases the release of neurotransmitters and downregulates beta-adrenergic receptors, thus ameliorating depressive symptoms and other disorders. Because TMS does not require anesthesia, it is an attractive alternative to ECT if conclusive evidence of its efficacy can be demonstrated. Some studies have suggested that it is as effective as ECT in non-psychotic patients. Adverse effects include seizures in previously seizure-free individuals, headache, and transient hearing loss. Patients with metal implanted in their bodies (for example, plates), pacemakers, heart disease or increased intracranial pressure should be carefully evaluated before receiving TMS.

THERAPEUTIC COMMUNITY

The concept of therapeutic community was first developed by Maxwell Jones in 1953.

He wrote a book entitled "Social Psychiatry" which was first published in England. Later on, when it was published in the United States, its title was changed to "Therapeutic Community."

Definition

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

Objectives

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

Elements of Therapeutic Community

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

Components of Therapeutic Community

Daily Community Meetings

- These meetings are composed of 60–90 patients. All levels of unit staff are involved,

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

Patient Government or Ward Council

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

Staff Meetings or Review

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

Living and Learning Opportunities

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

Advantages of Therapeutic Community

- Patient develops harmonious relationships with other members of the community
- Gains self-confidence

- Develops leadership skills
- Learns to understand and solve problems of self and others
- Becomes sociocentric
- Learns to live and think collectively with the members of the community
- Lastly, therapeutic community provides opportunities to participate in the formulation of hospital rules and regulations that affect patient's personal liberties like bedtime, meal time, weekend permission, control of radio or TV, social activities, late night privileges, etc.

Disadvantages of Therapeutic Community

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

Role of the Nurse

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

In conclusion, therapeutic community is an approach which is:

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

PSYCHOTHERAPY

Psychotherapy has been referred to as a systemic treatment primarily employing

Table 5.3: Types of psychotherapy

<i>Dimension</i>	<i>Types</i>
Depending on the number of patients taking part	» Individual psychotherapy
	» Group psychotherapy
Depending on the duration of treatment	» Long-term psychotherapy
	» Short-term psychotherapy
Depending on the depth of exploration	» Supportive psychotherapy
	» Deep psychotherapy
Depending on the amount of responsibility given to the patient	» Directive therapy
	» Non-directive therapy
Depending on the nature of the group	» Family therapy
	» Marital therapy
	» Group therapy
	» Therapy with children and adolescents, etc.

verbal communication as the means of treatment aimed at relieving the patient's symptoms and helping him to understand and modify his conduct so as to lead a well-adjusted life (Table 5.3).

PSYCHOANALYTIC THERAPY

Psychoanalysis was first developed by Sigmund Freud at the end of the 19th century. The most important indication for psychoanalytical therapy is the presence of long-standing mental conflicts, which may be unconscious but produce symptoms. In psychoanalysis, the focus is on the cause of the problem, which is buried somewhere in the unconscious. The therapist tries to take the patient into the past in an effort to determine where the problem began. The aim of the therapy is to bring all repressed material to conscious awareness so that the patient can work towards a healthy resolution of his problems, which are causing the symptoms.

Therapy Process

It is typical for the psychoanalyst to be positioned at the head of the patient and slightly behind, so that the patient cannot see the

therapist. This decreases any kind of non-verbal communication between the two people. The patient is typically on the couch, relaxed, and ready to focus on the therapist's instruction, which facilitates free association. The roles of the patient and psychoanalyst are explicitly defined by Freud. The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. The psychoanalyst is a shadow-person. He reveals nothing personal, nor does he give any directions to the patient. His verbal responses are for the most part brief and non-committal, so as not to interfere with the associative flow. He departs from this style of communication when an interpretation of behavior is made to the patient.

Some of the techniques used in psychoanalysis are free association, dream analysis, hypnosis, catharsis and abreaction therapy.

Free Association

In free association, the patient is allowed to say whatever comes to his mind, in response to a word that is given by the therapist. For example, the therapist might say 'mother' or 'blue' and the patient would give a response, also typically one word, to each of the words the therapist

says. The therapist then looks for a theme or pattern to the patient's responses. So, if the patient responds 'evil' to the word 'mother' or 'dead' to the word 'blue' the therapist might pick up one potential theme, but if the patient responds 'kind' and 'true' to the words 'mother' and 'blue' respectively, the therapist might hear a completely different theme. The theme may give the therapist an idea of the cause of the patient's emotional disturbance.

Dream Analysis

Freud believed that behavior is rooted in the unconscious and that dreams are a manifestation of the troubles people repress, the better way to get an idea of the problem is to monitor and interpret dreams. The patient is asked to keep a dream log. Analysis of the patient's dreams helps to gain additional insight into his problem and the resistances. Thus, dreams symbolically communicate areas of intrapsychic conflict. The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation. The process is complicated by the occurrence of transference reactions. This refers to the patient's development of strong positive or negative feelings towards the analyst, and they represent the patient's past response to a significant other, usually a parent. The therapist's reciprocal response to the patient is called countertransference. Such reactions must be handled appropriately before progress can be made. By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is also able to relate to others uninhibited by neurotic conflicts. Psychoanalytical therapy is a long-term proposition. The patient is seen frequently, usually five times a week. It is, therefore, time-consuming and expensive.

Hypnosis

Hypnosis is an artificially induced state in which the person is relaxed and usually

suggestible. The relaxation is guided by the therapist. Hypnosis is a means for entering an altered state of consciousness and in this state using visualization and suggestion to bring about desired changes in behavior and thinking. Hypnosis can be induced in many ways such as by using a fixed point for attention, rhythmic monotonous instructions, etc.

In hypnotherapy, relaxation is guided by the therapist who has been trained in techniques of trance formation and who then asks certain questions of the patient or uses guided imagery to help picture the situation in an effort to find the cause of the problem. At the end of the session, the therapist leaves some helpful hints for the patients. These are called posthypnotic suggestions and typically include positive, affirming statements for the patient to think about as well as instructions to help the person accomplish self-hypnosis.

Catharsis

Catharsis is, "the act of purging or purification or elimination of a complex by bringing it to consciousness and affording to expression". In psychoanalysis, the therapist helps the person see the root of the problem and then, by talking or some other means, allows the patient to learn to evacuate this problem from the psyche. This can take place in conjunction with other form of psychoanalysis.

These therapies are undertaken on a one-to-one basis between patient and the therapist. The nurse can be helpful in the treatment process by allowing the patient to talk about the experiences in therapy and by carefully documenting the responses of the patient.

Abreaction Therapy

Abreaction is a process by which repressed material, particularly a painful experience or conflict is brought back to consciousness. The person not only recalls but also relives the material, which is accompanied by the

appropriate emotional response. It is most useful in acute neurotic conditions caused by extreme stress (post-traumatic stress disorder, hysteria, etc.).

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

Method

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

INDIVIDUAL PSYCHOTHERAPY

Individual psychotherapy is a method of bringing about change in a person by exploring his or her feelings, attitudes, thinking and behavior.

Therapy is conducted on a one-to-one basis, i.e. the therapist treats one patient at a time. Patients generally seek this kind of therapy based on their desire. Such therapy helps to:

- Understand themselves and their behavior
- Make personal changes
- Improve interpersonal relationships
- Get relief from emotional pain or unhappiness.

Indications

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

Therapy Process

The patient is encouraged to discover for himself the reasons for his behavior. The

therapist listens to the patient and offers explanation and advice when necessary. By this he helps the patient to come to a greater understanding of self and to find a way of dealing with his problems. The relationship between the patient and the therapist proceeds through stages similar to those of the nurse-patient relationship: introduction, working and termination.

Approaches

There are four main approaches to individual therapy which include psychodynamic therapy, humanistic therapy, behavioral therapy and cognitive therapy.

Psychodynamic therapy is primarily based on psychoanalytic theory, the assumption that when a patient has insight into early relationships and experiences as the source of his or her problems they can be resolved.

Humanistic therapy centers on the patients view of the world and his or her problems. The goal is to help patients realize their full potential through the therapist's genuineness, unconditional positive regard, which fosters the patient's sense of self-worth and empathetic understanding of the patient's point of view. This therapy is nondirective but focuses on helping the patient to explore and clarify his or her own feelings and choices.

Behavior therapy does not foster awareness but emphasizes the principles of learning with positive or negative reinforcement and observational modeling.

Cognitive therapy focuses on identifying and correcting distorted thinking patterns that can lead to emotional distress and problem behaviors. Cognitive therapists believe that patients change their behaviors by changing their maladaptive thinking about themselves and their experiences. Patients are taught problem-solving skills and stress reducing methods. They learn that their psychological difficulties or problems can be solved through cognitive processing.

COGNITIVE THERAPY

Cognitive therapy is a psychotherapeutic approach based on the idea that behavior is secondary to thinking. It focuses on how patients think about themselves and their world, make changes in current ways of thinking and behavior.

Fundamental Assumptions

- Cognitive therapy is based on the premise that the way a person perceives an event, rather than the event itself, determines its relevance and the emotional response to it.
- It is time limited, attempting to cause change rapidly and often within an established time frame.
- Therapeutic change can be effected through an alteration of idiosyncratic, dysfunctional modes of thinking, leading to cognitive change.
- These therapies are based on the belief that patients are the architects of their own misfortune and have control over their thoughts and actions.
- They do not help the patient only to overcome the problem for which he or she is seeking help, they also help the patient learn something about the process of therapy and develop therapeutic skills applicable to other problems.
- Cognitive therapy aims at altering the cognitions for effecting a change in behavior.
- It implies that all psychiatric disorders have some amount of cognition impairment and an improvement in this enhances the patient's recovery.

Techniques of Cognitive Therapy

There are four main groups of cognitive techniques. They are the following:

- Techniques for stopping intrusive cognitions
- Techniques to counterbalance faulty cognitions

- Techniques for altering cognitions
- Techniques to resolve problems directly.

Techniques for Stopping Intrusive Cognitions

These methods aim at stopping intruding thoughts through distraction. Attention is directed to another mental act like doing mental arithmetic or copying a figure. The method of 'thought stopping,' as done in obsessional ruminations, is also tried.

Techniques to Counterbalance Faulty Cognitions

This involves counterbalancing intruding cognitions and the emotions provoked by them, with another thought. As an example, when an anxious patient with chest pain becomes apprehensive thinking that he has a 'heart problem,' he may be trained to think that it is only a muscular pain and does not relate to the heart.

Techniques for Altering Cognitions

These are aimed at changing the nature of cognitions. The patient is helped to identify 'maladaptive cognitions' and their 'logical errors.' Some errors which are not mutually exclusive and which occur in depression are given below:

- *Faulty inference:* This is making faulty interpretations of a situation or an event where there is no factual evidence to make such conclusions. For example, if a friend fails to respond to a letter sent by the patient, he considers it as a sign of the friend's hostility or dislike to the latter.
- *Overgeneralization:* This is making a general conclusion based on a single incident. An example is generalizing all students of a particular class as substandard, based on the poor marks scored by one student.
- *Magnification or minimization:* These are distorted evaluations. For example, a

minor error is magnified or an important achievement is minimized in an unrealistically distorted manner.

- *Unrealistic assumptions:* An example is the assumption that one can be happy only if one is a top scorer all the time.

Techniques to Resolve Problems Directly

These involve several steps and consist of:

- Defining the problem more clearly
- Dividing it into small subproblem which can be better managed
- Finding out alternate methods of solving each sub problem
- Considering the merits and demerits of each method and
- Selecting one method which is most advantageous at that instance.

Therapy Process

Therapy is result oriented and defines goals so that progress towards them can be monitored. The therapist is a coach and teacher for the patients learning new skills. Therapist may help the patient identify situations in which undesired thoughts and actions occur and then assist with the development of alternatives.

Its overall goal is to increase self-efficacy or proficiency and sense of control over life. Patient must participate actively and be committed to the decision for change. The patient-therapist interaction is a goal oriented collaborative partnership with a beginning, middle and an end.

Cognitive therapy helps people examine these beliefs, learn how they influence feelings and behaviors and identify and alter dysfunctional beliefs that predispose them to distort their experiences. By understanding the idiosyncratic ways the people perceive themselves, their experiences the world and the future, therapist can help the patient alter negative emotions, change their view of life experiences and behave more adaptively.

Indications

- Anxiety, eating disorders
- Personality disorders
- Suicidal thoughts or attempts
- Sexual disorders.

It is applicable for people of all ages and cultures and it is used in individual, family and group settings. Major therapies associated with cognitive behavioral therapy include: cognitive therapy developed by Aaron Beck in 1963, rational emotive behavioral therapy developed by Albert Ellis in 1962.

SUPPORTIVE PSYCHOTHERAPY

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

- **Ventilation:** It is a free expression of feelings or emotions. Patient is encouraged to talk freely whatever comes to his mind.
- **Environmental modification/manipulation:** Improving the well-being of mental patients by changing their living condition.
- **Persuasion:** Here the therapist attempts to modify the patient's behavior by reasoning.
- **Re-education:** Education to the patient regarding his problems, ways of coping, etc.
- **Reassurance:** Reassurance is used to dispel apprehension and restore confidence and to promote hope. However care should be taken against offering false reassurance and providing it prematurely even before the patient has fully opened up.
- **Explanation:** The explanation of the nature of symptoms and their causes is done by the therapist during the therapy. The choice of treatment and the likely outcome are explained to the patient.
- **Guidance:** Guidance involves offering direct advice on handling particularly difficult situation in the real life of the patient. He may be advised on how and

when he should seek help in future. Suggestion involves advising in an indirect manner.

Phases of Therapy

Initial phase focuses on assessment and relationship formation. Assessment encompasses full physical and psychiatric evaluation including level of motivation, the patient's strengths and weaknesses. The therapist should be able to empathize with the patient in order to understand him better.

The **working phase** involves intense therapeutic activity and there is a further exploration of the patient's problems and life situations. The various therapeutic techniques are applied and attempts are made to give the patient an insight into his problems.

The **terminal phase** is intended to strengthen the patient's improvement and to prepare him to end his treatment.

FAMILY AND MARITAL THERAPY

Family therapy is that branch of psychiatry which sees an individual's psychiatric symptoms as inseparably related to the family in which he lives. Thus, the focus of treatment is not the individual, but the family. Today, most family theorists identify the individual's problems as a symptom of trouble within the family.

Indications

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

Components of Therapy

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

Patient Selection

- Families may be referred for treatment by, private physicians, and agencies such as the school system, welfare board, parole officers, and judges.
- Some families are referred for therapy from emergency room psychiatric services after a visit caused by a crisis in the family, such as a drug overdose.
- On discharge from a psychiatric hospital, a patient and his family may be referred for family therapy, as part of follow-up services.
- Family therapy is the treatment of choice when there is a marital problem or sibling conflict; family therapy may also be indicated when problems are caused by using one child as the scapegoat.
- Situational crises such as the sudden death of a family member, and maturational crises such as birth of the first child may cause sufficient stress to warrant family therapy.

Types of Family Therapy

Individual Family Therapy

In individual family therapy, each family member has a single therapist. The whole family may meet occasionally with one or two of the therapists to see how the members are relating to one another and work out specific issues that have been defined by individual members.

Conjoint Family Therapy

The most common type of family therapy is the single-family group, or conjoint family therapy. The nuclear family is seen, and the issues and problems raised by the family are the ones addressed by the therapist. The way in which the family interacts is observed and becomes the focus of therapy. The therapist helps the family deal more effectively with problems as they arise and are defined.

Couples Therapy

Couples are often seen by the therapist together. The couple may be experiencing difficulties in their marriage, and in therapy, they are helped to work together to seek a resolution for their problems. Family patterns, interaction and communication styles, and each partner's goals, hopes and expectations are examined in therapy. This examination enables the couple to find a common ground for resolving conflicts by recognizing and respecting each other's similarities and differences.

Multiple Family Group Therapy

In multiple family group therapy, four or five families meet weekly to confront and deal with problems or issues they have in common. Ability or inability to function well in the home and community, fear of talking to or relating to others, abuse, anger, neglect, the development of social skills, and responsibility for oneself are some of the issues on which these groups focus. The multiple family group becomes the support for all the families. The network also encourages each person to reach out and form new relationships outside the group.

Multiple Impact Therapy

In multiple impact therapy, several therapists come together with the families in a community setting. They live together and deal with pertinent issues for each family member within the context of the group. Multiple impact therapy

is similar to multiple family group therapy except that it is more intense and time-limited. Like multiple family group therapy, it focuses on developing skills or working together as a family and with other families.

Network Therapy

Network therapy is conducted in people's homes. All individuals interested or invested in a problem or crisis that a particular person or persons in a family are experiencing take part. This gathering includes family, friends, neighbors, professional groups or persons, and anyone in the community who has an investment in the outcome of the current crisis. People who form the network generally know each other and interact on a regular basis in each other's lives. Thus, a network may include as many as 40 to 60 people.

The rewards are great when all the people involved mobilize energy for management of the problem. The power is in the network itself. The answers to each problem come from the network and how people in the network decide to manage each issue as it arises. The therapists serve as a guide to clarify issues, reinforce the importance of and need for the network towards its members collectively and individually, and assist in the development and effective management in the evolution of the problem resolution.

GROUP THERAPY

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

Selection

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

Contraindications

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

Group Size

Optimal size for group therapy is 8 to 10 members.

Frequency and Length of Sessions

Most group psychotherapists conduct group sessions once a week; each session may last for 45 minutes to 1 hour.

Approaches to Group Therapy

- The therapist's role is primarily that of a facilitator; he should provide a safe, comfortable atmosphere for self-disclosure
- Focus on the 'here and now'
- Use any transference situations to develop insight into their problems
- Protect members from verbal abuse or from scapegoating
- Whenever appropriate, provide positive reinforcement, this gives ego support and encourages future growth
- Handle circumstantial patients, hallucinating and delusional patients in a manner that protects the self-esteem of the individual and also sets limits on the behavior so as to protect other group members
- Develop ability to recognize when a group member is "fragile"; he should be approached in a gentle, supportive and non-threatening manner
- Use silence effectively to encourage introspection and facilitate insight
- Laughter and a moderate amount of joking can act as a safety valve and at times can contribute to group cohesiveness

- Role-playing may help a member develop insight into the ways in which he relates to others.

Therapeutic Factors Involved in Group Therapy

These involve sharing experiences, support to and from group members, socialization, imitation and interpersonal learning.

Sharing experience: This helps the patients to realize that they are not isolated and that others also have similar experiences and problems. Hearing from other patients that they have shared experiences is often more convincing and helpful than reassurance from the therapist.

Support to and from group members: Receiving help from other group members can be supportive to the person helped. The sharing action of being mutually supportive is an aspect of the group cohesiveness that can provide a sense of belonging for patients who feel isolated in their everyday lives.

Socialization: It is acquisition of social skills (for example, maintaining eye contact) within a group through comments that members provide about one another's deficiencies in social skills. This process can be helped by trying out new ways of interacting within the safety of the group.

Imitation: It is learning from observing and adopting the behaviors of other group members. If the group is run well, patients imitate the adaptive behaviors of other group members.

Interpersonal learning: It refers to learning about difficulties in relationships by examining the interaction of individuals with other members of the group.

Some Techniques Useful in Group Therapy

- Reflecting or rewarding comments of group members

- Asking for group reaction to one member's statement
- Asking for individual reaction to one member's statement
- Pointing out any shared feelings within the group
- Summarizing various points at the end of session.

In conclusion, one may say that group therapy plays a major role in the rehabilitation of the mentally ill individual. Group therapy gives an opportunity for immediate feedback from a patient's peer and a chance for both patient and therapist to observe the patient's psychological, emotional and behavioral response towards a variety of people. Thus, it helps the patient to master communication and interpersonal skills, problem-solving, decision making and assertive skills, thus enabling him to re-enter the society's mainstream with a greater degree of confidence.

BEHAVIOR THERAPY

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

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

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

Major Assumptions of Behavior Therapy

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

- All behavior is learned (adaptive and maladaptive)

- Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced
- Maladaptive behavior can be unlearned and replaced by adaptive behavior if the person receives exposure to specific stimuli and reinforcement for the desired adaptive behavior
- Behavioral assessment is focused more on the current behavior rather than on historical antecedents
- Treatment strategies are individually tailored.

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

Behavior Techniques

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

1. *Relaxation training:* There are many methods which can be used to induce relaxation.

Some of them are:

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

2. *Hierarchy construction:* Here the patient is asked to list all the conditions which provoke

anxiety. Then he is asked to list them in a descending order of anxiety provocation.

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

Indications:

- Phobias
- Obsessions
- Compulsions
- Certain sexual disorders.

Flooding: The patient is directly exposed to the phobic stimulus, but escape is made impossible. Prolonged contact with the phobic stimulus, the therapist's guidance and encouragement and his modeling behavior reduce anxiety.

Indication: Specific phobias.

Aversion therapy: Pairing of the pleasant stimulus with an unpleasant response, so that even in absence of the unpleasant response the pleasant stimulus becomes unpleasant by association. Punishment is presented immediately after a specific behavioral response and the response is eventually inhibited. Unpleasant response is produced by electric stimulus, drugs, social disapproval or even fantasy.

Indications:

- Alcohol abuse
- Paraphilic
- Homosexuality
- Transvestism.

Operant conditioning procedures for increasing adaptive behavior:

• *Positive reinforcement:* When a behavioral response is followed by a generally rewarding event such as food, praise or gifts, it tends to be strengthened and occurs more frequently than before the reward. This technique is used to increase desired behavior.

• *Token economy:* This program involves giving token rewards for appropriate or desired target behaviors performed by the patient. The token can later be exchanged for other rewards. For example, in inpatient hospital wards, patients receive a reward for performing a desired behavior, such as tokens which they may use to purchase luxury items or certain privileges.

Operant conditioning procedures to teach new behavior:

• *Modeling:* Modeling is a method of teaching by demonstration, wherein the therapist shows how a specific behavior is to be performed. In modeling, the patient observes other patients indulging in target behaviors and getting rewards for those behaviors. This will make the patient repeat the same behavior and earn rewards in the same manner.

• *Shaping:* In shaping, the components of a particular skill, the behavior is reinforced step-by-step. The therapist starts shaping by reinforcing the existing behavior. Once it is established, he reinforces the responses which are closest to the desired behavior and ignores the other responses. For example, to establish eye-to-eye contact, the therapist sits opposite the patient and reinforces him even if he moves his upper body towards him. Once this is established, he reinforces the person's head movement in his direction and this procedure continues till eye-to-eye contact is established.

• *Chaining:* Chaining is used when a person fails to perform a complex task. The complex task is broken into a number of small steps and each step is taught to the patient. In forward chaining, one starts with the first step, goes on to the second step, then to the third and so on. In backward chaining, one starts with the last step and goes on to the next step in a backward fashion. Backward chaining is

found to be more effective in training the mentally disabled.

Operant conditioning procedures for decreasing maladaptive behavior

- *Extinction/ignoring:* Extinction means removal of attention rewards permanently, following a problem behavior. This includes actions like not looking at the patient, not talking to the patient, or having no physical contact with the patient, etc. following the problem behavior. This is commonly used when patient exhibits odd behavior.
- *Punishment:* Aversive stimulus (punishment) is presented contingent upon the undesirable response. The punishment procedure should be administered immediately and consistently following the undesirable behavior with clear explanation. Differential reinforcement of an adaptive or desirable behavior should always be added when a punishment is being used for decreasing an undesirable behavior. Otherwise, the problem behaviors tend to get maintained because of the lack of adaptive behaviors and skill defect.
- *Timeout:* Timeout method includes removing the patient from the reward or the reward from the patient for a particular period of time following a problem behavior. This is often used in the treatment of childhood disorders. For example, the child is not allowed to go out of the ward to play if he fails to complete the given work.
- *Restitution (Over-correction):* Restitution means restoring the disturbed situation to a state that is much better than what it was before the occurrence of the problem behavior. For example, if a patient passes urine in the ward he would be required to not only clean the dirty area but also mop the entire/larger area of the floor in the ward.
- *Response cost:* This procedure is used with individuals who are on token programs for teaching adaptive behavior. When undesirable behavior occurs, a fixed number of

tokens or points are deducted from what the individual has already earned.

Assertiveness and social skills training:

Assertive training is a behavior therapy technique in which the patient is given training to bring about change in emotional and other behavioral pattern by being assertive. Patient is encouraged not to be afraid of showing an appropriate response, negative or positive, to an idea or suggestion. Assertive behavior training is given by the therapist, first by role play and then by practice in a real life situation. Attention is focused on more effective interpersonal skills. Social skills training helps to improve social manners like encouraging eye contact, speaking appropriately, observing simple etiquette, and relating to people.

PLAY THERAPY

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

Curative Functions

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

Diagnostic Functions

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

Types of Play Therapy

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

Free play vs controlled play therapy: In free play, the child is given freedom in deciding with what toys he wants to play. In controlled play therapy, the child is introduced into a scene where the situation or setting is already established.

Structured vs unstructured play therapy: Structured play therapy involves organizing the situation in such a way so as to obtain more information. In unstructured play therapy no situation is set and no plans are followed.

Directive vs non-directive play therapy: In directive play therapy, the therapist totally sets the directions, whereas in non-directive play therapy, the child receives no directions. Play therapy is generally conducted in a playroom. The playroom should be suitably stocked with adequate play material, depending upon the problems of the child.

PSYCHODRAMA

Psychodrama is a specialized type of group therapy that employs a dramatic approach in which patients become actors in life-situation scenarios. The goal is to resolve interpersonal conflicts in a less threatening atmosphere than the real-life situation would present.

In psychodrama, the patient is brought directly into the situation as an active participant. The director coordinates the process so that the group and the protagonist receive maximal benefit. Other group members act as auxiliary egos and play the roles of significant others with whom relationships are being explored.

The primary advantage of psychodrama is its direct access to re-enacting painful situations so that the painful emotions associated with them can be reworked, with the potential for

spontaneously learning new responses in a safe therapeutic environment.

MUSIC THERAPY

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

Advantages

- Facilitates emotional expressions
- Improves cognitive skills like learning, listening and attention span
- Social interaction is stimulated.

DANCE THERAPY

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

Advantages

- Helps to develop body awareness
- Facilitates expression of feelings
- Improves interaction and communication
- Fosters integration of physical, emotional and social experiences that result in a sense of increased self-confidence and contentment
- Exercise through body movement maintains good circulation and muscle tone.

RECREATIONAL THERAPY

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

Aims

- To encourage social interaction
- To decrease withdrawal tendencies
- To provide outlet for feelings
- To promote socially acceptable behavior
- To develop skills, talents and abilities

- To increase physical confidence and a feeling of self-worth.

Points to be Kept in Mind

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

Types of Recreational Activities

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

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

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

Suggested Recreational Activities for Psychiatric Disorders

Anxiety disorders: Aerobic activities like walking, jogging, etc.

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

Manic disorder: One-to-one basis individual games like shuttle badminton, ball badminton, etc.

Schizophrenia (paranoid): Activities requiring concentration like chess, puzzles.

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

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

Childhood and adolescent disorders: It is better to work with the child on a one-to-one basis and give him a feeling of importance.

Employ activities such as playing, story telling and painting. Adolescents fare better in groups; provide gross motor activities like sports and games to use up excess energy.

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

RELAXATION THERAPIES

Relaxation produces physiological effects opposite those of anxiety: slowed heart rate, increased peripheral blood flow and neuromuscular stability. There are many methods which can be used to induce relaxation.

Progressive Muscular Relaxation

It is a method of deep-muscle relaxation which is based on the premise that the body responds to anxiety-provoking thoughts and events with muscle tension. Excellent results have been observed with this method in the treatment of muscular tension, anxiety, insomnia, depression, fatigue, irritable bowel, muscle spasms, neck and back pain, high blood pressure, mild phobias, and stuttering.

Technique

In this procedure, the patient relaxes major muscle groups in fixed order beginning with the small muscle groups of the feet and working towards the head or vice-versa. Muscle relaxation can be done in sitting or lying down position. Each muscle group is tensed for 5-7 seconds and then relaxed for 20-30 seconds, during which time the individual concentrates on the difference in sensations between the two conditions. Soft, slow background music may facilitate relaxation.

Mental Imagery

It is a relaxation method in which patients are instructed to imagine themselves in a place

associated with pleasant relaxed memories. Such images allow patients to enter a relaxed state or experience a feeling of calmness and tranquility. The frame of reference is very personal, based on what each individual considers being a relaxing environment. Some might select a scene at the seashore, some might choose a mountain atmosphere, and some might choose floating through the air. The choices are as limitless as one's imagination.

The nurse using guided imagery can promote a sense of well-being in patients and help them change their perceptions about their disease, treatment and healing ability. Nurses can assist patients with imagery during a painful or stressful event. The nurse's certificate program in Imagery is endorsed by the American Holistic Nurse's Association (AHNA).

Yoga

It is based on the ancient Indian philosophy principle of mind-body unity; a chronically restless or agitated mind will result in poor health and decreased mental clarity. Yoga uses combination of physical postures (*Asanas*), breathing techniques (*Pranayamas*) and meditation to promote relaxation and enhance the flow of vital energy called prana. It is essential for a nurse to have baseline information and awareness of yoga which is purely Indian in origin. The Yoga system advocates identification of the soul (*Atman*) with its final aim being union with the Supreme Being (*Paramatma*). This is brought about by the following eight steps:

1. Self-control (*Yama*), obtained by such devices as chastity, non-stealing, non-violence, truthfulness, and avoidance of greed.
2. Religious observance (*Niyama*), through chanting of the Vedic hymns, austerity, purity and contentment.
3. Assumption of certain positions (*Aasana*).
4. Regulation of the breath (*Pranayama*), with controlled rhythmic exhalation, inhalation, and temporary suspension of breathing.

5. Restraint of the senses (*Pratyahara*).
6. Steadying of the mind (*Dharana*), through fixation on some part of the body, such as the nose or navel.
7. Meditation (*Dhyana*), on the true object of knowledge, the supreme spirit, to the exclusion of other things in life.
8. Profound contemplation (*Samadhi*), with such complete absorption and detachment that there is insensitivity to heat and cold, pain and pleasure.

Meditation

Meditation was used routinely in ancient Syria, India, Japan and the Monasteries of Europe. Meditation is a kind of self-discipline that helps one achieve inner peace and harmony by focusing uncritically on one thing at a time. Medical meditation—a coming together of meditation and yoga—balances and regenerates spiritual and physical energies, thus forging a healing alliance in which the spirit nurtures body and mind.

Mindful meditation refers to focusing on physical sensations, such as movement or breath, and on the thoughts in order to increase awareness and enhance living in the movement to the fullest extent possible. It promotes deep states of psychological and physical relaxation. It is beneficial for patients with depression and anxiety. Nurses can provide the time necessary for meditation. Nurses too could benefit from a meditation practice and could experience a brief meditation during breaks from patient care activities.

Biofeedback

Biofeedback is based on the idea that the autonomic nervous system can come under voluntary control through operant conditioning. Biofeedback is the use of instrumentation to become aware of processes in the body that usually go unnoticed and to help bring them under voluntary control. Biological conditions, such as muscle tension,

skin surface temperature, blood pressure and heart rate are monitored by the biofeedback equipment. People learn to control these functions by hearing or seeing signals from instruments. With special training, the individual learns to use relaxation and voluntary control to modify the biological condition, in turn indicating a modification of the autonomic function it represents.

Indications

Biofeedback is being employed in migraine, hypertension, phobias, low backache, cerebral palsy, upper motor neurone hemiplegia, irritable bowel syndrome, cardiac problems and several other neuro-psychiatric conditions.

Physical Exercise

Regular exercise is the most effective method of relieving stress. Physical exertion provides a natural outlet for the tension produced by the body in its state of arousal for "fight or flight". Aerobic exercises strengthen cardiovascular system and increase the body's ability to use oxygen more efficiently. Aerobic exercises include brisk walking, jogging, running, cycling, swimming and dancing. To achieve the benefit of exercises they must be performed regularly for atleast 30 minutes per day.

Studies indicate that physical exercise can be effective in reducing general anxiety and depression. Vigorous exercise has been shown to increase levels of serotonin and beta endorphins; both chemicals have been implicated in mood regulation. Depressed people are often deficient in serotonin. Endorphins act as natural narcotics and mood elevators.

Deep Breathing Exercise

Tension is released when the lungs are allowed to breath in as much oxygen as possible. Breathing exercises have been found to be effective in reducing anxiety, depression, irritability, muscular tension and fatigue.

Technique

Sit or lie down comfortably, inhale slowly through the nose and exhale through the mouth. While inhaling place one hand below the ribs. Allow that hand to expand outward when inhaled, let the hand fall back to its original position when exhaled. Exhalation should take twice as long as inhalation.

Psychoeducation

Psychoeducation is an evidence-based psychotherapeutic intervention. In this intervention, education about the nature of illness, its treatment, coping and management strategies, and skills needed to avoid relapse is provided to mentally ill patients and their family members with an intention to empower them in dealing with their condition in an optimal manner. It can be given to the patient in a one to one discussion or in a group by qualified health educators, such as nurses, social workers, psychologists, psychiatrists, occupational therapists, etc.

ROLE OF A NURSE IN PSYCHOLOGICAL THERAPIES

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

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

COMPLEMENTARY AND ALTERNATIVE THERAPIES IN PSYCHIATRY

A paradigm shift is occurring within our society wherein a growing number of people are adopting an expanded view of health which embraces a holistic perspective rather than a purely allopathic one. As a result, many are seeking and using a variety of complementary and alternative healing modalities. In an effort to promote primary healthcare, the World Health Organization (WHO) recommended in 1978 that traditional (alternative) medicine be promoted, developed and integrated wherever possible with modern, scientific medicine, stressing the necessity to ensure respect, recognition and collaboration among the practitioners of the various systems concerned.

The National Center for Complementary and Alternative Medicine (NCCAM) defines Complementary and Alternative Medicine (CAM) as a group of diverse medical and healthcare systems, practices and products that are not presently considered to be part of conventional medicine. Complementary therapies are those used in conjunction with conventional medical practices. Alternative

therapies are those that are used instead of conventional medicine (Box 5.4 and Table 5.4).

Box 5.4: Reasons why people seek CAM therapies

- » Wanting greater control over their lives
- » Having a sense of responsibility for their own healthcare
- » Wanting a more holistic orientation in healthcare
- » Concern over the side effects of conventional therapies
- » Finding the results of conventional treatments to be inadequate
- » A desire for cultural and philosophical congruence with personal beliefs about health and illness
- » Dissatisfaction with conventional healthcare
- » Unwillingness to 'grin and bear' the effects of diseases
- » The rapid pace and ease of information sharing
- » Media contributing in consumers' awareness of alternative therapies
- » Growing evidence of effectiveness of alternative therapies

Table 5.4: Major domains of complementary and alternative medicine used in psychiatry

<i>Alternative medical systems</i>	<i>Mind-body interventions</i>	<i>Biological-based therapies</i>	<i>Manipulative and body-based methods</i>	<i>Energy therapies</i>
» Acupuncture	» Meditation	» Herbal therapies	» Tai chi	Therapeutic touch
» Ayurveda	» Relaxation	» Aromatherapy	» Yoga	Reflexology
» Homeopathy	» Hypnosis	» Special diet therapies	» Massage	Electromagnetic therapy
» Naturopathy	» Art, music and dance therapy » Prayer » Imagery » Biofeedback » Body-mind » Spiritual Interventions	» Mega doses of vitamins or minerals		Light therapy

Principles Underlying Alternative Healing

In 1999, Eliopoulos identified five basic principles underlying CAM:

1. The body has the ability to heal itself.
2. Health and healing are related to the harmony of mind, body and spirit.
3. Basic good health practices build the foundation for healing.
4. Healing practices are individualized.
5. People are responsible for their own healing.

Acupuncture

Acupuncture dates back to 3000 BC in China. It is based on the belief that health is determined by a balance of energy flow or Qi, which puts one in harmony with the universe. Disease occurs with an imbalance of these forces and manifests as excesses or deficiencies of basic life energy in the particular organs. If the energy balance is not restored, then physical changes occur and disease becomes present in the body. Acupuncture helps correct and rebalance the energy flow and consequently relieves pain and restores health. The needles draw energy away from organs with excess and redirect it to organs with deficiencies.

Treatment consists of the practitioner inserting stainless steel needles into acu-points just under the skin and leaving them in place from a few minutes to more than an hour.

The benefits of acupuncture include:

- Improvement of microcirculation
- Relaxation of muscles
- Release of endorphins, enkephalins, serotonin and adrenocorticotrophic hormone (ACTH)
- Activation of B and T lymphocytes
- Improvement in the complete blood cell.

Ayurvedic Medicine

Ayurveda is the traditional medical system of India, originating more than 4,000 years ago. Ayurveda aims to integrate and balance the body, mind and spirit (holistic). This balance is believed to lead to contentment and health, and to help prevent illness. It is based on the theory that illness results from the imbalance of the body's life force, or *prana*. The balancing of this life force is determined by the equilibrium of the three bodily qualities, called *doshas*: *vata*, *pitta*, and *kapha*. Ayurveda uses diet, herbs, massage, yoga, internal cleansing and lifestyle adjustments to harmonize body, mind and spirit. Ayurveda seeks to remove the root cause of mental illness in a holistic way. Ayurvedic mental hospitals use *panchakarma* to treat all kinds of mental illnesses. Ayurveda is a natural antidote to disease as well as a powerful healer for stress. It can be applied to a wide range of emotional and mental issues like depression, bipolar disorders, fears, anxiety, addiction and schizophrenia.

Homeopathic Medicine

This medical system originated in Europe. Homeopathy seeks to stimulate the body's ability to heal itself by giving very small doses of highly diluted substances that in larger doses could produce illness or symptoms (an approach called 'like cures like'). Homeopaths believe that their remedies mobilize the body's vital force to orchestrate co-ordinated healing responses throughout the body system. The body translates the information on the vital force into local physical changes that lead to recovery from acute and chronic diseases. A nurse should know that remedies can be counteracted by strong chemicals, herbs and certain drugs.

Naturopathy

Naturopathy focuses on self-healing and health-care is tailored to the individual needs. The physician's primary role is that of a teacher establishing and maintaining an optimal health and balance, treatment of the whole person, prevention of disease through a healthy lifestyle and therapeutic use of nutrition.

Meditation: See page 155 for details.

Relaxation therapies: See page 154 for details.

Hypnosis: See page 143 for details.

Mental imagery: See page 154 for details.

Biofeedback: See page 155 for details.

Art, Music and Dance therapy

Art therapy helps the patient express his thoughts, emotions and feelings through his drawings. Musictherapy is the systematic application of music in a therapeutic environment to bring about desirable changes in behavior. Dance therapy is a psychotherapeutic use of movement, which furthers the emotional and physical integration of the individual.

Spiritual Healing and Prayer

Spiritual interventions focus on developing a sense of meaning, purpose and hope for individuals in their current life experience. Spiritual interventions involve listening to the person's story and facilitating the person to connect to God, a greater power, perhaps by using meditation or prayer. This may be a religious or non-religious experience depending on the individual's own spirituality.

Herbal Therapies

Herbal medicine, the oldest known form of healthcare, uses plants to treat disease and promote health. Herbal medicines are available as extracts (solutions obtained by steeping or soaking a substance, usually in water), tinctures (usually alcohol-based

preparations, with alcohol acting as a natural preservative), infusions (the most common method of internal herbal preparation, usually referred to as a tea), decoctions (similar to an infusion), pills, and powders; even a moistened cloth applied to the skin can act as a herbal remedy.

Use of herbal medicine poses many challenges and underscores the need for nurses at every level to become knowledgeable of herbal medicine to ensure safe and effective practice. Nurses should become familiar with contraindications and adverse effects. Nurses should encourage patients to discuss with their healthcare provider all natural remedies that they ingest. Some may potentiate the effects of psychotropic medications, while others may block the effects. A few others may increase adverse side effects.

Aromatherapy

Aromatherapy is concerned with the psychological, physiological and pharmacological effects of essential oils introduced by means of inhalation, olfaction and dermal application. The essential oils that are used in aromatherapy are distilled from flowers, roots, bark, leaves, wood resins and lemon or orange rinds. When essential oils are inhaled, aromas are detected by the olfactory receptor cells in the nares. The stimuli travel along the olfactory nerve to the brain where they are thought to play a role in emotions, memory and a variety of body functions and immune responses. Nurses should caution people who are considering aromatherapy to be aware that aromatic oils vary in quality, their production is not regulated and some may be toxic when inhaled. The skin should always be tested for allergies by applying a very small amount of the diluted oil before a whole treatment is tried. Oils should not be used near the eyes and should always be diluted in a suitable oil or water before application to skin. Oil should be stored in dark colored glass bottles, and kept away from sunlight.

Special Diet Therapies, Mega Doses of Vitamins or Minerals

Good nutrition can help with adaptation to the inevitable stresses of life by promoting a healthy body and a feeling of well-being. Nutritional deficiencies often first appear in the form of mental symptoms. Researchers believe that the imbalances in the system can be regulated by nutritional supplements. For example, depression may be caused by an amino acid imbalance or vitamin deficiency. The B-vitamins, omega-3 fatty acids and folic acid are helpful for regulating stress and balancing mood. Nurses must be sensitive to ethnic and cultural diets when planning healthcare activities. Some of these diets may pose health risks because of a lack of essential ingredients or interaction with prescribed medications.

T'ai chi and Qigong

T'ai chi (tie chee), sometimes defined as 'moving meditation' is a Chinese blend of exercise and energy work consisting of a series of choreographed, continuous slow movements performed with mental concentration and coordinated breathing. The purpose is to improve circulation, balance, flow of chi, reduce stress and anxiety and restore energy and health. Qigong is a therapeutic Chinese practice that includes gentle exercises for the breath, body, mind, and voice.

Yoga: See page 155 for details.

Massage

Massage is a systematic and scientific manipulation of the soft tissue of the body, first noted in the Vedic literature of India in 8000 BC. Alleged benefits include decreased stress and anxiety; enhanced body-mind connection for greater mental clarity, energy and performance; promotion of vitality; personal growth and emotional release. Massage also has a sedative effect on the nervous system, promotes

voluntary muscle relaxation and improves self image through reorganized posture. Nurses have traditionally used massage to ease a patient's discomfort and to develop a connection with the patient. Increasing numbers of nurses focus on this CAM modality as licensed massage therapists in private practice and are affiliated with the American Massage Therapy Association (AMTA).

Biofield Therapies

Therapeutic touch (TT) is a process by which practitioners believe that they can transmit energy to a person who is ill or injured to potentiate the healing process. It is derived from religious philosophies principle 'laying on of hands' which may also involve the healer passing hands over the body without actually touching it, to detect energy imbalances and redirect them through the energy of the therapist.

Delores Krieger (1979) coined the term 'therapeutic touch' and developed the TT program. TT then became a certification program of the American Nurses Association. Nurses have practiced various forms of TT for many years for relieving mental and emotional tension and anxiety; improving blood flow, easing pain and stimulating the immune system. Healing touch (HT) is a similar technique and became a certificate program of the American Holistic Nurse's Association in 1993.

Reflexology

People in India and China in 5000 BC and Egypt in 2330 BC recorded the use of reflexology. Reflexology involves massaging specific areas of the hands or feet to relieve stress or pain in the corresponding related area of the body. It is based on the premise that pressure to specific parts of the feet, hands and ears can create physiologic changes and promote overall well-being. The main goal is

to provide relaxation by removing tension in a zone area.

It is believed that foot reflexology, like other massages of the feet, can stimulate relaxation, which affects the autonomic response, which in turn affects the endocrine and immune systems and neuropeptides. Nurses need to instruct patient to consult experienced reflexologist when he/she has circulatory disorders of the extremities.

Bioelectromagnetic-based Therapies

Bioelectromagnetic therapy involves the use of magnetic fields in the prevention and treatment of disease. Magnetic field therapy uses two methods—static and pulsed. The static method involves placing magnets in belts, shoe inserts and mattresses for 2 to 24 hours. The pulses method involves using a machine to direct alternating electromagnetic

fields. Nurses should caution patients with pacemakers, defibrillators or other metallic parts in their bodies that they should avoid using magnets or magnetic bodies.

Light therapy: See page 139 for details.

Psychiatric Disorders and Related CAM Therapies

Most common evidence based CAM therapies have been used for some of the major psychiatric disorders (Box 5.5).

Psychiatric Nurse and CAM

A Holistic Approach

Because of its holistic focus on the person, the nursing profession has become increasingly interested in the use of CAM. As a result, it has integrated diverse therapies into the plan of care

Box 5.5: Major psychiatric disorders and related CAM therapies

Alcohol abuse

- » Acupuncture
- » Herbal therapy (kudzu)
- » Meditation/medical meditation
- » Yoga

Alzheimer's dementia

- » Herbal therapy (gingko)
- » Massage
- » Medical meditation

Anxiety

- » Acupressure
- » Biofeedback
- » Breathing and relaxation techniques
- » Guided imagery
- » Healing touch/therapeutic touch
- » Self-hypnosis
- » Massage
- » Meditation/medical meditation

Attention deficit hyperactivity disorder

- » Biofeedback

Depression

- » Acupuncture
- » Healing touch/therapeutic touch
- » Herbal therapy (St John's wort)
- » Meditation/medical meditation
- » Transcranial magnetic stimulation

Insomnia

- » Breathing and relaxation techniques
- » Herbal therapy (valerian)
- » Meditation

Obsessive-compulsive disorder

- » Acupuncture
- » Medical meditation

Stress

- » Breathing and relaxation exercises
- » Healing touch/therapeutic touch
- » Massage
- » Meditation/medical meditation

devised for patients. The most frequently employed therapies used by the nurses are massage, music, exercise, diet, prayer and counseling.

The basic principles that are woven through CAM are consistent with the nursing views of health and healing:

1. *The body has the ability to heal itself.* Florence Nightingale promoted this principle when she wrote that medicine and surgery can remove obstructions, but nature alone cures.
2. *Nursing attends to the needs of the whole person:* Whole-person care is the thread woven through the nursing process.
3. *Basic good health practices build the foundation for healing:* Nurses educate, counsel and coach individuals in diet, exercise, safe medication use, lifestyle modifications and other practices that promote good health.
4. *Healing practices are individualized:* Learning about the uniqueness of each patient through comprehensive assessment and planning and implementing care that is tailored to fit the patient are basic nursing standards of practice that foster individualized care.
5. *Patients are responsible for their own healing:* The promotion of self-care and maximum independence are highly valued foundations of nursing practice.

These basic principles of healing that guide CAM offer nursing an opportunity to highlight the nurse's historical and special role as healers in this new arena.

Integrating CAM into Conventional Settings—Nurse's Role

CAM therapies can have an important impact on psychiatric nursing practice. They are beneficial, safe, cost-effective and easily implemented throughout psychiatric settings. Nurses in psychiatric inpatient units using CAM therapies report better patient compliance, as well as a more relaxed manageable milieu.

As healers, nurses take on many roles when assisting patients to attain and maintain health; they act as helpers, facilitators, practitioners, educators, coordinators, advocates and leaders when providing care, serving as a bridge between the patient and physician.

Helper: Nurses are often in a position of being able to identify the need for CAM; suggest CAM therapies to treatment team members and to patient and their family members; help the patient become an informed health consumer; encourage patients to consider using a CAM therapy if appropriate.

Facilitator: Nurses need to integrate CAM into their nursing practice. This begins during the assessment process by exploring patients' use of CAM practices and products. Factors to assess include:

- CAM practices and products being used and sources
- Appropriateness of use of CAM practice and products
- Side effects and risks associated with use of CAM
- Conditions for which CAM currently is not used that could benefit by its use.

Through the assessment process nurses may identify the need to educate patients about the appropriateness of the CAM products and practices they are using. There may be situations in which nurses identify that specific conditions could benefit from the use of CAM therapies.

Practitioner: Nurses who have been certified to practice alternative therapy are referred to as holistic nurses. Nurses may be practitioners of CAM therapies in a variety of settings-hospitals, outpatient clinics, home, community, private practice office and so on. The most common CAM therapies that nurses provide are relaxation techniques (such as deep breathing, active progressive relaxation and meditation), body work techniques (such as massage), and energy therapies (such as therapeutic

touch and Reiki). Nurses should seek whatever additional education and training required for gaining competency in these therapies and ensuring compliance with state licensing laws. As always, nurse should respect patient's beliefs and wishes in terms of their pursuing any therapies.

Educator: Nurses play a significant role in making patients and their families aware of these methods and teaching them their effective use. Nurse has an obligation to provide empirical and high quality information on both CAM and conventional therapies. The extensive variety of alternative practices points towards the need for inclusion of CAM education in nursing school curriculum and the importance of CAM related continuing nursing education.

Coordinator: As a coordinator the nurse can integrate CAM services into a patient's plan of care, enlist the support of the treatment team, family members and friends and help patients to find providers. As CAM therapies are integrated into conventional care, nurses are the logical professionals to oversee the various parts and ensure they are working in harmony for the patient benefit.

Advocate: As patient advocates, nurses must request that complementary and alternative methods be made readily available to patients in hospitals and clinics, stressing the noninvasiveness and cost-effectiveness of alternative therapies.

Leader: Nurses can demonstrate leadership in helping conventional clinical settings integrate CAM therapies. In fact, nurse's holistic orientation and traditional coordination responsibilities make nurses logical for this role.

Complementary and alternative medicine offers nurses the potential for innovative practice models. Advanced preparation or certification in a specific modality enables nurses to offer a wider range of services to patients in traditional care settings. These new skills also enable nurses to establish private

practices in which patients directly contact nurses for specific therapies (for example, therapeutic touch and stress reduction classes).

Complementary and Alternative Therapies: An Indian Perspective

The Indian Systems of Medicine and Homeopathy (ISM&H) consist of Ayurveda, Siddha, Unani and Homeotherapy and therapies such as Yoga and Naturopathy. The Central Government of India created the department of the ISM&H in 1995 to provide focused attention for development and optimal utilization of ISM&H for the healthcare of the population; 18 states also have separate directorates of ISM&H. The 9th five-year plan envisages that the department of ISM&H should improve the quality of services. There are at present 22,735 ISM&H dispensaries which provide primary health care services. States like Himachal Pradesh and Kerala have ISM&H practitioners in primary healthcare in addition to physicians of modern medicine. Several states have ISM&H clinics in district hospitals.

The Central Council for Research in Ayurveda and Siddha (CCRAS) had set up Advanced Centre for Ayurveda in Mental Health and Neuro Sciences at the National Institute of Mental Health and Neurosciences (NIMHANS) in 1971. Presently, this center has undertaken research studies in areas like epilepsy, mental retardation, schizophrenia, etc.

The advanced center for yoga therapy and research at NIMHANS has started intervening in psychiatric disorders through yogic approach; a few nurses are involved in teaching basic yogic exercises to the mentally ill patients.

OCCUPATIONAL THERAPY

Occupational therapy is the application of goal-oriented, purposeful activity in the

assessment and treatment of individuals with psychological, physical or developmental disabilities.

Goal

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

Settings

Occupational therapy is provided to children, adolescents, adults and elderly patients. These programs are offered in psychiatric hospitals, nursing homes, rehabilitation centers, special schools, community group homes, community mental health centers, day care centers, halfway homes and de-addiction centers.

Advantages

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

Points to be Kept in Mind

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

Process of Intervention

It consists of six stages:

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

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

Types of Activities

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

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

Suggested Occupational Activities for Psychiatric Disorders

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

Depressive disorder: Simple concrete tasks which are achievable; it is important for the patient to experience success. Provide positive reinforcement after each achievement. For example, crafts, mowing lawn, weeding gardens.

Manic disorder: Non-competitive activities that allow the use of energy and expression of feelings. Activities should be limited and changed frequently. Patient needs to work in

an area away from distractions. For example, raking grass, sweeping, etc.

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

Schizophrenia (catatonic): Simple concrete tasks in which patient is actively involved. Patient needs continuous supervision, and at first works best on a one-to-one basis. For example, metal work, molding clay, etc.

Antisocial personality: Activities that enhance self-esteem and are expressive and creative, but not too complicated. Patient needs supervision to make sure each task is completed. For example, leather work, painting, etc.

Dementia: Group activities to increase feeling of belonging and self-worth. Provide those activities which promote familiar individual hobbies. Activities need to be structured, requiring little time for completion and not much concentration. Explain and demonstrate each task, then have patient repeat the demonstration. For example, cover making, packing goods, etc.

Substance abuse: Group activities in which patient uses his talents. For example, involving patient in planning social activities, encouraging interaction with others, etc.

Childhood and Adolescent Disorders

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

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

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

REVIEW QUESTIONS

Long Essays

1. Role of a nurse in administration of psycho-tropic drugs.
2. Role of a nurse in ECT management.
3. Describe therapeutic community.
4. Role of a nurse in occupational therapy.
5. Explain about alternative therapies in psychiatry.

Short Essays

1. Classification of psychotropic drugs
2. Classification of antipsychotic drugs
3. EPS
4. Neuroleptic malignant syndrome
5. Mood stabilizing drugs
6. Lithium
7. Drugs used in treatment of anxiety
8. Psychological therapies
9. Psychoanalytical therapy
10. Hypnosis
11. Abreaction therapy
12. Narcoanalysis
13. Individual psychotherapy
14. Family therapy
15. Group therapy
16. Recreation therapy
17. Play therapy

Short Answers

1. Drug-induced Parkinsonism
2. Akathisia
3. Dystonia
4. Complications of ECT
5. Dream analysis
6. Behavior therapy
7. Aversion therapy
8. Token economy
9. Psychodrama
10. Light therapy

MULTIPLE CHOICE QUESTIONS

1. What is a receptor?

- a. Binding site for neurotransmission
- b. Separates two neurons
- c. Situated in vesicles
- d. Releases chemicals

2. What is a synapse?

- a. Binding site for neurotransmission
- b. Separates two neurons
- c. Situated in vesicles
- d. Releases chemicals

3. Haloperidol is a/an:

- a. Antipsychotic
- b. Mood stabilizer
- c. Antidepressant
- d. Anticoagulant

4. After three days of taking haloperidol, the patient shows restlessness, becomes fidgety and is unable to sit still. Which of the following extrapyramidal symptoms is the patient experiencing?

- a. Drug induced Parkinsonism
- b. Acute dystonia
- c. Akathisia
- d. Tardive dyskinesia

5. A patient is on clozapine drug for the past 2 weeks. He reports fever, sore throat and general weakness. Which of the following nursing intervention is most appropriate?

- a. Inform the patient to take broad-spectrum antibiotics
- b. Discontinue the therapy
- c. Inform the patient to check WBC count
- d. Both b and c

6. Which of the following is a major side effect of typical antipsychotics?

- a. Tardive dyskinesia
- b. Thyroid abnormality
- c. Weight gain
- d. Headache

7. Which of the following drug needs a WBC level checked periodically?

- a. Lithium
- b. Clozapine
- c. Olanzapine
- d. Diazepam

8. A schizophrenia patient who is on Haloperidol since one week exhibits muscular spasms and involuntary movements of neck and jaw. The nurse interprets these findings as:

- a. Acute dystonia
- b. Tardive dyskinesia
- c. Akathisia
- d. Drug-induced parkinsonism

9. Atypical antipsychotics include:

- a. Haloperidol and Clozapine
- b. Chlorpromazine and Trifluoperazine
- c. Risperidone and Olanzapine
- d. Fluphenazine and Haloperidol

10. The treatment of choice for extrapyramidal symptom such as tardive dyskinesia is to:

- a. Administer anti-anxiety drugs as per order
- b. Administer sedatives as per order
- c. Discontinue the drugs
- d. Administer anticholinergic drugs as per order

11. Which of the following receptors are blocked by tricyclic antidepressants?

- a. Dopamine
- b. Norepinephrine
- c. GABA
- d. Anti-cholinergic

12. Which of the following instructions should the nurse include while imparting health education to a patient who has been prescribed lithium?

- a. Restrict fluid intake to one liter per daily
- b. Maintain a fluid intake of 2.5 to 3 liters daily

- c. Restrict sodium intake
d. Maintain potassium levels
- 13. A patient is on chlorpromazine drug, on assessment the patient demonstrates a shuffling gait, stooped posture, drooling and exhibits ataxia. The nurse concludes that the patient has developed:**
- Tardive dyskinesia
 - Drug-induced Parkinsonism
 - Dystonia
 - Akathisia
- 14. Therapeutic levels of lithium, are:**
- 0.5 mEq/L to 1.5 mEq/L
 - 0.6 mEq/L to 1.0 mEq/L
 - 0.8 mEq/L to 1.2 mEq/L
 - 1.0 mEq/L to 2.0 mEq/L
- 15. One of the side effects of an antipsychotic drug is abnormal, irregular choreo-athetoid movements of the muscles of the mouth, it is termed as:**
- Akathisia
 - Tardive dyskinesia
 - Agranulocytosis
 - Acute dystonia
- 16. Which of the following is the nurse's correct interpretation, when the patient has serum lithium level 2.0 mEq/L?**
- The levels are below therapeutic range; inform the physician
 - The levels are within therapeutic range; do nothing
 - The levels are elevated; patient should be assessed for lithium toxicity manifestations
 - The levels are slightly elevated; do nothing
- 17. Medications that affect psychic function are:**
- Mood stabilizers
 - Psychotropic drugs
 - Antidepressants
 - Anxiolytics
- 18. Autonomic side-effects are:**
- Dry mouth, constipation, cycloplegia
 - Weight gain, jaundice, dermatitis
- c. Photosensitivity, renal failure, jaundice
d. Agranulocytosis, tachycardia, hypotension
- 19. Exclude the antidepressant drug from the following:**
- Chlorpromazine
 - Clomipramine
 - Clozapine
 - Lithium
- 20. Patients on MAOI's should be advised not to ingest _____ rich foods to prevent hypertensive crisis.**
- Thiamine
 - Tyramine
 - Tyrosine
 - Thyroxine
- 21. Signs and symptoms of lithium toxicity include:**
- Constipation, dry mouth, drowsiness
 - Dizziness, thirst, dysuria, arrhythmias
 - Ataxia, tinnitus, blurred vision, diarrhea
 - Ataxia, muscle weakness, nausea and vomiting
- 22. Usual range of lithium dose in the treatment of Mania is:**
- 900–2000 mg
 - 600–900 mg
 - 900–1100 mg
 - 900–2100 mg
- 23. Contraindications of lithium are:**
- Renal diseases
 - Thyroid diseases
 - Pregnancy
 - All of the above
- 24. _____ indicates lithium toxicity.**
- 0.8 to 1.2 m Eq/L
 - 0.8 to 1.5 m Eq/L
 - 0.6 to 1.0 m Eq/L
 - More than 2.0 m Eq/L
- 25. Benzodiazepines reduce anxiety by acting on which neurotransmitter?**
- GABA
 - Sertraline
 - Noradrenaline
 - Dopamine

- 26. Which of the following condition is a primary indication for ECT?**
- Major depression
 - Simple schizophrenia
 - Anxiety disorder
 - Phobic disorder
- 27. Which of the following is a contraindication for ECT?**
- Brain tumor
 - Major mental illness
 - General weakness
 - Extreme sadness
- 28. Which of the following problem would a nurse need to address immediately in post-ECT recovery period?**
- Excessive sleepiness
 - Disorientation
 - Urinary incontinence
 - Changes in vital signs
- 29. A patient with which of the following disorder would a nurse need to prepare for ECT?**
- A 35-year female-patient with somatoform disorder
 - A 65-year-male patient with dementia
 - A 40-year-female patient with hypomania
 - A 32 year female patient with major depressive disorder
- 30. Which of the actions would be most appropriate for a patient scheduled for ECT at 10 am?**
- Providing clear liquid diet
 - Inserting urinary catheter
 - Administering atropine medication
 - Administering diazepam medication
- 31. Which of the following conditions is a contraindication of ECT treatment?**
- Osteoporosis
 - Diabetes mellitus
- 32. The patient has just awakened from an electroconvulsive therapy treatment. The most appropriate nursing action at this time would be to:**
- Arrange for the patient's diet to be served
 - Orient the patient
 - Observe the patient for signs of suicidal behavior
 - Observe the patient for hallucinatory behavior
- 33. The elements of therapeutic community includes all, except:**
- Free communication
 - Shared responsibilities
 - Active participation
 - Free association
- 34. Who developed the psychoanalytic theory?**
- Sigmund Freud
 - Maxwell Jone
 - Aaron Beck
 - Albert Ellis
- 35. Techniques used in psychoanalysis include all, except:**
- Free association
 - Dream analysis
 - Abreaction therapy
 - Psychotherapy
- 36. Cognitive techniques include all, except:**
- Abreaction therapy
 - Thought stopping techniques
 - Problem resolving techniques
 - Counter balance faulty cognitions
- 37. The optimal size for group therapy is:**
- 15–20 members
 - 8–10 members

- c. 20–25 members
- d. 15–25 members

38. Which of the following is a specialized type of group therapy?

- a. Psychodrama
- b. Psychotherapy
- c. Supportive psychotherapy
- d. Behavior therapy

39. Relaxation therapies include all, except:

- a. Meditation
- b. Deep breathing exercise
- c. Yoga
- d. Catharsis

40. Behavior therapy techniques include all, except:

- a. Modeling
- b. Exposure and response prevention
- c. Reinforcement schedules
- d. Free association

41. Systematic desensitization consists of the following steps, except:

- a. Relaxation training
- b. Hierarchy construction
- c. Desensitization of stimulus
- d. Resolving unconscious conflicts

42. Which of the following is a technique used in hypnosis?

- a. Flooding
- b. Questioning
- c. Suggestion
- d. Desensitization

43. The theory of operant conditioning was proposed by:

- a. Ian Pavlov
- b. Watson
- c. B F Skinner
- d. Harry Stock Sullivan

KEY

1. a	2.b	3. a	4. c	5. d	6. a	7. b	8. a	9. c	10. d
11. b	12. b	13. b	14. c	15. b	16. c	17. b	18. a	19. b	20. b
21. d	22. d	23. d	24. d	25. a	26. a	27. a	28. d	29. d	30. c
31. c	32. b	33. d	34. a	35. d	36. a	37. b	38. a	39. d	40. d
41. d	42. c	43. c							

Chapter 6

Nursing Management of Patient with Schizophrenia, and Other Psychotic Disorders

The word 'Schizophrenia' was coined by the Swiss psychiatrist Eugen Bleuler in 1908. It is derived from the Greek words skhizo (split) and phren (mind).

SCHIZOPHRENIA CLASSIFICATION (ICD10)

- F20–F29 : Schizophrenia, schizotypal and delusional disorders
- F20 : Schizophrenia
- F20.0 : Paranoid schizophrenia
- F20.1 : Hebephrenic schizophrenia
- F20.2 : Catatonic schizophrenia
- F20.3 : Undifferentiated schizophrenia
- F20.4 : Post-schizophrenic depression
- F20.5 : Residual schizophrenia
- F20.6 : Simple schizophrenia
- F21 : Schizotypal disorder.

DEFINITION

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

EPIDEMIOLOGY

Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures across the world. About 15%

of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50% of all mental hospital beds.

About three to four per 1000 in every community suffer from schizophrenia. About one percent of the general population stand the risk of developing this disease in their lifetime. Schizophrenia is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 35 years for women. About two-thirds of cases are in the age group of 15 to 30 years. The disease is more common in lower socioeconomic groups.

ETIOLOGY

Many authorities suggest that multiple factors must cause schizophrenia, because no single theory satisfactorily explains the disorder.

Biological Theories

Biologic explanations include biochemical, neurostructural, genetic, perinatal risk factors and other theories.

Biochemical Theories

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

Other biochemical hypotheses: Various other biochemicals have been implicated in the predisposition to schizophrenia. These include abnormalities in the neurotransmitters norepinephrine, serotonin, acetylcholine and gamma-aminobutyric acid (GABA), and neuroregulators, such as prostaglandins and endorphins.

Neurostructural Theories

Research suggests that the prefrontal cortex and limbic cortex may never fully develop in the brains of persons with schizophrenia. Computed tomography and magnetic resonance imaging (MRI) studies of brain structure show:

- Decreased brain volume
- Larger lateral and third ventricles
- Atrophy in the frontal lobe, cerebellum and limbic structures
- Increased size of sulci on the surface of the brain.

Genetic Theories

The disease is more common among people born of consanguineous marriages. Studies show that relatives of schizophrenics have a much higher probability of developing the disease than the general population (Box 6.1).

Perinatal Risk Factors

Multiple non-genetic factors influence the development of schizophrenia (Box 6.2).

Box 6.1: Genetic risk of schizophrenia

- » Identical twin affected—50%
- » Fraternal twin affected—15%
- » Brother or sister affected—10%
- » One parent affected—15%
- » Both parents affected—35%
- » Second degree relative affected—2–3%
- » General population—1%
(No affected relative)

Box 6.2: Prenatal and perinatal risk factors for schizophrenia

- » Maternal influenza
- » Birth during late winter or early spring
- » Complications of pregnancy particularly during labor and delivery

Psychodynamic Theories

These theories focus on individual's responses to life events.

Developmental Theories

According to Freud, there is regression to the oral stage of psychosexual development, with the use of defense mechanisms of denial, projection and reaction formation. The individuals have poor ego boundaries, fragile ego, inadequate ego development, superego dominance, regressed ID behavior, love-hate (ambivalent) relationships and arrested psychosexual development.

Family Theories

Family relationships act as major influence in the development of illness.

Mother-child relationship: Early theorists characterized the mothers of schizophrenics as cold, over-protective, and domineering, thus retarding the ego development of the child.

Dysfunctional family system: Hostility between parents can lead to a schizophrenic daughter (marital skew and schism).

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

Vulnerability-stress Model

This model recognizes that both biologic and psychodynamic predispositions to schizophrenia when coupled with stressful life events can precipitate a schizophrenic

process. According to this model, people with a predisposition to schizophrenia may avoid serious mental disorders if they are protected from the stresses of life. Individual with a similar vulnerability may succumb to schizophrenia if exposed to stressors.

Social Factors

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

PSYCHOPATHOLOGY

Stransky (1914), using a metaphor from neurology, proposed 'intrapsychic ataxia' as the basic symptom of dementia praecox (schizophrenia). He described a lack of co-ordination between emotions and thinking, which is now generally accepted and referred to as incongruity of affect.

Bleuler said loosening in the association of ideas was the primary and fundamental disturbance. Through the loosened links in the chain associations instinctual desired and unconscious wishes can intrude into the consciousness of the patient; his repressed complexes gain the upper hand and can entirely rule his life and behavior. The result is the disruption or distortion of his personality. He is at the mercy of his emotions and withdrawn from reality whenever it is opposed to the whim of his complexes. According to Bleuler, primary symptoms are weakening of will-power, emotional stiffness and flattening, and ambivalence. Delusions, hallucinations and catatonic symptoms are regarded as secondary.

Berze (1914) thought that insufficient and lowering of psychic activity, based on organic damage of unknown nature, is the primary symptom of schizophrenia. The lowered mental activity may prevent the making of

a clear distinction between what is real and what is imaginary causing the schizophrenic to indulge in delusional ways of thinking and behaving.

McGhie (1961) concluded that both genetic predisposition towards inadequate ego development and family influences which may help to loosen the patient's hold on reality have to be invoked to account for schizophrenia. All these essential psychological abnormalities affect the different mental functions and to build-up from these abnormalities the most typical syndromes.

Commonly affected mental functions are disturbance in thinking, volition, perception, emotions and catatonic symptoms.

CLINICAL FEATURES

Symptoms of schizophrenia may appear suddenly or develop gradually over time. Tension, the inability to concentrate, insomnia, withdrawal or cognitive deficits may precede the first psychotic episode.

Eugene Bleuler (1857–1939) cited symptoms referred to as Bleuler's 4 As (Box 6.3).

Kurt Schneider proposed the first rank symptoms of schizophrenia in 1959. The

Box 6.3: Bleuler's four A's

- » **Affective disturbance:** Inability to show appropriate emotional responses (inappropriate), blunted or flattened affect
- » **Autistic thinking:** It is a thought process in which the individual is unable to relate to others or to the environment. Preoccupation with the self, with little concern for external reality
- » **Ambivalence:** It refers to contradictory or opposing emotions, attitudes, ideas or desires for the same person, thing or situation, simultaneous opposite feelings
- » **Associative looseness:** Inability to think logically. The stringing together of unrelated topics

presence of even one of these symptoms is considered to be strongly suggestive of schizophrenia (Box 6.4).

The predominant clinical features in acute schizophrenia are delusions, hallucinations and interference with thinking. Features of this kind are often called positive symptoms or psychotic features while most of the patients

Box 6.4: Schneider's first-rank symptoms of schizophrenia (SFRS)

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

Table 6.1: Positive and negative symptoms of schizophrenia

Positive	Negative
» Delusions	» Affective flattening or blunting
» Hallucinations	» Avolition— apathy (lack of initiative)
» Excitement or agitation	» Attentional impairment
» Hostility or aggressive behavior	» Anhedonia (inability to experience pleasure)
» Suspiciousness, ideas of reference	» Alogia (lack of speech output)
» Possible suicidal tendencies	

recover from acute illness, some progress to the chronic phase, during which time the main features are negative symptoms. Once the chronic syndrome is established, few patients recover completely (Table 6.1).

The signs and symptoms commonly encountered in schizophrenic patients may be grouped as follows:

Thought and Speech Disorders

- Autistic thinking (preoccupations totally removing a person from reality).
- Loosening of associations (a pattern of spontaneous speech in which the things said in juxtaposition lack a meaningful relationship with each other).
- Thought blocking (a sudden interruption in the thought process).
- Neologism (a word newly coined, or an everyday word used in a special way, not readily understood by others).
- Poverty of speech (decreased speech production).
- Poverty of ideation (speech amount is adequate but content conveys little information).

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

Disorders of Perception

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

Disorders of Affect

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

Disorders of Motor Behavior

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

Other Features

- Decreased functioning in work, social relations and self-care, as compared to earlier life

- Loss of ego boundaries
- Loss of insight
- Poor judgment
- Suicide can occur due to the presence of associated depression, command hallucinations, impulsive behavior, or return of insight that causes the patient to comprehend the devastating nature of the illness and take his life
- There is usually no disturbance of consciousness, orientation, attention, memory and intelligence
- There is no underlying organic cause.

CLINICAL TYPES

Schizophrenia can be classified into the following subtypes:

1. Paranoid
2. Hebephrenic (disorganized)
3. Catatonic
4. Residual
5. Undifferentiated
6. Simple
7. Post-schizophrenic depression

Paranoid Schizophrenia

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

- *Delusions of persecution:* In persecutory delusions, individuals believe that they are being malevolently treated in some way. Frequent themes include being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed or obstructed in the pursuit of long-term goals.
- *Delusions of reference:* In this delusion, the individual believes that events, objects, behavior of others have got an unusual significance for one-self. The individual may falsely believe that others are talking about him.

- *Delusions of jealousy:* The content of jealous delusions centers around the theme that the person's sexual partner is unfaithful. The idea is held on inadequate grounds and is unaffected by rational judgment.
- *Delusions of grandiosity:* Individuals with grandiose delusions have irrational ideas regarding their own worth, talent, knowledge or power. They may believe that they have a special relationship with famous persons, or grandiose delusions of a religious nature may lead to assumption of the identity of a great religious leader.
- *Hallucinatory voices* that threaten or command the patient, or auditory hallucinations without verbal form, such as whistling, humming and laughing.
- *Other features* include disturbance of affect (though affective blunting is less than in other forms of schizophrenia), volition, speech and motor behavior.

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

Hebephrenic (Disorganized) Schizophrenia

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

Catatonic Schizophrenia

Catatonic (Cata-disturbed) schizophrenia is characterized by marked disturbance of

motor behavior. This may take the form of catatonic stupor, catatonic excitement and catatonia alternating between excitement and stupor.

Clinical Features of Excited Catatonia

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

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

Clinical Features of Retarded Catatonia (Catatonic Stupor)

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

Residual Schizophrenia

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

Undifferentiated Schizophrenia

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

Simple Schizophrenia

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

Post-schizophrenic Depression

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

COURSE AND PROGNOSIS

The classic course is one of exacerbations and remissions. In general, schizophrenia has been described as the most crippling and devastating of all psychiatric illnesses. Several studies have found that over the 5–10 years period after the first psychiatric hospitalization for schizophrenia, only about 10 to 20% of patients can be described as having a good outcome. More than 50% of patients have a poor outcome, with repeated hospitalizations (Table 6.2).

Table 6.2: Prognostic factors in schizophrenias

<i>Good prognostic factors</i>	<i>Poor prognostic factors</i>
Abrupt or acute onset	Insidious onset
Later onset	Younger onset
Presence of precipitating factor	Absence of precipitating factor
Good premorbid personality	Poor premorbid personality
Paranoid and catatonic subtypes	Simple, undifferentiated subtypes
Short duration: <6 months	Long duration: >2 years
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 or widowed
Out-patient treatment	Institutionalization

DIAGNOSIS

A mental status examination, psychiatric history and careful clinical observation form the basis for diagnosing schizophrenia. Rule out physical disorders, substance induced psychosis and primary mood disorders with psychotic features. Official diagnosis is based on ICD 10 criteria.

Investigations

- No diagnostic test definitively confirms schizophrenia, tests may be ordered to rule out disorders that cause psychosis, including vitamin deficiencies, uremia, thyrotoxicosis and electrolyte imbalances.
- CT scan and MRI show enlarged ventricles, enlargement of the sulci on the cerebral surface and atrophy of the cerebellum.

TREATMENT MODALITIES

Pharmacotherapy

An acute episode of schizophrenia typically responds to treatment with antipsychotic agents, which are most effective in its treatment. Conventional antipsychotics are now used less frequently, because of their only partial efficacy and adverse effects. Some non-compliant patients may receive fluphenazine or Haloperidol depot formulations. These are long-acting IM doses that release the drug gradually over several weeks (Box 6.5).

Atypical antipsychotics control wider range of signs and symptoms than conventional agents do and cause few or no adverse motor affects.

Clozapine may cause agranulocytosis—a potentially fatal blood disorder marked by a low white blood cell count and pronounced neutrophil depletion. Patient receiving Clozaine requires routine blood monitoring to detect the disorder because it is reversible if caught early (Box 6.6).

Other drugs which are used in the treatment of schizophrenia are antidepressants, mood stabilizers, benzodiazepines, etc.

(Refer Appendix 21 for a detailed description of these drugs).

Electroconvulsive Therapy

Indications for electroconvulsive therapy (ECT) in schizophrenia include:

- Catatonic stupor
- Uncontrolled catatonic excitement

Box 6.5: Conventional antipsychotics

- » Chlorpromazine: 300–1500 mg/day PO; 50–100 mg/day IM
- » Fluphenazine decanoate: 25–50 mg IM every 1–3 weeks
- » Haloperidol: 5–100 mg/day PO; 5–20 mg/day IM
- » Trifluoperazine: 15–60 mg/day PO; 1–5 mg/day IM

Box 6.6: Commonly used atypical antipsychotics

- » Clozapine: 25–450 mg/day PO
- » Risperidone: 2–10 mg/day PO
- » Olanzapine: 10–20 mg/day PO
- » Quetiapine: 150–750 mg/day PO
- » Ziprasidone: 20–80 mg/day PO
- » Aripiprazole: 10–15 mg/day PO
- » Paliperidone: 1.5–12 mg/day PO
- » Amisulpride: 400–800 mg/day PO

- Severe sideeffects with drugs
- Schizophrenia refractory to all other forms of treatment
- Usually 8–12 ECTs are needed.

Psychological Therapies

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

Behavior therapy: Behavior therapy is useful in reducing the frequency of bizarre, disturbing and deviant behavior, and increasing appropriate behaviors.

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

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

Family therapy: Family therapy typically consists of a brief program of family education about schizophrenia. It has been found that relapse rates of schizophrenia are higher in families with high expressed emotions (EE), where significant others make critical comments, express hostility or show emotional over-involvement. The

significant others are, therefore, taught to decrease expectations and family tensions, apart from being given social skills training to enhance communication and problem-solving.

Psychosocial Rehabilitation

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

NURSING MANAGEMENT

Nursing Assessment

Schizophrenic patients in an acute episode of the illness are seldom able to make a significant contribution to their history. Data may be obtained from family members, other people familiar with the patient and also from old records. A nursing assessment includes information regarding any previous incidence of mental illness or psychotic episodes.

- Observe behavior pattern, posturing, psychomotor, disturbance, appearance, hygiene
- Identify the type of disturbance the patient is experiencing
- Ask the patient about feelings while thought alterations are evident
- Note the effect and emotional tone of the patient and whether they are appropriate in relation to the thought or present situation
- Assess for theme and content of delusional thinking. If the delusion is persecution oriented, assess the nature of the threat and risk for violence
- Assess speech patterns associated with the delusions
- Assess for ability to perform self-care activity, i.e. sleep pattern and interaction with other patients

<i>Objective signs</i>	<i>Subjective symptoms</i>
» Withdrawal behavior	» Hallucination
» Hostility	» Illusions
» Inadequate or inappropriate communication/speech	» Paranoid thinking
» Inadequate food and fluid intake	» Anhedonia
» Psychomotor agitation	» Confusion
» Catatonic rigidity	» Ideas of reference
» Stereotype behavior	» Thought blocking
» Apathy	» Retarded thinking
» Ambivalence	
» Mutism	
» Inability to trust others	» Insomnia

- Determine any suicidal intent or recent attempts that may have been made (Table 6.3).

Nursing Diagnosis I

Disturbed thought process, related to inability to trust, panic anxiety, possible hereditary or biochemical factors evidenced by delusional thinking, extreme suspiciousness of others.

Objective: The patient will:

- Eliminate pattern of delusional thinking
- Demonstrate trust in others
- Demonstrate decreased anxiety level
- Demonstrate improved reality orientation.

Intervention: See Table 6.4.

Barriers to successful intervention:

- Becoming anxious
- Focusing on delusions
- Attempting to prove the patient is wrong
- Setting unrealistic goals

Table 6.4: Nursing interventions for delusional behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Assess the content of the delusion without appearing to probe	Provides baseline data to plan accurate care
Initially clarify meanings, for example, "Who do you think is trying to hurt you?"	Provides baseline data to plan accurate care
Assess the intensity, frequency and duration of the delusion	Provides baseline data to plan accurate care
Assess the context and environmental triggers for the delusional experience	Helps to reduce environmental triggering factors
Approach the patient with calmness, empathy and gentle eye contact	Non-verbal nursing approaches foster the development of trust between nurse and the patient
When patients are suspicious, they may be afraid of everyone, everything and every interaction around them. The nurse must communicate clearly, directly with simple statements	This communication improves patient's understanding
Misinterpretations of patients are clarified, arguments are avoided	Arguing with a patient about delusion is ineffective, inappropriate and may strengthen the patient's belief
Distract the patient from delusions that tend to exacerbate aggressive or potentially violent episodes. Promote activities that require attention to physical skills and will help the patient use time constructively	Engaging the patient in constructive activities increases the reality base and decreases the risk for violent episodes that are provoked by delusions
Careful monitoring is needed if the delusions lead patients to harm themselves or others	Early intervention may prevent aggressive response to delusions
Discourage long discussions about the irrational thinking. Instead talk about real events and real people	Discussions that focus on the false ideas are purposeless and useless and may even aggravate the condition
Following interventions will help highly suspicious patients: » Use the same staff as far as possible » Be honest and keep all the promises » Avoid physical contact in the form of touching the patient » Avoid laughing, whispering or talking quietly where the patient can see but cannot hear what is being said » Avoid competent activities » Use assertive, matter-of-fact yet friendly approach	To promote trust To prevent the patient from feeling threatened
Encourage the patient to express feelings as much as possible	Provides relief from stress
Patient's participation is encouraged in providing care but not forced	This increases feelings of self-worth and facilitates trust
Educate the patient and family or significant others about the patient's symptoms, the importance of medication compliance, and follow-up visits	This will facilitate learning and increase knowledge base, ensure the patient's continued treatment and prevent relapse after discharge from the hospital

Nursing Diagnosis II

Impaired health maintenance related to inability to trust, extreme suspiciousness evidenced by poor diet intake, inadequate food and fluid intake, difficulty in falling asleep.

Objectives : The patient will:

- Maintain adequate nutrition, hydration and elimination
- Maintain adequate sleep and rest
- Take medication as administered.

Interventions: See Table 6.5.

Nursing Diagnosis III

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.

Objectives : The patient will:

- Demonstrate increased interest in self-care
- Complete daily activities with minimum assistance
- Demonstrate adequate personal hygiene skills

Interventions: See Table 6.6.

Table 6.5: Nursing interventions to improve health

<i>Nursing Interventions</i>	<i>Rationale</i>
Assess for malnutrition and dehydration	If the patient's delusions are related to food they may refuse to eat because the patient believes that the food is poisoned
Monitor food and fluid intake	Patient's physiological problems are the first priority. The patient may be unaware of or may ignore his or her needs for food and fluids
Creative approaches may need to be taken with patients who are not eating, such as allowing to take packed foods, fruits, eggs, etc.	To ensure that self-care needs are met
Suspicious patient's sleep may be disturbed by nightmares or severe anxiety so that he cannot fall asleep: provide less stimulating environment (dim light, comfortable bed, less noise, etc.)	Patient may feel more comfortable in less stimulating environment
Administer sedatives if needed	To facilitate normal sleep
Prevent day time naps by involving actively in physical exercises or day treatment program. Example, referral to rehabilitation programs, job training programs, sheltered workshops, etc.	To facilitate normal sleep pattern
If the patient is suspicious or is reluctant to take medications, allow the patient to open the sealed medication packed	The patient has the opportunity to see the medications sealed in packages, which may decrease suspicion
If toileting needs are not being met, establish a structured schedule for the patient	A structured schedule will help the patient establish a pattern so that he can develop a habit of toileting independently
Monitor the patient's elimination patterns. If constipation occurs use medications to establish regularity	Constipation frequently occurs with the use of major tranquilizers, decreased food and fluid intake, and decreased activity level

Table 6.6: Nursing interventions to improve self-care activities

<i>Nursing interventions</i>	<i>Rationale</i>
Assess patient's ability to meet self-care activities	Provides base line data
Provide assistance with self-care needs as required. Some patients who are severely withdrawn may require total care	Patient's safety and comfort are nursing priorities. Good physical grooming can enhance confidence in social situation
Develop a structured schedule for patient's routine for hygiene, toileting, and meals	A structured schedule will help the patient establish a pattern so that he can develop a habit
Encourage the patient to independently perform as many activities as possible	Independent accomplishment enhances self-esteem and promotes repetition of desirable behavior
Praise the patient for complete activities of daily living and for initiating self-care activities	Positive reinforcement enhances self-esteem and promotes repetition of desirable behavior
Encourage wearing appropriate clothes for the setting	Appropriate clothing enhances confidence in social situations
Role model appropriate behavior and explain any task in short simple steps	Short simple steps and role modeling will be easier for the patient to perform activities
Allow the patient enough time to complete any task	It may take the patient longer to dress or comb his or her hair because of a lack of concentration and short attention span
Gradually withdraw assistance and supervise the patient's grooming or other self-care skills	It will improve the patient's independence

Nursing Diagnosis IV

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.

Objectives :The patient will:

- Not injure others or destroy property or self
- Verbalize feelings of anger or frustration
- Express decreased feeling of agitation fear or anxiety.

Interventions: See Table 6.7.

Nursing Diagnosis V

Risk for self-inflicted or life-threatening injury related to command hallucinations evidenced by suicidal ideas, plans or attempts.

Objective: Patient will not harm self.

Interventions: See Table 6.8.

Nursing Diagnosis VI

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.

Objectives :The patient will:

- Demonstrate decreased hallucinations
- Interact with others
- Verbalize plans to deal with hallucinations, if they recur.

Interventions: See Table 6.9.

Nursing Diagnosis VII

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.

Table 6.7: Nursing interventions for violent behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Maintain low level of stimulation (low lighting, low noise, few people, etc.) in the patient's environment	Anxiety levels rise in a stimulating environment and may trigger aggression
Observe patient's behavior frequently	Close observation is necessary so that interventions can be provided to ensure patient's or other's safety
Remove all dangerous objects from the patient's environment	To prevent the patient from using them to harm self or others in an agitated state
Provide a structured environment with scheduled routine activities of daily living	Lack of structure and unexplained changes usually increase agitation and anxiety. Structure enhances the patient's security
Be alert for signs of increasing fear, anxiety, or agitation so that we may intervene as early as possible and prevent harm to the patient or others	The earlier the intervention, the easier it is to calm the patient and prevent harm
Do not use physical restraints or techniques without sufficient reason	The patient has a right to the fewest restrictions possible within the limits of safety
Talk with the patient in a low calm voice	Using a low voice may help to calm the patient
Have a sufficient staff available to indicate a show of strength to the patient if it becomes necessary	This shows the patient evidence of control over the situation and provides some physical security for the staff
Administer tranquilizers as prescribed. Use mechanical restraints if necessary in some cases	If the patient is not calmed by 'talking down' or the use of medications, restraints may have to be used as a last resort
Apply mechanical restraints safely. Check extremities for color temperature, and pulse distal to the restraints for every 15 minutes	Mechanical restraints applied too tightly can impair circulation of blood
If necessary loosen the restraints one at a time to exercise limbs or change the patient's position	The patient may continue to be agitated while in restraints. Loosening one restraint and reapplying it before loosening another can minimize chances of injury to self or others
Perform passive range of motion on restrained limbs and reposition the patient at least every 2 hourly	These actions minimize the deleterious effects of immobility
As agitation subsides encourage the patient to express his feelings	Expression of feelings will decrease anxiety
Help the patient identify and practice ways to relieve anxiety, such as deep breathing, meditation, listening to music, etc.	These activities decrease anxiety
Redirect violent behavior with physical outlets for example exercises	Physical exercise is a safe and effective way of relieving pent-up tension

Table 6.8: Nursing interventions to prevent self-harm

<i>Nursing Intervention</i>	<i>Rationale</i>
Assess the nature and severity of hallucinations by asking the patient to describe	Provides information on risk for self-directed behavior
Create a safe environment for the patient, remove all potentially harmful objects from patient's vicinity (sharp objects, straps, belts, glass items, alcohol, etc.)	Improves patient's safety
Ask the patient directly, "have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan?"	The risk of suicide is greatly increased if the patient has developed a plan and if means exist for the patient to execute the plan
Keep the patient near the nurses station	To improve patient's safety
Do not allow the patient to put the bolt on his side of the door of bathroom or toilet	To improve patient's safety

Table 6.9: Nursing interventions for hallucinatory behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Nurse should be patient, show acceptance and use active listening skills	To establish trusting, interpersonal relationship
Assess for type of hallucinations and characteristics of hallucinations	To determine whether hallucinations are command hallucinations that directs the patient to hurt him or others
Ask what voices are saying and whose voice it is. Avoid further discussion of hallucination to prevent reinforcing inappropriate behavior	To determine whether hallucinations are command hallucinations that directs the patient to hurt him or others
Observe the patient for hallucinating behavior like talking to self, laughing to self, stopping in mid-sentence	Listening and observing are the key to successful intervention
Determine precipitating factors that may exacerbate the patient's hallucinatory experience	Identifying stressors may help to prevent the severity of the hallucinating experience
Interrupt hallucination by calling patient by name or other distraction or move the patient to another area. Be alert to cues that patient is hallucinating	Decreased stimuli provides fewer opportunities for misperception
Help the patient understand the connection between anxiety and hallucinations	If patient can learn to interrupt escalating anxiety, hallucinations may be prevented
Help patient learn that he can dismiss hallucinations by humming or whistling or saying 'go away' or 'be quiet'	Helps in dealing with hallucinations

Contd...

Contd...

Provide a busy schedule of activity to prevent being all alone. Provide conversation or a concrete activity of interest to the patient	When engaged in real activities and interactions it becomes more difficult for him to respond to hallucinations
Show acceptance of the patient's behavior and of the patient as a person	The patient may need help to see that hallucinations are a part of the illness, not under the patient's control
Listen actively to the patient's family/significant others, allowing them to express fears and anxieties about mental illness, giving them support and empathy and emphasizing patient's strengths	Helps family members to respond adaptively to the difficult situation
Educate the patient and family/significant others about the patient's symptoms, the importance of medication compliance	This will facilitate learning and increase the knowledge base of the patient and family/significant others, ensure patient's continuity of treatment and prevent relapses after discharge

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

Interventions: See Table 6.10.

Nursing Diagnosis VIII

Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by loosening of associations, echolalia, verbalizations that reflect concrete thinking, and poor eye contact.

Objective: Patient will be able to communicate appropriately and comprehensibly by the time of discharge.

Interventions: See Table 6.11.

Nursing Diagnosis IX

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

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

Interventions: See Table 6.12.

Evaluation

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

Table 6.10: Nursing interventions for withdrawn behavior

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

Table 6.11: Nursing interventions for impaired verbal communication

<i>Nursing Interventions</i>	<i>Rationale</i>
Attempt to decode incomprehensible communication pattern. Seek validation and clarification by stating, "Is it what you mean...?" or "I don't understand what you mean by that. Would you please clarify it for me?"	These techniques reveal how the patient is being perceived by others, while the responsibility for not understanding is accepted by the nurse
Facilitate trust and understanding by maintaining staff assignments as consistently as possible. The techniques of verbalizing the implied is used with the patient who is mute (either unable or unwilling to speak). For example, 'That must have been a very difficult time for you when your mother left. You must have felt all alone'	This approach conveys empathy and encourages the patient to disclose painful issues
Anticipate and fulfill patient's needs until functional communication pattern returns	Self-care ability may be impaired in some patients who may need assistance initially

Table 6.12: Nursing interventions to improve family coping skills

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

- Has the patient established trust with at least one staff member?
 - Is delusional thinking still prevalent?
 - Are hallucinations still evident?
 - Is the patient able to interact with others appropriately?
 - Is the patient able to carry out all activities of daily living independently?
- When evaluating the effectiveness of planned interventions, the nurse should look for signs that indicate improved functioning of the patient. These are:
- Communication with staff and other patients in an appropriate manner and reality based conversation is evidence of improved thinking process.
 - A decrease in bizarre and inappropriate behavior is evidence of improved thinking and perception.
 - Reduced suspiciousness is evidenced by increased willingness to trust staff and other patients.
 - Compliance with taking medications and increased food intake are also evidence

that the patient has decreased fear of poisoning.

- Expression of feelings is a positive step as they move toward identification of social support.
- Involvement in ward activities is a demonstration of their willingness to engage in the company of others.

OTHER 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.

ICD10 includes the following disorders under this category:

F22 : Persistent delusional disorders

F23 : Acute and transient psychotic disorders

F24 : Induced delusional disorders

F25 : Schizoaffective disorders

Capgras syndrome

Persistent Delusional Disorder

It is a relatively stable and chronic course, characterized by presence of well-systematized delusions of non-bizarre type. The emotional response and 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 (must be present for at least 3 months)
- Absence of significant or persistent hallucinations
- Absence of organic mental disorders, schizophrenia and mood disorders.

Very often these individuals are able to carry on a near normal social and occupational life without arousing suspicion regarding the delusional disorder.

Acute and Transient Psychotic Disorders

These disorders neither follow the course of schizophrenia nor resemble mood disorders in clinical picture and 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 and intensity from day-to-day or within the same day.
- Marked emotional turmoil, which ranges from intense feelings of happiness and ecstasy to anxiety and irritability.
- Do not fulfill the criteria for schizophrenia.

Induced Delusional Disorders

This is an uncommon delusional disorder characterized by a sharing of delusions between usually two (folie a deux) or occasionally more persons, who usually have a closely knit emotional bond. Only one person has the 'genuine' delusions due to an underlying psychiatric disorder. On separation of the two, 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 and mood disorders are prominently present within the same episode.

Types

- Schizoaffective disorder—depressed type
- Schizoaffective disorder—manic type
- Schizoaffective mixed type

Capgras Syndrome (The Delusion of Doubles)

It is characterized by delusional conviction that 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 and persistent mental illness with an onset in early adulthood, is not usually associated with older adults. The prevalence was thought to decline with aging as a result of early mortality, decreased symptom severity and recovery.
- Late-onset schizophrenia (after 45 years) is more prevalent in women than in men and characterized by paranoid delusions. It has varying 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.

FOLLOW-UP, HOMECARE AND REHABILITATION FOR SCHIZOPHRENIA PATIENT

The requirements for patients with schizophrenia are regular medication, support from family, training to family members in caring of patient, support in crises, rehabilitation, acceptance and integration into the community.

Patients with schizophrenia are no longer hospitalized for long periods. Most return to live in the community with assistance provided by family and support services. Complete remission is uncommon in patients with schizophrenia. Patients with chronic schizophrenia may never be entirely free of psychotic symptoms but can learn to manage them. Individuals who chronically experience hallucinations, especially the auditory command type, require closer supervision.

Patient and Family Teaching

- Explain to the patient and family that schizophrenia is a chronic disorder with symptoms that affect the person's thought processes, mood, emotions and social functions throughout the person's lifetime.
- Teach the patient and family about the importance of medication compliance and the therapeutic/non-therapeutic effects of antipsychotic medications.
- Instruct the patient and family to recognize impending symptom exacerbation and to notify physician when the patient poses a threat or danger to self or others and requires hospitalization.
- Teach the patient and family to identify psychosocial or family stressors that may exacerbate symptoms of the disorder and methods to prevent them.

Expressed Emotions

Caring for a person with schizophrenia is highly challenging and might result in a negative emotional atmosphere in the patient's family. This negative family atmosphere causes not only relapse of symptoms (deterioration in or worsening of symptoms after a temporary improvement) and rehospitalization, but it has significant effect on the course of the illness. One of the contributing factors to relapse in psychiatric disorders especially in schizophrenia is expressed

emotion (EE). EE is the critical, hostile, and emotionally over-involved attitude that relatives have towards a family member with a mental disorder. The symptoms of the patient influences the caregiver's EE and this in turn influences the symptom relapse in patients. Hence, the treatment should attempt at a holistic, multidisciplinary, biopsychosocial approach, which should manage the patient and family in all dimensions.

The psychosocial interventions, such as psychoeducation, teaching communication skills, problem-solving skills, social skills, healthy coping strategies, providing occupational training and crisis management with the ongoing pharmacotherapy proved effective in reducing the high EE and improving treatment outcome.

Rehabilitation of Schizophrenia Patients

The focus of psychiatric rehabilitation is strengthening self-care and promoting and improving quality of life through relapse prevention. Psychiatric rehabilitation has improved outcomes by providing community support services to decrease hospital readmission rates and increase community integration.

Rehabilitative services for schizophrenia patients are:

- Social skills training
- Vocational rehabilitation
- Half-way homes
- Long-term homes
- Day hospitals, etc.

Nurses need to be familiar with the agencies in the community that provide these services. Collaborative relationships between mental health care providers and community agencies are absolutely essential if rehabilitation is to succeed. Nurses introduce them with local rehabilitation centers on self-help groups to patients and family members to reduce readmissions.

May 24th of every year is observed as World Schizophrenia Day.

REVIEW QUESTIONS

Long Essays

1. Discuss the concepts of schizophrenia and identify predisposing factors, write a note on nursing management of a patient with paranoid schizophrenia.
2. Discuss nursing management of a patient with catatonic schizophrenia.

Short Essays

1. Types of schizophrenia
2. Schizophrenia
3. Excited catatonia
4. Dynamics of schizophrenia

Short Answers

1. Schizophrenia
2. Delusional disorder
3. Catatonic stupor

MULTIPLE CHOICE QUESTIONS

1. **The word schizophrenia was coined by:**
 - a. Eugen Bleuler
 - b. Emil Kraepelin
 - c. Sigmund Freud
 - d. Schneider
2. **First rank symptoms of schizophrenia (FRSS) was explained by:**
 - a. Eugen Bleuler
 - b. Emil Kraepelin
 - c. Sigmund Freud
 - d. Schneider
3. **A patient with schizophrenia exhibits flattening of emotions. The nurse documents this finding as:**
 - a. Anhedonia
 - b. Regression
 - c. Blunted affect
 - d. Asociality

- 4. The “four A’s” of schizophrenia include all, except:**
- Autistic thinking
 - Associative looseness
 - Ambivalence
 - Auditory hallucinations
- 5. Which of the following is a negative symptom of schizophrenia?**
- Delusions
 - Apathy
 - Hallucinations
 - Thought disturbances
- 6. Which of the following is a positive symptom of schizophrenia?**
- Delusions
 - Apathy
 - Ambivalence
 - Irritability
- 7. Motor disturbances are present in _____ schizophrenia.**
- Paranoid schizophrenia
 - Hebephrenic schizophrenia
 - Catatonic schizophrenia
 - Residual schizophrenia
- 8. Mutism, negativism, waxy flexibility, bizarre posture and stupor are characteristics of:**
- Paranoid schizophrenia
 - Hebephrenic schizophrenia
 - Catatonic schizophrenia
 - Residual schizophrenia
- 9. Suspiciousness, auditory hallucinations, disturbance in affect and speech are characteristics of:**
- Paranoid schizophrenia
 - Hebephrenic schizophrenia
 - Catatonic schizophrenia
 - Residual schizophrenia
- 10. Incoherence, giggling, mirror gauging, grimacing and mannerisms are characteristics of:**
- Paranoid schizophrenia
 - Hebephrenic schizophrenia
 - Catatonic schizophrenia
 - Residual schizophrenia
- 11. Pathological repetition involving imitation of speech of another person is termed as:**
- Echolalia
 - Echopraxia
 - Encopresis
 - Enuresis
- 12. Pathological repetition by imitation of the behavior of another person is termed as:**
- Echolalia
 - Echopraxia
 - Encopresis
 - Enuresis
- 13. Delusion of reference is best illustrated by:**
- The neighbor is trying to kill me
 - The food is being poisoned
 - The news announcer on TV is talking about me
 - The night shift nurse does not like me
- 14. During his assessment interview, a schizophrenic patient tells the nurse, “My life partner is unfaithful and having an extra marital affair”. The nurse documents that the patient is experiencing:**
- Delusion of persecution
 - Delusion of jealousy
 - Delusion of grandiosity
 - Illogical thinking
- 15. A patient is refusing to take the food. He says that food is poisoned. Which of the following is the most appropriate nursing intervention?**
- Assure the patient that the food is not poisoned
 - Assure the patient by tasting the patient's food
 - Explain the patient that it is a symptom of disease
 - Allow the patient to take packed foods, fruits, eggs etc.

- 16. Patient with a history of schizophrenia has been admitted for suicidal ideation. The patient states "God is telling me to kill myself right now." The nurse's best response is:**
- I understand that God's voice is real to you, but I do not hear anything. I will stay with you
 - Do not worry the voices are part of your illness
 - The voices are all in your imagination, think of something else and it will go away
 - Do not think of anything right now, just go and relax
- 17. Which of the following statements of a patient would require the immediate attention of the nurse?**
- I am getting thoughts of hurting myself, they are scary to me
 - I am not getting sleep
 - I thought about taking alcohol regularly
 - I want to be free from all these medicines
- 18. A patient who was wandering aimlessly around the streets, unkempt and having inappropriate behavior, on observation is found talking and laughing to self, and at times irritable. Which of the following disorder meets these characteristics?**
- Borderline personality disorder
 - Chronic anxiety disorder
 - Chronic schizophrenia
 - Major depressive disorder
- 19. Which of the following nursing intervention is most appropriate for a patient talking and laughing to self?**
- Explain to the patient that such behavior is inappropriate
 - Ignore the patient behavior
 - Divert the patient by engaging in one or other activities
 - Isolate the patient in another room
- 20. Which of the following nursing intervention/s is most appropriate for a patient exhibiting agitation and violent behavior?**
- Maintain low level of stimuli in the environment
 - Frequent observation of the behavior
 - Remove all dangerous objects from the patient environment
 - All of the above
- 21. Which of the following nursing intervention/s is most appropriate for a patient who is having poor verbal communication?**
- Explain to the patient the cause for impaired verbal communication
 - Give positive reinforcement for patient's voluntary interaction with others
 - Provide a structured schedule for activity
 - All of the above
- 22. What is relapse ?**
- It is a stage of diminution in symptoms
 - Deterioration of symptoms
 - Recurrence of symptoms
 - Worsening of symptoms after temporary improvement
- 23. What is remission?**
- It is a stage of reduction in symptoms
 - Deterioration of symptoms
 - Recurrence of symptoms
 - Worsening of symptoms after temporary improvement
- 24. Which of the following is a contributory factor for relapse among schizophrenia patients?**
- Expressed emotions
 - Adequate support system
 - Adequate drug compliance
 - Regular follow-up

25. What is expressed emotion?

- a. Critical attitude of the family members toward the patient
- b. Hostile attitude of family members toward the patient
- c. Over involvement attitude of family members toward the patient
- d. All of the above

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. a | 2. d | 3. c | 4. d | 5. b | 6. a | 7. c | 8. c | 9. a | 10. b |
| 11. a | 12. b | 13. c | 14. b | 15. d | 16. a | 17. a | 18. c | 19. c | 20. d |
| 21. b | 22. d | 23. a | 24. a | 25. d | | | | | |

Chapter 7

Nursing Management of Patient with Mood Disorders

MOOD DISORDERS

Mood disorders are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, which is not due to any other physical or mental disorder. The prevalence rate of mood disorders is 1.5 percent, and it is uniform throughout the world.

Classification of Mood Disorders

F30–F39 : Mood (affective) disorders

- F30 : Manic episode
- F31 : Bipolar affective disorder
- F32 : Depressive episode
- F33 : Recurrent depressive disorder
- F34 : Persistent mood disorder
- F38 : Other mood disorders
- F39 : Unspecified mood disorder.

MANIC EPISODE

Mania refers to a syndrome in which the central features are over-activity, mood change (which may be towards elation or irritability) and self-important ideas. The lifetime risk of manic episode is about 0.8–1%. This disorder occurs in episodes lasting usually 3–4 months, followed by complete recovery.

Classification of Mania (ICD10)

- F30 : Manic episode
- F30.0 : Hypomania

- F30.1 : Mania without psychotic symptoms
- F30.2 : Mania with psychotic symptoms
- F30.8 : Other manic episodes
- F30.9 : Manic episode unspecified.

Etiology

Neurotransmitter and structural hypotheses: Manic episodes are related to excessive levels of norepinephrine and dopamine, an imbalance between cholinergic and noradrenergic systems or a deficiency in serotonin.

Biologic findings suggest that lesions are more common in this population in areas of the brain such as the right hemisphere or bilateral subcortical and periventricular gray matter.

Genetic considerations: Monozygotic (identical) twins have a higher rate of incidence than normal siblings and other close relatives. Siblings and close relatives have a higher incidence of manic-depressive illness than a general population, and cyclothymic characteristics are common among family members of bipolar patients.

- First degree relative: 5–10% chance
- Identical twin with bipolar disorders: About 40–70% chance

Psychodynamic theories: Developmental theorists have hypothesized that faulty family dynamics during early life are responsible for manic behaviors in later life. Another

psychodynamic hypothesis explains manic episodes as a defense against or denial of depression.

Psychopathology of Mania

Manic state shows lack of inhibition, apparent quickness of psychological reaction, distractability, and flight of ideas. Elation of mood is accompanied by a feeling of general well-being, which in the manic state is manifested as lack of insight.

Abraham believed that the manic episodes may reflect an inability to tolerate a developmental tragedy, such as the loss of a parent. Klein viewed mania as a defensive reaction to depression. Bipolar disorder most likely results from an interaction between genetic, biological and psychosocial determinants.

Clinical Features

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

Elevated, Expansive or Irritable Mood

Elevated mood in mania has four stages depending on the severity of manic episodes (Box 7.1).

Expansive mood is unceasing and unselective enthusiasm for interacting with people and surrounding environment. Sometimes irritable

Box 7.1: Four stages of elevated mood

- » Euphoria (Stage I): Increased sense of psychological well-being and happiness not in keeping with ongoing events
- » Elation (Stage II): Moderate elevation of mood with increased psychomotor activity
- » Exaltation (Stage III): Intense elevation of mood with delusions of grandeur
- » Ecstasy (Stage IV): Severe elevation of mood, intense sense of rapture or blissfulness seen in delirious or stuporous mania

mood may be predominant, especially when the person is stopped from doing what he wants. There may be rapid, short-lasting shifts from euphoria to depression or anger.

Psychomotor Activity

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

Speech and Thought

- *Flight of ideas:* Thoughts racing in mind, rapid shifts from one topic to another
- *Pressure of speech:* Speech is forceful, strong and difficult to interrupt. Uses playful language with punning, rhyming, joking, teasing and speaks loudly
- *Clang association:* These are ideas that are related only by similar or rhyming sounds rather than actual meaning
- Delusions of grandeur
- Delusions of persecution
- Distractibility.

Other Features

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

Symptoms of Hypomania

Hypomania is a lesser degree of mania. There is a persistent mild elevation of mood and increased sense of psychological well-being and happiness not in keeping with ongoing events. In some cases, irritability, conceit, and boorish behavior may take the place of the more usual euphoric sociability.

Concentration and attention may be impaired, thus diminishing the ability to settle down to work or to relaxation and leisure, but this may not prevent the appearance of interests in quite new ventures and activities. In fact, the ability to function becomes better in hypomania, and there is a marked increase in productivity and creativity; many artists and writers have contributed significantly during such periods.

Diagnosis

- Psychological tests such as young Mania Rating Scale
- ICD10 diagnostic criteria
- Based on signs and symptoms.

Treatment Modalities

Pharmacotherapy

- Lithium: 900–2100 mg/day
 - Carbamazepine: 600–1800 mg/day
 - Sodium valproate: 600–2600 mg/day
 - Lamotrigine: 25–200 mg/day
 - Other drugs: Clonazepam, calcium channel blockers, etc.
- (Refer Chapter 5 for more details on these drugs).

Electroconvulsive Therapy

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

Psychosocial Treatment

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

Nursing Management for Mania

Nursing Assessment

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

During assessment the nurse should include mood and affect, thinking and perceptual ability, sleep disturbances, changes in energy level and character of speech patterns. Mood and affect should be assessed for congruency. Note patterns of verbal speech. The tone of voice, pace at which thoughts are processed and communicated and the rate at which words are spoken are all relevant. Assess for sleeping and eating patterns, energy levels and weight changes (Table 7.1).

Table 7.1: Objective signs and subjective symptoms of manic patient

Objective signs	Subjective symptoms
<ul style="list-style-type: none"> » Disturbance of speech » Rapid speech » Loud, pressured speech » Easily distracted » Over activity » Mood lability » Weight changes 	<ul style="list-style-type: none"> » Feelings of joy » Rapid mood swings » Sleep disturbances » Delusions and hallucinations

Nursing Diagnosis I

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

Objective: Patient will not injure self.

Interventions: See Table 7.2.

Nursing Diagnosis II

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

Objective: Patient will not harm self or others.

Interventions: See Table 7.3.

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

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

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

Nursing Diagnosis III

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

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

Intervention: See Table 7.4.

Nursing Diagnosis IV

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

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

Intervention: See Table 7.5.

Table 7.2: Nursing interventions for hyperactive behavior

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

Table 7.3: Nursing interventions for manic violent behavior

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

Table 7.4: Nursing interventions to improve nutritional status of manic patient

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

Table 7.5: Nursing interventions for manipulative behavior

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

Nursing Diagnosis V

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

Objective: Patient will have realistic expectations about self.

Intervention: See Table 7.6

Nursing Diagnosis VI

Interupped family processes related to euphoric—mood and grandiose ideas, manipulative behavior, refusal to accept responsibility for own actions.

Objective: The family members will demonstrate coping ability in dealing with the patient.

Intervention: See Table 7.7.

Evaluation

Evaluation focuses on determining whether improvement has occurred in the patient's thought processes, behavior, and overall

functioning. Improved communication and social interaction result as thought processes become more rational and reality oriented. As mood states are reduced the patient is able to eat and sleep with less disturbance.

Nursing Management for Hypomania

Assessment

Assessment includes judging the severity of the symptoms, forming an opinion about the causes, assessing the patient's social resources, and gauging the effect of the disorder on other people.

- In assessing the severity of symptoms, the patient's capacity to work or engage in family life and social activities should be noted. This is important to prevent the patient from causing himself long-term difficulties due to ill-judged decisions and unjustified extravagance
- Usually, the causes may be endogenous, but it is important to identify any life events that may have provoked the onset. Sometimes,

Table 7.6: Nursing interventions to improve self-esteem among manic patient

<i>Nursing interventions</i>	<i>Rationale</i>
Ask how patient would like to be addressed. Avoid approaches that imply different perception of the patient's importance	Grandiosity is thought actually to reflect low self-esteem
Explain rationale for requests by staff unit routine, etc. Strictly adhere to courteous approaches, matter-of-fact style and friendly attitudes	Nursing approaches should reinforce patient's dignity and worth; understanding reasons enhances co-operation with regimen
Encourage verbalization and identification of feelings related to issues of chronicity, lack of control over-self, etc	Problem solving begins with agreeing on the problem
Offer matter-of-fact feedback regarding unrealistic plans. Help him to set realistic goals for himself	Unrealistic goals will increase failures and lower self-esteem even more
Encourage patient to view life after discharge and identify aspects over which control is possible. Through role play, practice how he will demonstrate that control	Role rehearsal is helpful in returning patient to the level of independent functioning. When the individual is functioning well, sense of self-esteem is enhanced

Table 7.7: Nursing interventions to improve family coping skills

<i>Nursing interventions</i>	<i>Rationale</i>
Determine individual situation and feelings of individual family members like guilt, anger, powerlessness, despair and alienation	Living with a family member having bipolar illness fosters a multitude of feelings and problems that can affect interpersonal relationships and may result in dysfunctional responses and family disintegration
Assess patterns of communication. For example: Are feelings expressed freely? Who makes decisions? What is the interaction between family members?	Provides clues to the degree of problem being experienced by individual family members and coping skills used to handle the crisis
Determine patterns of behavior displayed by patient in his relationships with others, e.g. manipulation of self-esteem of others, limit testing, etc	These behaviors are typically used by the manic individual to manipulate others. The result is alienation, guilt, ambivalence and high rates of divorce
Assess the role of patient in the family, like provider, etc. and how the illness affects the roles of other members	When the role of an ill person is not filled family disintegration can occur
Provide information about behavior patterns and expected course of the illness	Assists family to understand the various aspects of bipolar illness. This may relieve guilt and promote family discussions of the problems and solutions

the episode may follow physical illness, treatment by drugs (especially steroids), or surgical operations

- The patient's resources and effect of symptoms on other people should be assessed. The patient's responsibilities in the care of dependent children or at work should be considered carefully.

Nursing Diagnosis I

Risk of injury related to inability to perceive potentially harmful situations evidenced by impulsive behavior.

Objective: To reduce risky behavior and avert injury.

Intervention: See Table 7.8.

Nursing Diagnosis II

Impaired social interaction related to short attention span, high level of distractibility and labile mood, evidenced by insufficient or excessive quantity or ineffective quality of social exchange.

Objective: Patient will demonstrate acceptable interaction with others.

Intervention: See Table 7.9.

Nursing Diagnosis III

Ineffective coping skills related to poor impulse control evidenced by acting out behavior.

Objective: Patient will not harm self or others.

Intervention: See Table 7.10.

Nursing Diagnosis IV

Disturbed thought process related to disorientation and decreased concentration evidenced by disruption in activities.

Objective: Patient will demonstrate adequate cognitive function.

Intervention: See Table 7.11.

Evaluation

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

DEPRESSIVE EPISODE

Depression is a widespread mental health problem affecting many people. The lifetime

Table 7.8: Nursing interventions to reduce risky behavior and avert injury among hypomanic patients

<i>Nursing interventions</i>	<i>Rationale</i>
Talk with the patient about safe and unsafe behavior	This provides the patient with clear expectations
Assess the frequency and severity of accidents	It is necessary for baseline data
Provide supervision for potentially dangerous situations. Limit the patient's participation in activities when safety cannot be ensured	This is necessary, because the patient's ability to perceive harmful consequences of a behavior is impaired
State expectations for behavior in clear terms	The patient may be unable to process social cues to guide reasonable behavior choices
Make correct feedback as specific as possible. For example, "Do not jump down the stairs. Walk down one step at a time"	Specific feedback will help the patient understand expectations
Set limits that are directly related to the undesirable behavior. Institute them as soon as possible after the occurrence of the behavior. Continuous supervision is needed to prevent the patient from developing full-blown manic symptoms	The patient will be better able to draw the correlation between undesirable behavior and consequences if the two are related to each other

Table 7.9: Nursing interventions to improve social interaction among hypomanic patients

<i>Nursing interventions</i>	<i>Rationale</i>
Identify the factors that aggravate and alleviate the patient's performance	External stimuli that exacerbate the patient's problems can be identified and minimized
Provide an environment as free from distractions as possible. Gradually increase the amount of environmental stimuli	The patient's ability to deal with external stimulation is impaired
Give instructions slowly, using simple language and concrete directions	The patient's ability to comprehend complex instructions is reduced
Provide positive feedback for completion of each step of desirable activity/behavior	Positive feedback increases the likelihood of desirable behavior
Protect other patients from being drawn into the patient's influence, especially those who might be non-assertive or vulnerable	Patients with hypomania have manipulative behavior

Table 7.10: Nursing interventions to increase self-control among hypomanic patients

<i>Nursing interventions</i>	<i>Rationale</i>
State rules, expectations and responsibilities clearly to the patient, including consequences for exceeding limits	Clear expectations give the patient limits to which his behavior must conform, and what to expect if he exceeds those limits
Use time out when the patient begins to lose behavioral control	Time out period is not a punishment but an opportunity for the patient to regain control
Encourage the patient to verbalize his feelings	It is an initial step towards resolving difficulties
Teach the patient a simple problem solving process: Describe the problem, list alternatives, evaluate choices, and select and implement an alternative	The patient's ability to think, judge or solve problems is impaired

Table 7.11: Nursing interventions to improve cognitive function in hypomanic patients

<i>Nursing interventions</i>	<i>Rationale</i>
Use a firm yet calm, relaxed approach	The nurse's presence and manner will help to communicate her interest
Set and maintain limits on behavior that is destructive or adversely affects others	Limits must be established by others when the patient is unable to use internal controls effectively
Decrease environmental stimuli whenever possible. Respond to cues of increased restlessness or agitation by removing stimuli and perhaps isolating the patient, to single or private occupancy room may be beneficial	The patient's ability to deal with stimuli is impaired
Provide a consistent structured environment. Let the patient know what is expected of him. Set goals with the patient as soon as possible	Consistency and structure can reassure the patient and foster desirable behavior

risk of depression in males is 8–12% and in females it is 20–26%. Depression occurs twice as frequently in women as in men. The median age at onset of bipolar disorder is 18 years in men and 20 years in women. The highest incidence of depressive symptoms has been indicated in individuals without close interpersonal relationships and in persons who are divorced or separated. Prevalence of suicide shows large peak in the spring and a smaller one in October. Major depressive disorders often co-occur with other psychiatric and substance-related disorders. Depression often is associated with a variety of medical conditions.

Depression is one of the leading causes of disability across the world. The World Health Organization 2006 estimates that depression will rank second only to heart disease by 2020 in terms of global disability. An estimated 3–4% of India's 100 crore plus population suffer from major mental disorders and about 7–10% of the population suffers from minor depressive disorders (Sinha 2011).

Classification of Depression (ICD10)

- F32 : Depressive episode
- F32.0 : Mild depressive episode
- F32.1 : Moderate depressive episode
- F32.2 : Severe depressive episode without psychotic symptoms
- F32.3 : Severe depressive episode with psychotic symptoms
- F32.8 : Other depressive episodes—atypical depression
- F32.9 : Depressive episode, unspecified
- F33 : Recurrent depressive disorder.

Etiology

Biological Theories

The etiology of depression has been biologically attributed to alterations in neurochemical, genetic, endocrine and circadian rhythm functions.

Neurochemical: Research findings suggest that depression results when levels of norepinephrine and serotonin decrease and dysregulation of acetylcholine and GABA occurs.

Genetic theories:

- Major depressive disorders occur more often in first degree relatives than they do in the general population.
- Studies of identical twins show that when one twin is diagnosed with major depression, the other twin has a greater than 70% chance of developing it.

Endocrine theories: Normally, the hypothalamic-pituitary-adrenal (HPA) axis is a system that mediates the stress response. However, in some depressed people this system malfunctions and creates cortisol, thyroid and hormonal abnormalities.

Circadian rhythm theories: Circadian rhythms are responsible for the daily regulation of wake-sleep cycles, arousal and activity patterns, and hormonal secretions. Individuals experiencing circadian rhythm changes are at increased risk for developing depressive symptoms and other mood symptoms. These changes might be caused by medications, nutritional deficiencies, physical or psychological illnesses, hormonal fluctuations.

Changes in brain anatomy: Loss of neurons in the frontal lobes, cerebellum and basal ganglia has been identified in depression.

Psychosocial Theories

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

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

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

- Negative expectations of the environment
- Negative expectations of the self
- Negative expectations of the future.

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

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

Transactional Model of Stress/ Adaptation

According to transactional model of stress/adaptation, depression occurs as a combination of predisposing factors (family history and biochemical alterations), past experiences (object loss in infancy, defect in cognitive development) and existing conditions (lack of adequate support system, inadequate coping skills, other physiological conditions). Because of weak ego strength, patient is unable to use coping mechanisms effectively. Maladaptive coping mechanisms used are denial, regression, repression, suppression, displacement and isolation. All these factors lead to clinical depression.

Psychopathology

The psychopathology of the affective disorders can most easily be described by reference to the similarity of the abnormal affect with normal emotions of the same kind. In depression, the patients' sadness deepens to a morbid depression, and the difficulty in concentration becomes retardation of all thought and action. Depressive patients may show a complete failure of all insight, deny that they are ill and hold steadfastly to their ideas of guilt and punishment.

Clinical Features

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

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

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

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

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

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

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

Box 7.2: Somatic symptoms of depression

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

Somatic symptoms of depression are also termed as 'melancholic features' in DSMIV (Table 7.12).

Other Features

- Difficulties in thinking and concentration
- Subjective poor memory
- Menstrual or sexual disturbances
- Vague physical symptoms such as fatigue, aching discomfort, constipation, etc. (Box 7.12).

Diagnosis

- Psychological tests—Beck depression inventory. Hamilton rating scale for depression to assess severity and prognosis.
- Dexamethasone suppression test showing failure to suppress cortisol secretions in depressed patients.
- Toxicology screening suggesting drug-induced depression.
- Based on ICD10 criteria.

Table 7.12: Symptoms of depression

Common symptoms	Other symptoms
Apathy	Fatigue
Sadness	Thoughts of death
Sleep disturbances	Decreased libido
Hopelessness	Dependency
Helplessness	Spontaneous crying
Worthlessness	Passiveness
Guilt, Anger	

Treatment Modalities**Psychopharmacology**

Antidepressants establish a blockade for the reuptake of norepinephrine and serotonin into their specific nerve terminals. This permits them to linger longer in synapses and to be more available to postsynaptic receptors. Antidepressants also increase the sensitivity of the postsynaptic receptor sites. SSRIs act by inhibiting the reuptake of serotonin and increasing its levels at the receptor site. Tricyclic antidepressants mode of action is by blocking the reuptake of norepinephrine (NE) and/or serotonin (5-HT) at the nerve terminals, thus increasing the NE and 5-HT levels at the receptor site. MAOIs are responsible for the degradation of catecholamines after reuptake. The final effect is the same, a functional increase in the NE and 5-HT levels at the receptor site. Atypical antidepressants modestly inhibit the reuptake of norepinephrine and dopamine.

Major categories of antidepressants are:

1. Selective Serotonin Reuptake Inhibitors (SSRIs)
Citalopram (Celexa), Fluoxetine (Prozac), Sertraline (Zoloft)
2. Tricyclic Antidepressants (TCAs)
Amitriptyline (Elavil), Clomipramine (Anafranil), Imipramine (Tofranil), Doxepin (Adapin, Sinequan)
3. Monoamine oxidase inhibitors (MAOIs).
Isocarboxazid (Marplan), Phenelzine (Nardil)
4. Other Newer Antidepressant drugs
Bupropion, Mirtazapine
(Refer Chapter 5, Page 128 for more details)

Physical Therapies

1. *Electroconvulsive therapy (ECT):* Severe depression with suicidal risk is the most important indication for ECT (Refer Chapter 5, Page 137 for more details).
2. *Light therapy:* Sometimes called phototherapy involves exposing the patient to an

artificial light source during winter months to relieve seasonal depression. The light source must be very bright, full-spectrum light, usually 2,500 lux (See Chapter 5, page 139 for more details).

3. *Repetitive transcranial magnetic stimulation (TMS) and vagus nerve stimulation (VNS)* directly affect brain function by stimulating the nerves that are direct extensions of the brain (Refer Chapter 5, Page 140 for more details).

Psychosocial Treatment

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

Nursing Management of Major Depressive Episode

Nursing Assessment

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

- Presence of marked helplessness
- Male sex
- More than 40 years of age
- Unmarried, widowed or divorced
- Written or verbal communication of suicidal intent or plan
- Early stages of depression
- Recovery from depression (at the peak of depression the patient is usually either too depressed or too retarded to commit suicide)
- Period of three months from recovery. The nurse should routinely enquire about the patient's work, finances, family life, social activities, general living conditions and physical health. It is also important to consider whether the patient could endanger other people, particularly if there are depressive delusions and the patient may act on them
- Observe for mood, affect, thinking, perceptual ability, somatic complaints, sleep disturbances, and changes in energy level
- Determine the amount of assistance required for personal hygiene, and elimination needs
- Assess for any suicidal ideation and whether a plan has been devised
- Assess for objective signs and subjective symptoms (Table 7.13)

Table 7.13: Objective signs and subjective symptoms of depression

<i>Objective signs</i>	<i>Subjective symptoms</i>
Alterations of activity	Anhedonia
Poor personal hygiene	Worthlessness, hopelessness, helplessness
Apathy	
Altered social interactions » Impairment of cognition » Somatic symptoms » Delusions and hallucinations	Suicidal ideas

Nursing Diagnosis I

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

Objective: Patient will not harm self.

Intervention: See Table 7.14.

Nursing Diagnosis II

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

Table 7.14: Nursing interventions for suicidal behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Ask the patient directly, "Have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan?"	The risk of suicide is greatly increased if the patient has developed a plan and if means exist for the patient to execute the plan
Create a safe environment for the patient. Remove all potentially harmful objects from patient's vicinity, for example—sharp objects, straps, belts, glass items, alcohol, etc. Supervise closely during meals and medication administration	Patient's safety is nursing priority
Formulate a short-term verbal or written contract that the patient will not harm self. Secure a promise that the patient will seek out staff when feeling suicidal	A degree of the responsibility for his safety is given to the patient. Increased feelings of self-worth may be experienced when patient feels accepted unconditionally regardless of behavior
It may be desirable to place the patient near the nursing station. Do not leave the patient alone. Observe for passive suicide—the patient may starve or fall asleep in the bath-tub or sink	Patient's safety is nursing priority
Close observation is especially required when the patient is recovering from the disease	At the peak of depression the patient is usually too retarded to carry out his suicidal plans
Do not allow the patient to put the bolt on his side of the door of bathroom or toilet	Patient's safety is nursing priority
If the patient suddenly becomes unusually happy or gives any other clues of suicide, special observation may be necessary	-do-
Encourage the patient to express his feelings, including anger	Depression and suicidal behavior may be viewed as anger turned inward on the self. If the anger can be verbalized in a non-threatening environment, the patient may be able to eventually resolve these feelings

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

Intervention: See Table 7.15.

Table 7.15: Nursing interventions for grief reaction

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

Nursing Diagnosis III

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

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

Intervention: See Table 7.16.

Nursing Diagnosis IV

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

Table 7.16: Nursing interventions for over dependence behavior

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

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

Intervention: See Table 7.17.

Table 7.17: Nursing interventions to improve self-esteem in depressed patients

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

Nursing Diagnosis V

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

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

Intervention: See Table 7.18.

Table 7.18: Nursing interventions to improve communication skills in depressed patients

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

Nursing Diagnosis VI

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

Objective: Patient will sleep adequately during the night.

Interventions: See Table 7.19.

Table 7.19: Nursing interventions to improve sleeping pattern

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

Nursing Diagnosis VII

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

Objective: Patient's nutritional status will improve.

Intervention: See Table 7.20.

Nursing Diagnosis VIII

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

Table 7.20: Nursing interventions to improve nutritional status in depressive patients

<i>Nursing interventions</i>	<i>Rationale</i>
Closely monitor the patient's food and fluid intake; maintain intake and output chart	These are useful data for assessing nutritional status
Record patient's weight regularly	-do-
Find out the likes and dislikes of the person before he was sick and serve the best preferred food	To encourage eating and improve nutritional status
Serve small amounts of a light or liquid diet frequently that is nourishing	-do-
Record the patient's pattern of bowel elimination	To assess for constipation
Encourage more fluid intake, roughage diet and green leafy vegetables	For relief of constipation if present

Objective: Patient will maintain adequate personal hygiene.

Interventions: See Table 7.21.

Evaluation

Evaluation will focus on determining whether improvement has occurred in the patient's thought processes, behavior and overall functioning. Interest and participation in self-care and hygiene show an elevation in self-appreciation. Increased hope and worth relieves the acute need for self-destruction. As depression reduces, the patient is able to eat and sleep with fewer disturbances.

Evaluation is facilitated by using the following types of questions:

- Has self-harm to the individual been avoided?

Table 7.21: Nursing interventions to improve self-care for depressed patients

<i>Nursing interventions</i>	<i>Rationale</i>
Ensure that he takes his bath regularly	Depressive patient will not have any interest for self-care and may need assistance
Do not ask the patient's permission for a wash or bath. For instance, do not ask "Do you want to have a bath?" Instead lead the patient to the action with positive suggestions, for example, "The water is ready, let me take you for a bath"	Positive suggestions will usually enhance patient's co-operation
When the patient has taken care of himself, express realistic appreciation	Positive reinforcement will improve desirable behavior

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

BIPOLAR MOOD DISORDER (BIPOLAR AFFECTIVE DISORDER, MANIC DEPRESSIVE DISORDER)

This is characterized by recurrent episodes of mania and depression in the same patient at different times. Typically, the patient experiences extreme highs (mania or hypomania) alternating with extreme lows (depression); interspersed between the highs and lows are periods of normal mood. Onset usually occurs between ages 20 and 30. Symptoms sometimes appear in late childhood or early adolescence (Table 7.22 and Fig. 7.1).

Table 7.22: Signs and symptoms of bipolar disorders

<i>Manic phase</i>	<i>Depressive phase</i>
Expansive, grandiose, or hyperirritable mood	Low self-esteem
Increased psychomotor activity, such as agitation, pacing or hand-wringing	<i>Overwhelming inertia:</i> Feelings of hopelessness, apathy, or self-reproach
Excessive social extroversion	Difficulty concentrating or thinking clearly (without obvious disorientation or intellectual impairment)
Rapid speech with frequent topic changes	
Decreased need for sleep and food	Psychomotor retardation
Impulsivity	Anhedonia
Impaired judgment	Suicidal ideation

Classification

- F31.0: Bipolar affective disorder, current episode hypomania.
- F31.1: Bipolar affective disorder, current episode mania without psychotic symptoms.
- F31.2: Bipolar affective disorder, current episode mania with psychotic symptoms.
- F31.3: Bipolar affective disorder, current episode mild or moderate depression.
- F31.4: Bipolar affective disorder, current episode severe depression without psychotic symptoms.
- F31.5: Bipolar affective disorder, current episode severe depression with psychotic symptoms.

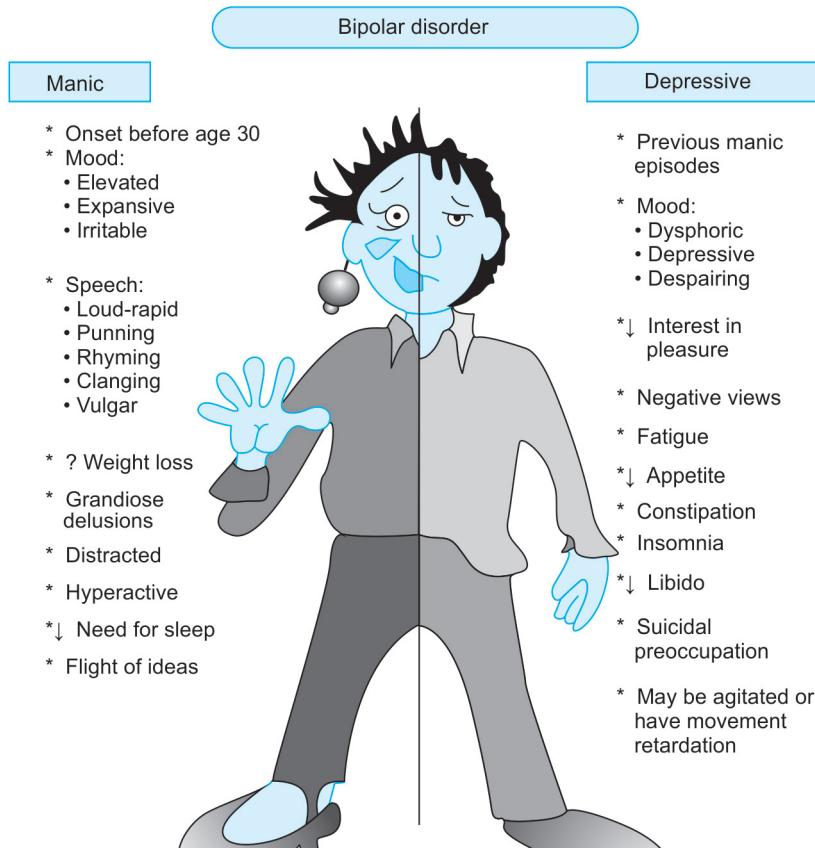
**Fig. 7.1:** Features of bipolar disorder

Table 7.23: Bipolar disorder—Good and poor prognostic factors	
<i>Good prognostic factors</i>	<i>Poor prognostic factors</i>
Abrupt or acute onset	Double depression
Severe depression	Comorbid physical disease, personality disorders or alcohol dependence
Typical clinical features	
Well-adjusted premorbid personality	Chronic ongoing stress
Good response to treatment	Poor drug compliance
	Marked hypochondriacal features or mood-incongruent psychotic features

F31.6: Bipolar affective disorder, current episode mixed.

Etiology

- Precise cause unknown
- Genetic, biochemical and psychological factors may play a role
- May be triggered by stressful events, anti-depressant use
- Sleep deprivation and hypothyroidism.

Diagnosis

- Based on signs and symptoms
- ICD10 criteria.

Treatment

- Lithium
- Valporic acid
- Carbamazepine
- Antidepressants
- Antipsychotics (if necessary).

Course and Prognosis of Mood Disorders

An average manic episode lasts for 3–4 months, while a depressive episode lasts for 4–9 months (Table 7.23).

Recurrent Depressive Disorder

This disorder is characterized by recurrent depressive episodes. The current episode is specified as mild, moderate and severe, without psychotic symptoms, severe with psychotic symptoms.

PERSISTENT MOOD DISORDER

Classification

- F34.0 Cyclothymia
- F34.1 Dysthymia
- F34.8 Other persistent mood disorders
- F34.9 Persistent mood disorder, unspecified

Cyclothymia

Cyclothymic disorder is characterized by short periods of mild depression alternating with short periods of hypomania; between the depressive and manic episodes, brief periods of normal mood occur. Both depressive and hypomanic phases are shorter and less severe than those in bipolar I or II disorder.

Etiology

Genetic factors (most likely cause)—family history of bipolar disorder, major depression, substance abuse, or suicide in many patients.

Clinical Features

Hypomanic phase

- Insomnia
- Hyperactivity and physical restlessness
- Irritability or aggressiveness
- Grandiosity or inflated self-esteem
- Increased productivity, creativity.

Depressive phase

- Insomnia or hypersomnia
- Feelings of inadequacy
- Decreased productivity
- Social withdrawal
- Loss of libido or interest in pleasurable activities

- Lethargy
- Suicidal ideation

Diagnosis

- Based on ICD10 criteria
- Rule out physical and psychiatric disorders that can mimic cyclothymic disorder, for example, endocrine disorders, uremia, vitamin deficiency, epilepsy, borderline personality disorder, mood disorders caused by substance abuse, etc.

Treatment Modalities

- Lithium
- Carbamazepine
- Valporic acid
- Verapamil
- Various antidepressants
- Individual psychotherapy
- Couple or family therapy.

Nursing Interventions

- Explore ways to help patient cope with frequent mood changes
- Encourage vocational opportunities that allow flexible hours
- Encourage patients with artistic ability to pursue their talents as a creative outlet.

Dysthymia

Dysthymic disorder, or dysthymia, refers to mild depression that lasts at least 2 years in adults or 1 year in children. It is twice as common in women as in men and more prevalent among the poor and unmarried.

Etiology

- Below-normal serotonin levels
- Increased vulnerability when multiple stressors and personality problems are combined with inadequate coping skills.

Clinical Features

Psychological Symptoms

- Persistent sad, anxious, or empty mood
- Excessive crying
- Increased feelings of guilt, helplessness, or hopelessness.

Physiologic Symptoms

- Weight or appetite changes
- Sleep difficulties
- Reduced energy level (Table 7.24).

Diagnosis

- Careful psychiatric examination and medical history
- Based on ICD10 criteria.

Table 7.24: Differences between somatic (major/endogenous depression/melancholia) and neurotic depression (reactive)

<i>Endogenous depression</i>	<i>Neurotic depression</i>
Caused by factors within the individual	Caused by stressful events
Premorbid personality: Cyclothymic or dysthymic	Premorbid personality: anxious, or obsessive
Early morning awakening (late insomnia)	Difficulty in falling asleep (early insomnia)
Patient feels more sad in the morning	Patient feels more sad in the evening
Feels better when alone	Feels better when in a group
Psychotic features like psychomotor retardation, suicidal tendencies, delusions, etc. are common	Usually psychomotor agitation and no other psychotic features
Relapses are common	Relapses are uncommon
ECT and anti-depressants are used for management	Psychotherapy and antidepressants are used for management
Insight is absent	Insight is present

Treatment

- Short-term psychotherapy
- Behavioral therapy
- Group therapy.
- Antidepressants, such as SSRIs or TCAs, especially for patients who exhibit pessimism.

Nursing Interventions

- Provide supportive measures, such as reassurance, warmth, availability, and acceptance
- Teach patient about the illness
- Encourage positive health habits.

GERIATRIC CONSIDERATIONS

- Late onset bipolar disorder is rare. Depression is common among the elderly and is markedly increased when elders are medically ill
- Elders tend to have psychotic features, particularly delusions, more frequently than younger people with depression
- Suicide among persons older than age 65 is doubled compared with suicide rates of persons younger than 65
- Elders are treated for depression with ECT more frequently than younger persons
- Elder persons have increased tolerance for side effects of antidepressant medications. However, they may not be able to tolerate high doses

- Accompanying stresses can put older adults at risk for clinical depression (Fig. 7.2).

FOLLOW-UP, HOME CARE AND REHABILITATION

Patient and Family Teaching (Depression)

- Teach about the illness of depression. Learning about the beginning symptoms of relapse may assist patients to seek treatment early and avoid a lengthy recurrence.
- Discuss the importance of support groups and assist in locating resources.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.
- Tell the family to offer the patient some household responsibilities, within the patient's level of capability to promote self-esteem.
- Teach the family to recognize symptoms of suicidal ideation and how to conduct a suicide assessment.
- Emphasize that antidepressants can cause constipation, which may be prevented with a good bowel regimen, adding fiber to the diet and drinking water.
- Avoid making life changes while the patient is experiencing or recovering from depression.
- Help the patient and family identify community resources such as suicide hotlines.

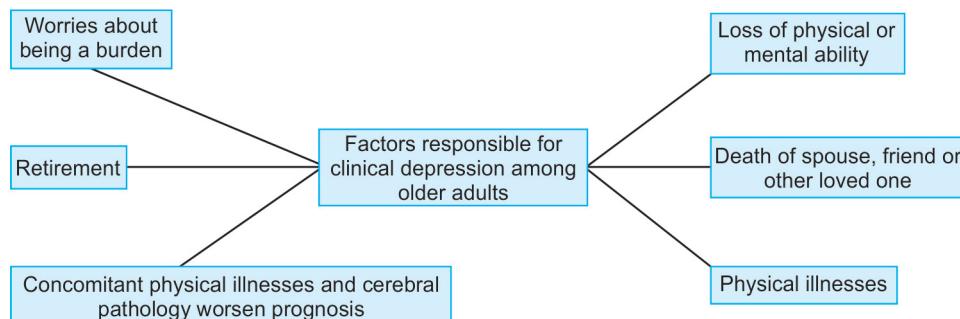


Fig. 7.2: Factors responsible for clinical depression among older adults

Patient and Family Teaching (Mania)

- Teach about bipolar illness and ways to manage the disorder
- Teach about medication management, including the need for periodic blood work and management of side effects
- For patients taking lithium, teach about the need for adequate salt and fluid intake
- Teach the patient and family about signs of toxicity and the need to seek medical attention immediately
- Teach about behavioral signs of relapse and how to seek treatment in early stages
- Educate the patient and family about risk taking behavior and how to avoid it.

REHABILITATION

Inform regarding areas of rehabilitation such as services like day care centers, sheltered workshops, continuous care clinics, etc. Other aspects of rehabilitation includes teaching basic house keeping course, money management, transportation, decision-making and appropriate leisure time activities according to the level of disability seen in individual patients.

September 10th of every year is observed as World Suicide Prevention Day.

REVIEW QUESTIONS

Long Essays

1. Define mania, list etiological factors related to manic episode. Describe nursing management for acute manic state patient.
2. Explain nursing management for hypomania patient.
3. Explain causes of depression. Describe nursing management for severe depression patient.

Short Essays

1. Symptoms of hypomania
2. Good and poor prognostic factors in mood disorders
3. Cyclothymia
4. Dysthymia
5. Bipolar affective disorder

Short Answers

1. Lithium
2. Antidepressants
3. List psychological therapies for depressive disorder
4. Somatic symptoms of depression

MULTIPLE CHOICE QUESTIONS

1. **Following are the clinical features of mania, except:**
 - a. Elation of mood
 - b. Disorientation
 - c. Increased psychomotor activity
 - d. Self important ideas
2. **Neurotransmitters involved in manic episode are:**
 - a. Excessive levels of norepinephrine and dopamine
 - b. Decreased levels of norepinephrine and dopamine
 - c. Excessive levels of serotonin
 - d. Decreased levels of dopamine
3. **Grandiose delusions occur in which of the following disorder?**
 - a. Manic disorder
 - b. Obsessive compulsive disorder
 - c. Phobic disorder
 - d. Anxiety disorder
4. **The drug of choice for mood disorder is:**
 - a. Haloperidol
 - b. Imipramine
 - c. Lithium
 - d. Chlorpromazine

- 5. A patient is brought to the psychiatric OPD by his family members. On performing mental status examination patient's speech is found to shift rapidly from one topic to another. This can best be described as:**
- Loosening of association
 - Echolalia
 - Poverty of speech
 - Flight of ideas
- 6. A patient with mania says, "we can, pan, scan, ran, plan.." the nurse identifies this as:**
- Clang association
 - Echolalia
 - Word salad
 - Neologism
- 7. When a patient is in a state of rapture he is in:**
- Euphoria
 - Elation
 - Exaltation
 - Ecstasy
- 8. A patient is on Lithium drug for 10 days, on the 10th day his serum lithium level is 1.0 mEq/L. The nurse knows that this value indicates:**
- A toxic level
 - Laboratory error
 - A therapeutic blood level of the drug
 - Unusual response of the drug
- 9. A patient has been taking Lithium carbonate for his hypomania. While taking this drug which mineral would you recommend in adequate quantities?**
- Sodium
 - Iron
 - Iodine
 - Calcium
- 10. Which of the following statements would indicate that the patient has understood the functioning of Lithium drug:**
- "I need to restrict high salt content foods"
 - "If I forget a dose, I can double the dose the next time I take it"
- c. "I should maintain adequate fluid intake"**
- d. "I need to take adequate protein"**
- 11. All of the following nursing interventions are most appropriate for a patient with violent behavior, except:**
- Recognize that violent behavior is a part of manic episode
 - Set limits for his behavior
 - Ignore patient behavior
 - Provide safe environment
- 12. Which of the following activity is more appropriate to channelize the hyperactive behavior of a manic patient?**
- Engage patient in writing activities
 - Engage patient in craft activities
 - Engage patient in group activities
 - Engage patient in aerobics
- 13. Which of the following foods are recommended for manic patients?**
- Finger foods
 - Liquid foods
 - Semi-solid foods
 - Favorite foods
- 14. Which of the following nursing interventions is most appropriate to manage manipulative behavior of a manic patient?**
- Engage patient in physical activities
 - Keep environmental stimuli to a minimum
 - Set limits on patient behavior
 - Use punishment techniques
- 15. Depression is characterized by all, except:**
- Psychomotor retardation
 - Loosening of association
 - Inability to experience pleasure in any activity
 - Pervasive sadness
- 16. Triad symptoms of depression include:**
- Suicidal ideas, hopelessness, decreased appetite
 - Pervasive sadness, anhedonia, decreased psychomotor activity

- c. Worthlessness, disturbed sleep, delusions
- d. Monotonous voice, preoccupations, poor memory.

17. Worthlessness, hopelessness and helplessness are characteristic features of:

- a. Paranoid schizophrenia
- b. Depression
- c. Mania
- d. Obsessive compulsive disorder

18. Which patient among the following requires nurse's immediate attention?

- a. A patient who is refusing to attend group meetings
- b. A patient with rapid and irrelevant speech
- c. A patient who has been sleeping for only 2 hours in the night
- d. A patient who is expressing suicidal ideation

19. Which of the following is a priority nursing assessment for patient with depression?

- a. Nutritional status
- b. Fluid and electrolyte imbalance
- c. Suicidal ideation
- d. Sleep disturbances

20. Which of the following would be a priority intervention for a patient who attempted suicide previously?

- a. Ask the patient frankly if he/she has a thought of, or has plans of committing suicide
- b. Avoid bringing up the subject of suicide in case you induce ideas of self harm in the patient

- c. Actively involve the patient in the unit activities so that he/she will not think of suicide
- d. Explain the consequences of suicidal attempts to the patient

21. A patient was hospitalized following a suicide attempt after losing a job. One week later, a sudden apparent improvement is observed in the patient. The nurse understands that the most probable reason is that the patient:

- a. has gotten some information about a new job
- b. has established supportive relationships with the personnel
- c. has been relieved of a stressful work environment
- d. may be committed to suicide and has a workable plan

22. Mr. X is taking fluoxetine hydrochloride for the treatment of depression and asks the nurse about the time lag for maximum therapeutic response to occur. The nurse's best response is:

- a. First week
- b. Second week
- c. Third week
- d. Fourth week

23. Cyclothymic disorder is characterized by:

- a. Short periods of major depression and severe manic episodes
- b. Short periods of mild depression and hypomania
- c. Short periods of moderate depression and severe mania
- d. Short periods of major depression and hypomania.

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. b | 2. a | 3. a | 4. c | 5. d | 6. a | 7. d | 8. c | 9. a | 10. c |
| 11. c | 12. d | 13. a | 14. c | 15. b | 16. b | 17. b | 18. d | 19. c | 20. a |
| 21. d | 22. c | 23. b | | | | | | | |

Chapter 8

Nursing Management of Patient with Neurotic, Stress-related and Somatization Disorders

INTRODUCTION

Neurotic disorder (neurosis) is a less severe form of psychiatric disorder where, patients show either excessive or prolonged emotional reaction to any given stress. These disorders are not caused by organic disease of the brain and, however severe, do not involve hallucinations and delusions (Table 8.1).

They are classified under F4 in ICD10.

Classification (ICD10)

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

Table 8.1: Differences between psychotic disorder (psychosis) and neurotic disorder (neurosis)

	Psychosis	Neurosis
Etiology		
Genetic factors	More important	Less important
Stressful life events	Less important	More important
Clinical features		
Disturbances of thinking and perception	Common	Rare
Disturbances in cognitive function	Common	Rare
Behavior	Markedly affected	Not affected
Judgment	Impaired	Intact
Insight	Lost	Present
Reality testing	Lost	Present
Treatment		
Drugs	Major tranquilizers commonly used	Minor tranquilizers and anti-depressants are commonly used
ECT	Very useful	Not useful
Psychotherapy	Not much useful	Very useful
Prognosis	Difficult to treat; relapses are common; complete recovery may not be possible	Relatively easy to treat; relapses are uncommon; complete recovery is possible

- F45 Somatoform disorders
 F48 Other neurotic disorders.

PHOBIC ANXIETY DISORDER

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

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

A phobia is an unreasonable fear of a specific object, activity or situation. This irrational fear is characterized by various features (Box 8.1).

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

Classification (ICD10)

- F40.0 : Agoraphobia
- F40.1 : Social Phobia
- F40.2 : Specific phobias
- F40.8 : Other phobic anxiety disorders
- F40.9 : Phobic anxiety disorder, unspecified.

Types of Phobia

- Simple phobia
- Social phobia
- Agoraphobia.

Box 8.1: Features of irrational fear

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

Simple phobia (Specific phobia): It is an irrational fear of a specific object or stimulus. Simple phobias are common in childhood. By early teenage, most of these fears are lost, but a few persist till adult life. Sometimes they may reappear after a symptom-free period. Exposure to the phobic object often results in panic attacks (Box 8.2).

Signs and symptoms of specific phobia:

- Irrational and persistent fear of object or situation
- Immediate anxiety on contact with feared object or situation
- Loss of control, fainting, or panic response
- Avoidance of activities involving feared stimulus
- Anxiety when thinking about stimulus
- Worry with anticipatory anxiety
- 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.

Signs and symptoms of social phobia:

- Hyperventilation
- Sweating, cold and clammy hands
- Blushing

Box 8.2: Examples of some specific phobias

- » Acrophobia—fear of heights
- » Hematophobia—fear of the sight of blood
- » Claustrophobia—fear of closed spaces
- » Gamophobia—fear of marriage
- » Insectophobia—fear of insects
- » AIDS phobia—fear of AIDS
- » Zoophobia—fear of animals
- » Microphobia—fear of germs
- » Brontophobia—fear of thunder
- » Algophobia—fear of pain

- Palpitations
- Confusion
- Gastrointestinal symptoms
- Trembling hands and voice
- Urinary urgency
- Muscle tension
- Anticipatory anxiety
- Fear or embarrassment or ridicule.

Anticipatory anxiety occurs well in advance of a particular situation such as a public speech or social event. This leads to thoughts of dread leading up to the event. The added anxiety results in actual or perceived failure in the situation, leading to embarrassment and further anxiety. This pattern sets up a vicious cycle of persistent discomfort that can be incapacitating. Many people who have social phobia are underachievers because of test anxiety, poor job performance, or poor communication skills. They may have few or no friends, a decreased support system, and poor interpersonal relationships.

Agoraphobia: It is characterized by an irrational fear of being in places away from the familiar setting of home, in crowds, or in situations that the patient cannot leave easily.

As the agoraphobia increases in severity, there is a gradual restriction in normal day-to-day activities. The activity may become so severely restricted that the person becomes self-imprisoned at home.

Signs and symptoms:

- Overriding fear of open or public spaces (primary symptom)
 - Deep concern that help might not be available in such places
 - Avoidance of public places and confinement to home.
- When accompanied by panic disorder, fear that having panic attack in public will lead to embarrassment or inability to escape (for symptoms of a panic attack).

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

Etiology

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

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

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

Course

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

Diagnosis

- No specific diagnostic test, diagnosis confirmed if ICD10 criteria met
- 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, sertraline, phenelzine)

Behavior therapy:

- Desensitization therapy to gradually reintroduce the feared situation while coaching the patient on relaxation techniques (progressive muscle relaxation, deep-breathing exercises, listening to calming music)
- Role-playing in guided imagery to allow the patient to rehearse ways to relax while confronting a feared object or situation
- Assertive training to help the patient become assertive in her interpersonal interactions
- Modeling behavior:
 - Patient observes someone modeling or demonstrating appropriate behavior when confronted with the feared situation
- A cognitive behavioral technique called negative thought stopping to reduce the frequency and duration of disturbing thoughts by interrupting them and substituting competing thoughts:
 - Teaches patient to recognize negative thoughts
 - Involves using an intense distracting stimulus (such as snapping a rubber band around the wrist) to stop the thought
 - With practice, allows patient to control thoughts without using distracting stimulus.

Psychotherapy: Supportive psychotherapy is a helpful adjunct to behavior therapy and drug treatment.

(Refer Chapter 5 for details on these therapies).

Nursing Management

Nursing Assessment

Focus on physical symptoms, precipitating factors, avoidance behavior associated with phobia, impact of anxiety on physical functioning, normal coping ability, thought content and social support systems.

History and MSE

- During assessment of patients with high levels of anxiety the nurse should make observations of thought processes, affect, communication, psychomotor, and physiological responses
- The nurse should use directive questions to elicit subjective information about how the patient is currently feeling and what happened before the onset of symptoms
- Ask the patient about other somatic symptoms such as fatigue, muscle aches, eating patterns, bowel habits, sleeping patterns and non-verbal fatigue
- Note the patient's affect, observe for congruence of non-verbal and verbal messages
- Assess for communication pattern
- The patient's ability to perform and complete tasks should be observed
- Particular attention to specific anxiety-reducing behaviors. For example, leaving group therapy, going to bathroom, avoiding an activity, etc.
- Assess for social support system.

Nursing Diagnosis I

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

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

Intervention: See Table 8.2.

Table 8.2: Nursing interventions to reduce anxious behavior

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

Nursing Diagnosis II

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

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

Intervention: See Table 8.3.

Evaluation

Effectiveness of planned interventions will be demonstrated in the patient's ability to recognize and deal with the anxiety producing factors. Relaxed participation in unit activities and reports of longer periods of restful sleep indicate reduced anxiety. Reassessment is conducted to determine if the nursing interventions have been

Table 8.3: Nursing interventions to reduce social isolation behavior in anxious patients

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

successful in achieving the objectives of care. Following questions are helpful in evaluation:

- Does the patient face phobic object/situation without anxiety?
- Does the patient voluntarily participate in group activities?
- Is the patient able to demonstrate techniques that he may use to prevent anxiety from escalating to the panic level?

PANIC DISORDER

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

Classification (ICD10)

- F41.0 : Panic disorder
- F41.1 : Generalized anxiety disorder
- F41.2 : Mixed anxiety and depressive disorder
- F41.9 : Other specified anxiety disorders.

Etiology of Anxiety Disorders [both Panic Disorder and Generalized Anxiety Disorder (GAD)]

- **Genetic theory:** Anxiety disorder is most frequent among relatives of patients with this condition. About 15 to 20% of the first-degree relatives of patients with anxiety disorder exhibit anxiety disorders themselves. The concordance rate in monozygotic twins of patients with panic disorder is 80%.

- **Biochemical factors:** Alteration in GABA levels may lead to production of clinical anxiety.
- **Psychodynamic theory:** According to this theory, anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanisms of ego come into action. In anxiety, repression fails to function adequately and the secondary defense mechanisms are not activated. Hence, anxiety comes to the forefront.
- **Behavioral theory:** Anxiety is viewed as an unconditional inherent response of the individual to a painful stimulus.
- **Cognitive theory:** According to this theory, anxiety is related to cognitive distortions and negative automatic thoughts.

Clinical Features

- Shortness of breath and smothering sensations
- Heart beat rapid and pounding
- Choking, chest discomfort or pain
- Palpitations
- Sweating, dizziness, unsteady feelings or faintness
- Nausea or abdominal discomfort
- Depersonalization or derealization
- Numbness or tingling sensations
- Flushes or chills
- Trembling or shaking
- Fear of dying or having a heart attack
- Fear of being out of control, agoraphobia, depression.

Course

The onset is usually in early third decade with often a chronic course. It occurs recurrently every few days. The episode is usually sudden in onset and lasts for a few minutes. More than 95% of those diagnosed with agoraphobia have an accompanying diagnosis of panic disorder. Up to two-thirds of those with this disorder also experience

depression or engage in substance abuse to cope with anxiety.

Diagnosis

- Tests to rule out organic or pharmacologic basis for symptoms (some physical conditions and drug effects can mimic panic disorder)
- Serum glucose measurements to rule out hypoglycemia
- Thyroid function tests to rule out hyperthyroidism
- Urine and serum toxicology tests to rule out presence of psychoactive substances such as barbiturates, caffeine and amphetamines
- Based on ICD10 criteria.

Treatment Modalities

Pharmacotherapy:

- Benzodiazepines (for example, alprazolam, clonazepam)
- Antidepressants for panic disorder
- Beta-blockers to control severe palpitations that have not responded to anxiolytics (for example, propranolol).

Behavioral therapies:

- Relaxation techniques to help the patient cope with a panic attack by easing physical symptoms and directing attention elsewhere
- Deep breathing exercises, which also reduce the risk of hyperventilation
- Progressive relaxation, which involves conscious tightening and relaxation of the skeletal muscles in a sequential fashion
- Positive verbalization or guided imagery, in which the patient elicits peaceful mental images or some other purposeful thought or action, promoting feelings of relaxation, renewed hope, and a sense of being in control of a stressful situation
- Listening to calming music.

Cognitive therapy:

- Teaches the patient to replace negative thoughts with more realistic, positive ways of viewing the attacks
- Helps the patient to identify possible triggers for the panic attacks, such as a particular thought or situation or even a slight change in heartbeat
- Helps the patient to identify and evaluate the thoughts that precede anxiety, and then restructures them to gain a more realistic perception.

GENERALIZED ANXIETY DISORDER

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

Clinical Features

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

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

Physical:

- Gastrointestinal: Dry mouth, difficulty in swallowing, epigastric discomfort, frequent or loose motions
- Respiratory: Constriction in the chest, difficulty inhaling, overbreathing
- Cardiovascular: Palpitations, discomfort in chest

- Genitourinary: Frequency or urgent micturition, failure of erection, menstrual discomfort, amenorrhea
- Neuromuscular system: Tremor, prickling sensations, tinnitus, dizziness, headache, aching muscles
- Sleep disturbances: Insomnia, night terror
- Other symptoms: Depression, obsessions, depersonalization, derealization.

Course

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

Diagnosis

- Anxiety is a central feature of many mental disorders, psychiatric evaluation to rule out phobias, OCD, depression and acute schizophrenia.
- Based on ICD10 criteria.

Treatment Modalities

Pharmacotherapy:

- Antianxiety agents: Benzodiazepines (Alprazolam, Clonazepam). These drugs reduce anxiety by decreasing vigilance, easing somatic symptoms
- TCAs: Imipramine, Buspirone
- SSRIs
- Beta-blockers control severe palpitations that have not responded to anxiolytics (for example, propranolol).

Behavior therapy:

- Biofeedback to decrease physical symptoms of anxiety by teaching the patient how to become aware of and then consciously control various body functions (including blood pressure, heart and respiratory rates, skin temperature and perspiration)
- Relaxation techniques: Jacobson's progressive muscle relaxation technique, yoga, pranayama, meditation and self-hypnosis
- Supportive psychotherapy.

Cognitive therapy: To reduce cognitive distortions by teaching the patient how to restructure her thoughts and view her worries more realistically. In one approach, patient is taught to record worries and list evidence that justifies or contradicts each one. Patient learns that 'worrying about worry' maintains anxiety; avoidance and procrastination are ineffective problem-solving techniques.

Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

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

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

Intervention: See Table 8.4.

Nursing Diagnosis II

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

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

Intervention: See Table 8.5.

Table 8.4: Nursing interventions to reduce panic anxiety

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

Table 8.5: Nursing interventions to improve self-control in anxious patients

<i>Nursing interventions</i>	<i>Rationale</i>
Allow patient to take as much responsibility as possible for self-care activities, provide positive feedback for decisions made	Providing choices will increase patient's feeling of control
Assist patient to set realistic goals	Unrealistic goals set the patient up for failure and reinforce feelings of powerlessness
Help identify life situations that are within patient's control	Patient's emotional condition interferes with the ability to solve problems
Help patient identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability	Assistance is required to perceive the benefits and consequences of available alternatives accurately, to deal with unresolved issues and accept what cannot be changed

Evaluation

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

- Is the patient experiencing a reduced level of anxiety?
- Does the patient recognize symptoms as anxiety-related?

- Is the patient able to use newly learned behavior to manage anxiety?

OBSESSIVE-COMPULSIVE DISORDER

Definition

According to ICD9, obsessive-compulsive disorder (OCD) is a state in which "the

outstanding symptom is a feeling of subjective compulsion—which must be resisted—to carry out some action, to dwell on an idea, to recall an experience, or ruminate on an abstract topic. Unwanted thoughts, which include the inconsistency of words or ideas are perceived by the patient to be inappropriate or nonsensical. The obsessional urge or idea is recognized as alien to the personality, but as coming from within the self. Obsessional rituals are designed to relieve anxiety, for example, washing the hands to deal with contamination. Attempts to dispel the unwelcome thoughts or urges may lead to a severe inner struggle, with intense anxiety" (Box 8.3).

The disorder may begin in childhood, but more often begins in adolescence or early adulthood. It is equally common among men and women. The course is usually chronic. Many OCD sufferers also have major depressive disorder, panic disorder, social phobia, specific phobia, eating disorder, substance abuse or personality disorders.

Classification (ICD10)

F42 : Obsessive-compulsive disorder

F42.0 : Predominantly obsessive thoughts or ruminations

Box 8.3: Characteristics of obsessive-compulsive disorder

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

- F42.1 : Predominantly compulsive acts
 F42.2 : Mixed obsessional thoughts and acts
 F42.8 : Other obsessive-compulsive disorders
 F42.9 : Obsessive-compulsive disorder, unspecified.

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 first-degree relatives of obsessive-compulsive disorder patients are also affected with the disorder.

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

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

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

Behavior theory: This theory explains obsessions as a conditioned stimulus to anxiety. Compulsions have been described as learned behavior that decreases the anxiety 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: These are words, ideas and beliefs that intrude forcibly into the

Box 8.4: Common types of obsessive thought content

- » Contamination
- » Repeated doubts
- » Orderliness
- » Impulses
- » Sexual imagery

patient's mind. They are usually unpleasant and shocking to the patient and may be obscene or blasphemous (Box 8.4).

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

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

Obsessional doubts: These may concern actions that may not have been completed adequately. The obsession often implies some danger such as forgetting to turn off the stove or not locking a door. It may be followed by a compulsive act such as the person making multiple trips back into the house to check if the stove has been turned off. Sometimes these may take the form of doubting the very fundamentals of beliefs, such as, doubting the existence of God and so on.

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

Obsessional rituals: These may include both mental activities such as counting repeatedly in a special way or repeating a certain form of words, and repeated but senseless behaviors such as washing hands 20 or more times a day. Sometimes such compulsive acts may be preceded by obsessional thoughts; for example, repeated handwashing may be preceded by thoughts of contamination.

Box 8.5: Signs and symptoms of obsessive-compulsive disorder

- » Recurrent unwanted thoughts referencing contamination, sexuality, aggression, need for perfection, or abnormal doubt
- » Attempts to reduce the effect of the thoughts with other thoughts
- » Repetitive acts, impulses or rituals such as washing hands, checking, rearranging things for perfect alignment, repeating words or phrases
- » Recognition that the thoughts are produced in his or her own mind
- » Lack of concentration and task completion
- » Impaired social or work functioning

These patients usually believe that the contamination is spread from object to object or person to person even by slight contact and may literally rub the skin off their hands by excessive hand washing.

Obsessive slowness: Severe obsessive ideas or extensive compulsive rituals characterize obsessional slowness in the relative absence of manifested anxiety. This leads to marked slowness in daily activities (Box 8.5).

Course and Prognosis

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

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

Diagnosis

- Suggested by demonstration of ritualistic behavior that is irrational or excessive

- MRI and CT shows enlarged basal ganglia in some patients
- Positron-emission tomography scanning shows increased glucose metabolism in part of the basal ganglia
- Based on ICD10 criteria.

Treatment

Pharmacotherapy:

- Antidepressants (for example, fluvoxamine, sertraline, etc.)
- Anxiolytics (for example, benzodiazepines)

Behavior therapy:

- Exposure and response prevention
- Thought stoppage
- Relaxation techniques
- Desensitization
- Aversive conditioning.

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

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

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

Relaxation technique: It includes deep breathing exercise, progressive muscle relaxation, meditation, imagery and music.

(Refer Chapter 5, Page 150 for desensitization and aversive conditioning techniques).

Other therapies:

- Supportive psychotherapy
- ECT—for patients' refractory to other forms of treatment.

Nursing Management

Nursing Assessment

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

Nursing Diagnosis I

Ineffective individual coping related to underdeveloped 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.

Intervention: See Table 8.6.

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.

Intervention: See Table 8.7.

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?

Table 8.6: Nursing interventions to reduce obsessive-compulsive behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Work with patient to determine types of situations that increase anxiety and result in ritualistic behaviors	Recognition of precipitating factors is the first step in teaching the patient to interrupt escalating anxiety
Initially meet the patient's dependency needs. Encourage independence and give positive reinforcement for independent behaviors	Sudden and complete elimination of all avenues for dependency would create intense anxiety on the part of the patient. Positive reinforcement enhances self-esteem and encourages repetition of desired behaviors
In the beginning of treatment, allow plenty of time for rituals. Do not be judgmental or verbalize disapproval of the behavior	Denying patient this activity may precipitate panic anxiety
Support patient's efforts to explore the meaning and purpose of the behavior	Patient may be unaware of the relationship between emotional problems and compulsive behaviors. Recognition is important before change can occur
Provide structured schedule of activities for patient, including adequate time for completion of rituals	Structure provides a feeling of security for the anxious patient
Gradually begin to limit amount of time allotted for ritualistic behavior as patient becomes more involved in unit activities	Anxiety is minimized when patient is able to replace ritualistic behaviors with more adaptive ones
Give positive reinforcement for non-ritualistic behaviors	Positive reinforcement encourages repetition of desired behaviors
Help patient learn ways of interrupting obsessive thoughts and ritualistic behavior with techniques such as thought stopping, relaxation and exercise	These activities help in interruption of obsessive thoughts

Table 8.7: Nursing interventions to improve role-related responsibilities in OCD patients

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

- Is the patient able to use newly learned behaviors 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 symptoms like anxiety, despair and anger or over activity. These symptoms are clearly related to the stressor. If removal from the stressful environment is possible, the symptoms resolve rapidly.

Post-traumatic stress disorder (PTSD): Post-traumatic stress disorder is characterized by hyperarousal, re-experiencing of images of the stressful events and avoidance of reminders. PTSD is of a reaction to extreme stressors such as floods, earthquakes, war, rape or serious physical assault. The symptoms may develop after a period of latency, within 6 months after the stress or may be delayed (Box 8.6).

The general approach is to provide emotional support, to encourage recall of the traumatic events. Benzodiazepine drugs may be needed to reduce anxiety (Box 8.7).

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.

Box 8.6: Signs and symptoms of PTSD

- » Intense feeling of fear and dread following traumatic event
- » Mental reruns of the event (flashbacks)
- » Emotional numbness following the event
- » Avoidance of people, places or things associated with events
- » Insomnia, recurring distressing dreams,
- » Increased vigilance or watchfulness
- » Startles easily
- » Depression
- » Irritability and aggressiveness
- » Impaired social or work functioning difficulty in interpersonal relationships

Box 8.7: Nursing interventions

- » Establish trusting relationship
- » Encourage the patient to express her grief, complete the mourning process
- » Use crisis intervention techniques as needed
- » Assist in regaining control over angry outbursts by identifying how anger escalates
- » Encourage move from physical to verbal expressions of anger
- » Teach the patient about medications and adverse effects and advise her not to discontinue medication without physician consultation

Treatment

Drug treatment:

- Antidepressants
- Benzodiazepines

Psychological therapies:

- Supportive psychotherapy
- Crisis intervention
- Stress management training.

CONVERSION DISORDER

Conversion disorder is characterized by the presence of one or more symptoms suggesting

Box 8.8: Common signs and symptoms of conversion disorder

- » The symptoms are produced because they reduce the anxiety of the patient by keeping the psychological conflict out of conscious awareness, a process called as primary gain
- » These symptoms of conversion are often advantageous to the patient. For example, a woman who develops psychogenic paralysis of the arm may escape from taking care of an elderly relative. Such an advantage is called as secondary gain
- » The patient does not produce the symptoms intentionally
- » The patient shows less distress or shows lack of concern about the symptoms, called as labelle indifference
- » Physical examination and investigations do not reveal any medical or neurological abnormalities
- » Lack of conscious control over the symptoms
- » Impaired functioning in social work related areas caused by symptoms
- » Functional ability and symptoms inconsistent with usual neurological disorders

the presence of a neurological disorder that cannot be explained by any known neurological or medical disorder. Instead, psychological factors like stress and conflicts are associated with onset or exacerbation of the symptoms. Patients are unaware of the psychological basis and are thus not able to control their symptoms (Box 8.8).

In ICD10, conversion disorder is subsumed under “dissociative disorders of movement and sensation,” a subtype under dissociate (conversion) disorders. It is further classified into dissociative motor disorders, dissociative anesthesia and sensory loss and dissociative convulsions.

Conversion disorders were formerly termed as ‘hysteria.’ The term is now changed because

the word ‘hysteria’ is used in everyday speech when referring to any extravagant behavior, and it is confusing to use the same word for a different phenomena that falls under this syndrome.

Dissociative Motor Disorders

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

Dissociative Convulsions (hysterical fits or pseudo-seizures)

It is characterized by convulsive movements and partial loss of consciousness. Differential diagnosis with true seizures is important (Table 8.8).

Dissociative Sensory Loss and Anesthesia

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

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

DISSOCIATIVE DISORDER

Dissociation is the mechanism that allows our mind to separate certain memories from conscious awareness. The dissociative disorders are described as a disturbance in the

Table 8.8: Differences between epileptic seizures and dissociative convulsions

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

ordinarily organized functions of the conscious awareness, memory and identity (Boxes 8.9 and 8.10).

Dissociative amnesia: Most often, dissociative amnesia follows a traumatic or stressful life situation. There is a sudden inability to recall important personal information particularly concerning the stressful life event. The extent

Box 8.9: Common features of dissociative disorder

- » Disturbance in the normal integrated functions of consciousness, identity and/or memory
- » The disturbance may be sudden or gradual, and the disturbance is usually temporary, recovery is often abrupt
- » These disorders tend to occur in response to severe trauma or abuse. A frequent stressful situation is an ongoing war
- » Significant impairment in general and social functioning
- » Detailed physical examination and investigations do not reveal any abnormality that can explain the symptoms adequately

Box 8.10: Common clinical types

- » Dissociative amnesia
- » Dissociative fugue
- » Dissociative identity disorder
- » Trance and possession disorders
- » Other dissociative disorders

of the disturbance is too great to be explained by ordinary forgetfulness. The amnesia may be localized, generalized, selective or continuing in nature.

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

Dissociative identity disorder (multiple personality disorder)

In this disorder, the person is dominated by two or more personalities of which only one

is manifest at a time. Usually one personality is not aware of the existence of the other personalities. Each personality has a full range of higher mental functions and performs complex behavior patterns. Transition from one personality to another is sudden, and the behavior usually contrasts strikingly with the patient's normal state.

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

Other dissociative disorders: 'Ganser's syndrome' (hysterical pseudodementia) is commonly found in prison inmates. The characteristic feature is 'vorbeireden' - giving approximate answers to questions. The term 'approximate answers' denotes answers to simple questions that are plainly wrong, but are clearly related to the correct answers in a way that suggest that the latter is known. For example, when asked to add three and three, a patient might answer seven and when asked four and five, might answer ten; each answer is one greater than the correct answer. Hallucinations are usually visual and may be elaborate.

Etiology of Conversion and Dissociative Disorders

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

The symptoms are symbolically related to the conflict.

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

Diagnosis

- Rule out physical disorders and substance abuse
- Standard tests including the Dissociative Experiences Scale and the Dissociative Disorders Interview schedule to demonstrate presence of dissociation
- ICD10 criteria.

Treatment Modalities

- Free association
- Hypnosis
- Abreaction therapy
- Supportive psychotherapy
- Behavior therapy (aversion therapy, operant conditioning, etc.)
- Drug therapy: Drugs have a very limited role. A few patients have anxiety and may need short-term treatment with benzodiazepines.

Nursing Management

Nursing Assessment

During the diagnostic process, any physical condition that could produce the symptoms of amnesia and dissociation must be ruled out. Psychological tests are used to further evaluate the authenticity of the symptoms. Collect information related to childhood or adult trauma. Along with a physical assessment a baseline psychosocial assessment is done to determine behavioral alterations such as disorientation,

level of anxiety, amnesia, depression and level of functioning.

Nursing Diagnoses

- Disturbed thought process related to memory loss and repressed trauma
- Self-care deficit related to trance like state or aimless wandering
- Ineffective individual coping related to repressed memories and issues, loss of identity or travel away from home
- Personality identity disturbance related to childhood trauma or more than one personality state
- Anxiety related to repressed traumatic events or loss of identity.

Nursing Intervention

The nurse must first establish a trusting and supportive therapeutic relationship with the patient. It is important to use active listening and communication techniques that encourage verbalization of feelings, conflicts and information regarding the traumatic events that led to the current dissociative state. Patients need encouragement and support to achieve control over their anxiety and previous dissociative response to those situations that trigger the symptoms.

- Monitor physician's ongoing assessments, laboratory reports and other data to rule out organic pathology
- Identify primary and secondary gains
- Do not focus on the disability; encourage patient to perform self-care activities as independently as possible. Intervene only when patient requires assistance
- Do not allow the patient to use the disability as a manipulative tool to avoid participation in the therapeutic activities
- Withdraw attention if the patient continues to focus on physical limitations
- Encourage patient to verbalize fears and anxieties

- Positive reinforcement for identification or demonstration of alternative adaptive coping strategies
- Identify specific conflicts that remain unresolved and assist patient to identify possible solutions
- Assist the patient to set realistic goals for the future
- Help the patient to identify areas of life situation that are not within his ability to control
- Encourage verbalization of feelings related to this inability
- Promote a safe environment
- Identify environmental stressors that trigger the dissociative symptoms and decrease anxiety producing stimuli
- Assist the patient to identify alternatives to self-injury such as physical exercise, written method of expression or creative art and task oriented activities, which provide a means of nonverbal expression of thoughts
- Encourage the patient to keep a daily dairy of thoughts and feelings.

Evaluation

During the evaluation process, assess for decrease in dissociative episodes, improvement in level of functioning. The patient must also come to an understanding of the relationship between the dissociative state and the increased anxiety that is felt as repressed past trauma is triggered by environmental factors.

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 are 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. The symptoms are vague, presented in a dramatic manner and involve multiple organ systems (Box 8.11).

Hypochondriasis: Hypochondriasis is defined as a persistent preoccupation with a fear or belief of having a serious disease despite repeated medical reassurance (Box 8.12).

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.

Box 8.11: Common signs and symptoms of somatization disorder

- » Multiple somatic complaints, unexplained by medical findings
- » Complaints of pain in at least four different locations
- » Two gastrointestinal, one sexual or reproductive and one neurologic symptom
- » Moderate to severe anxiety
- » Inability to voluntarily control the symptoms
- » Dependency with demanding, attention getting behaviors
- » Secondary gain
- » Significant distress or impairment in social or occupational areas

Box 8.12: Common signs and symptoms of hypochondriasis

- » Fear or preoccupation with body functioning misperceived as a major illness
- » Repeated healthcare visits seeking verification of fear (doctor shopping)
- » Symptoms reported in specific detail
- » Involvement of one or more body systems
- » Unconvinced by repeated examinations, investigations and reassurance that disease does not exist
- » Impaired social and family relationships

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

- Respond to patient with understanding and patience
- Identify types of primary and secondary gain achieved by symptoms
- Minimize time and attention given to physical symptoms
- Encourage patient to keep a diary of daily happenings and feelings, along with physical symptoms
- Encourage the patient to make decisions and take responsibility for situations related to them
- Help the patient to identify more effective coping mechanisms rather than the somatic symptoms.

OTHER NEUROTIC DISORDERS

According to ICD10, the other neurotic disorders are neurastenia, 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 one's own reality is temporarily changed or lost.

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.

GERIATRIC CONSIDERATIONS

- Common anxiety disorders during late life are phobias, agoraphobia and GAD.
- Anxiety that starts for the first time during late life is frequently associated with depression, dementia, physical illness or medication toxicity or withdrawal.
- Though less common, panic attacks can occur in late life and are related to depression or a physical illness such as cardiovascular, gastrointestinal or chronic pulmonary diseases.
- The treatment of choice for anxiety disorders in the elderly is selective serotonin reuptake inhibitor (SSRI) antidepressants. Initial treatment involves doses lower than the usual starting doses for adults to ensure the elderly patient can tolerate the medication.

FOLLOW-UP, HOME CARE AND REHABILITATION—NEUROTIC DISORDERS

- The people with anxiety disorders, somatoform disorders and dissociative disorders are often treated in the community clinics, physician office and psychiatric OPDs. Issues to be considered during outpatient therapy include, identifying and strengthening support symptoms and locating community resources.
- For people with anxiety disorders, the goal is effective management of stress and anxiety, not the total elimination of anxiety. Learning anxiety management techniques and effective methods of coping with life and its stresses is essential for overall improvement in life quality.
- Follow-up interventions are helpful especially for anxiety disorder patients. During follow-up meet the patient and family members to discuss realistic expectations for the patient.

- Teach the patient stress management techniques such as relaxation, guided imagery and meditation, encourage him to practice regularly.
- Teach the patient about medications and lifestyle changes like, exercise regularly, eat well-balanced meals, get enough rest and sleep, limit intake of caffeine and alcohol.
- Encourage the patient to express his feeling through laughing, crying, etc.
- It is important for the nurse to educate the patient and family members about the physiology of anxiety, early symptoms of anxiety so as to prevent it from escalating (for example, sweaty palms, racing heart, difficulty concentrating or attending).
- Educate the patient and family about medications (therapeutic dose, frequency of administration, side effects, untoward effects) and the importance of compliance.
- Teach the patient and family to identify stressors and situations that promote or exacerbate anxiety and to avoid them as much as possible.
- Teach the patient and family how to access community resources and support groups, reliable educational sources on the internet.

REVIEW QUESTIONS

Long Essays

1. List anxiety disorders. Describe nursing management for a patient with acute anxiety state.
2. What is obsessive compulsive disorder? Describe nursing management for obsessive compulsive disorder.

Short Essays

1. Differences between psychotic and neurotic disorders
2. Neurotic disorders

3. Panic disorder
4. Anxiety neurosis
5. Ritualistic behavior
6. Dissociative disorder
7. Differences between epileptic seizures and pseudo seizures
8. Somatoform disorder
9. Multiple personality
10. Post-traumatic stress disorder

Short Answers

1. Phobia
2. Agoraphobia
3. Obsession
4. Geriatric considerations for neurotic disorders

MULTIPLE CHOICE QUESTIONS

1. **Characteristic features of neurotic disorder include all the following, except:**
 - a. Having insight
 - b. Subjective distress
 - c. Reasonably preserved behavior
 - d. Delusions and hallucinations
2. **State of uneasiness arising out of anticipation of danger is termed as:**
 - a. Anxiety
 - b. Phobia
 - c. Obsessions
 - d. Compulsions
3. **In which of the following condition does an individual experience intermittent anxiety arising out of particular circumstances?**
 - a. Panic disorder
 - b. Anxiety disorder
 - c. Phobic disorder
 - d. Dissociative disorder
4. **Social phobia refers to an:**
 - a. Irrational fear of a specific object
 - b. Irrational fear of performing activities in the presence of others

- c. Irrational fear of being in places away from the home setting
d. Irrational fear of society
- 5. Which of the following is an example of simple phobia?**
- Fear of public places
 - Fear of insects
 - Fear of performing activities
 - Avoidance of public places
- 6. Irrational fear of being in places away from home setting is termed as:**
- Agoraphobia
 - Acrophobia
 - Algophobia
 - Claustrophobia
- 7. Fear of heights is termed as:**
- Acrophobia
 - Claustrophobia
 - Algophobia
 - Gamophobia
- 8. The following are the symptoms of anxiety, except:**
- Palpitations
 - Gastric discomfort
 - Frequency of urination
 - Bradycardia
- 9. A patient has sudden attacks of anxiety predominated by physical symptoms accompanied by fear of serious consequence such as a heart attack. This is the characteristic of which disorder?**
- Panic disorder
 - Phobia disorder
 - Generalized anxiety disorder
 - Obsessive compulsive disorder
- 10. Which of the following behavior modification technique is useful in the treatment of phobias?**
- Token economy
 - Modeling
 - Desensitization therapy
 - Positive reinforcement
- 11. Which of the following is used in the treatment of anxiety disorders?**
- Antipsychotics
 - Mood stabilizers
 - Anxiolytics
 - Anticonvulsants
- 12. To overcome phobias patients are taught to associate relaxation techniques with fearful stimuli that replace previous learned harmful responses, this method is referred to as:**
- Free association
 - Aversive conditioning
 - Role playing
 - Systematic desensitization
- 13. The following are all characteristics of obsessional thoughts in OCD, except:**
- Arising of unwanted thoughts
 - Feeling of subjective compulsions
 - Experiencing subjective distress
 - Experiencing powerlessness
- 14. Signs and symptoms of OCD include all, except:**
- Obsessive thoughts
 - Compulsive acts
 - Lack of concentration and task completion
 - Ordered flight of ideas
- 15. Which of the following defense mechanisms is commonly used by OCD patients?**
- Sublimation
 - Projection
 - Denial
 - Undoing
- 16. Which of the following medications can be used to treat patients with anxiety disorders?**
- Haloperidol
 - Alprazolam
 - Clozapine
 - Resperidone
- 17. The following behavior techniques are useful in the treatment of OCD, except?**
- Exposure and response prevention
 - Thought stoppage
 - Aversive conditioning
 - Restitution

- 18. Recurrent, intrusive, senseless ideas, thoughts, and images that are egodystonic and involuntary are termed as:**
- Obsessions
 - Compulsions
 - Hypochondreasis
 - Obstrusiveness
- 19. Condition which involves internal debates in which arguments for and against even simplest everyday actions are reviewed is called:**
- Obsessional doubts
 - Obsessional ruminations
 - Obsessional images
 - Obsessional impulses
- 20. Which of the following nursing interventions is most appropriate for a patient with compulsive acts?**
- Recognize that this behavior is a part of OCD
 - Set limits for his compulsive acts
 - Ignore patient behavior
 - Provide positive reinforcement for non-ritualistic behavior
- 21. Three months after a traumatic experience Ms Z is re-experiencing images of stressful events, insomnia and depression. She is likely to be suffering:**
- Acute stress reaction
 - Post-traumatic stress disorder
 - Adjustment disorder
 - Somatic disorder
- 22. All the following features characterize a conversion disorder, except:**
- Neurological symptoms
 - Stress exacerbate symptoms
 - Lack of conscious control over the symptoms
 - Persistent pain
- 23. "La belle indifference" is seen in:**
- Dissociative disorders
 - Phobic disorders
 - Schizophrenic disorder
 - Bipolar affective disorders
- 24. All the following features characterize a hysterical fit, except:**
- Movements are irregular and bizarre
 - Incontinence of urine does not occur
 - Tongue bite is absent
 - It usually occurs in the absence of people and unsafe places
- 25. A sudden unexpected travel away from home/work place with assumption of new identity and inability to recall the past is called:**
- Dissociative identity disorder
 - Dissociative amnesia
 - Dissociative fugue
 - Trance and possession disorder
- 26. Which statement supports a psychodynamic theory in the etiology of dissociative disorders?**
- Symptoms are precipitated by excessive cortical arousal
 - Symptoms are caused by dysfunction in the hippocampus
 - Symptoms are related to trauma
 - Repression defense mechanism is used to reduce emotional pain
- 27. All the following features characterize a hypochondriasis, except:**
- Persistent preoccupation with a fear of having serious diseases
 - Repeated health care visits
 - Unconvinced by repeated investigations
 - Physical symptoms are managed by denial defense mechanism
- 28. The manifestation of physical symptoms caused by psychological distress is indicative of which of the following disorder?**
- Panic disorder
 - Somatization disorder
 - Conversion disorder
 - Dissociative disorder
- 29. A condition wherein the individuals have excessive worry or belief that they are suffering from a physical illness despite lack of medical evidence is typical of:**

- a. Generalized anxiety disorder
- b. Hypochondriasis
- c. Somatoform disorder
- d. Dissociative disorder

30. Which of the following is not an anxiety disorder?

- a. Post-traumatic stress disorder
- b. Obsessive-compulsive disorder
- c. Panic disorder
- d. Multiple personality disorder

31. The best nursing intervention for a patient with hypochondriasis is to:

- a. Collect detailed history to rule out physical disorder
- b. Instruct the patient to take prescribed medications
- c. Assist the patient to focus on her/his abilities and strengths
- d. Explain side effects of medication

KEY

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- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. d | 2. a | 3. c | 4. b | 5. b | 6. a | 7. a | 8. d | 9. a | 10. c |
| 11. c | 12. d | 13. d | 14. d | 15. d | 16. b | 17. d | 18. a | 19. b | 20. d |
| 21. b | 22. d | 23. a | 24. d | 25. c | 26. d | 27. d | 28. b | 29. b | 30. d |
| 31. c | | | | | | | | | |

Chapter 9

Nursing Management of Patient with Substance Use Disorder

Disorders due to psychoactive substance use refer to conditions arising from the abuse of alcohol, psychoactive drugs and other chemicals such as volatile solvents. These are classified under F1 in ICD10.

The term *substance* is used in reference to any drug, medication, or toxin that shares the potential for abuse. *Addiction* is a physiologic and psychologic 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: It refers to maladaptive pattern of substance use that impairs health in a broad sense.

Dependence: It refers to certain physiological and psychological phenomena induced by the repeated taking of a substance.

Tolerance: It is a state in which after repeated administration, a drug produces a decreased effect, or increasing doses are required to produce the same effect.

Withdrawal state: A group of signs and symptoms recurring when a drug is reduced in amount or withdrawn, which last for a limited time. The nature of the withdrawal state is related to the class of substance used.

CLASSIFICATION

- F10-F19 : Mental and behavior disorders due to psychoactive substance use
- F10 : Mental and behavioral disorders due to use of alcohol
- F11 : Mental and behavioral disorders due to use of opioids
- F12 : Mental and behavioral disorders due to use of cannabinoids
- F13 : Mental and behavioral disorders due to use of sedatives or hypnotics
- F14 : Mental and behavioral disorders due to use of cocaine
- F16 : Mental and behavioral disorders due to use of hallucinogens.

COMMONLY USED PSYCHOTROPIC SUBSTANCE

- Alcohol
- Opioids
- Cannabis
- Cocaine
- Amphetamines and other sympathomimetics
- Hallucinogens, for example, LSD, phencyclidine

- Sedatives and hypnotics, for example, barbiturates
- Inhalants, for example, volatile solvents
- Nicotine
- Other stimulants, for example, caffeine.

ETIOLOGICAL FACTORS IN PSYCHOACTIVE SUBSTANCE USE

Biological Factors

- *Genetic vulnerability:* Family history of substance use disorder, for example, twin studies suggest that genetic mechanisms might account for alcohol consumption. Research suggests that alcohol dependence and other substance addictions may be associated with genetic variations in 51 different chromosomal regions.
- *Biochemical factors:* For example, role of dopamine and norepinephrine have been implicated in cocaine, ethanol and opioid dependence. Abnormalities in alcohol dehydrogenase or in the neurotransmitter mechanism are thought to play a role in alcohol dependence.
- *Neurobiological theories:* Drug addicts may have an inborn deficiency of endorphins. According to another neurobiological theory, enzymes produced by a given gene might influence hormones and neurotransmitters, contributing to the development of a personality that is more sensitive to peer pressure.
- Withdrawal and reinforcing effects of drugs (they serve as maintaining factors).
- Comorbid medical disorder (for example, to control chronic pain).

Behavioral Theories

- Behavioral scientists view drug abuse as the result of conditioning, or cumulative reinforcement from drug use.
- Drug use causes euphoric experience perceived as rewarding, thereby motivating user to keep taking the drug (which then serves as a biological reward).

- Stimuli and settings associated with drug use may themselves become reinforcing or may trigger drug craving that can lead to relapse (many recovering addicts change their environment to eliminate cues that could promote drug use).

Psychological Factors

- General rebelliousness
- Sense of inferiority
- Poor impulse control
- Low self-esteem
- Inability to cope with the pressures of living and 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 periods of education
- Unemployment
- Overcrowding
- Poor social support
- Effects of television and other mass media
- Occupation: Substance use is more common in chefs, bartenders, executives, salesmen, actors, entertainers, army personnel, journalists, medical personnel, etc.

Easy Availability of Drugs

- Taking drugs prescribed by doctors (for example, benzodiazepine dependence)
- Taking drugs that can be bought legally without prescription (for example, nicotine, opioids)
- Taking drugs that can be obtained from illicit sources (for example, street drugs).

Psychiatric Disorders

Substance use disorders are more common in depression, anxiety disorders (particularly social phobias), personality disorders (especially antisocial personality) and occasionally in organic brain disease and schizophrenia.

Risk Factors for Alcohol Dependence

Age: The earlier a person begins drinking, the greater the risk for dependence. People with a history of abuse, family violence, family history of alcoholism, depression and stressful life events are at high-risk for early drinking.

Gender: Studies suggest that women are more vulnerable than men to many of long-term consequences of alcoholism like alcohol hepatitis, cirrhosis of liver and brain cell damage by alcohol.

History of abuse: Individuals who were abused as children have a higher risk for substance abuse. They also have worse response to treatment than those without such a history.

CONSEQUENCES OF SUBSTANCE ABUSE

- Substance abuse commonly leads to physical dependence, psychological dependence, or both.
- It may cause unhealthy lifestyles and behaviors such as poor diet.
- Chronic substance abuse impairs social and occupational functioning, creating personal, professional, financial, and legal problems (drug seeking is commonly associated with illegal activities, such as robbery or assault).
- Drug use beginning in early adolescence may lead to emotional and behavioral problems, including depression, problems with family relationships, problems with

or failure to complete school, and chronic substance abuse problems.

- In pregnant women, substance abuse jeopardizes fetal well-being.
- IV drug abuse may lead to life-threatening complications.
- Psychoactive substances produce negative outcomes in many patients, including maladaptive behavior, “bad trips,” and even long-term psychosis.
- Illicit street drugs pose added dangers; materials used to dilute them can cause toxic or allergic reactions.

ALCOHOL DEPENDENCE SYNDROME

Alcoholism refers to the use of alcoholic beverages to the point of causing damage to the individual, society or both.

Properties of Alcohol

Alcohol is a clear colored liquid with a strong burning taste. The rate of absorption of alcohol into the bloodstream 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 and a small amount is exhaled.

A concentration of 80–100 mg of alcohol per 100 mL of blood is considered intoxication. A person with 200–250 mg will be toxic, sleepy, confused and his thought process will be altered. If blood level is 300 mg/100 mL of blood the person may lose consciousness. A concentration of 500 mg/100 mL is fatal. All the symptoms change according to tolerance.

Epidemiology

WHO released a Global Status Report on alcohol and health 2014, taking into account individuals aged 15 and above, who consumed alcohol. According to this report, around 30% of the total population of India

consumed alcohol in the year 2010. The per capita consumption of alcohol in the country increased from 1.6 liters during the period 2003–2005, to 2.2 liters during the period 2010–2012. Kerala led the States in terms of alcohol consumption followed by Maharashtra and Punjab. It was also revealed that over 11% of the population in India indulged in heavy or binge-drinking. On the 'Years of Life Lost' scale, which is based on alcohol-attributable years of life lost, India has been rated 4 on a scale of 1 to 5. This implies that the alcohol consuming population of our country loses most years of their life because of drinking and its consequences. Alcohol consumption also contributes to about 10% of the disease burden due to tuberculosis, epilepsy, hemorrhagic stroke and hypertensive heart disease in the world, the report added.

ICD10 Criteria for Alcohol Dependence

- A strong desire to take the substance
- Difficulty in controlling substance taking behavior
- A physiological withdrawal state
- Development of tolerance
- Progressive neglect of alternative pleasures or interests
- Persisting with substance use despite clear evidence of harmful consequences.

Signs and Symptoms 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 and opioids
- Nutritional deficiency (vitamins and minerals)

- Secretive behavior (may attempt to hide disorder or alcohol supply)
- Consumption of alcohol-containing products (mouthwash, aftershave lotion, hair spray, lighter fluid)
- Denial of problem
- Tendency to blame others and rationalize problems (possibly displacing anger, guilt, or inadequacy onto others to avoid confronting illness).

Psychiatric Disorders due to Alcohol Dependence

Acute intoxication: Acute intoxication develops during or shortly after alcohol ingestion. It is characterized by clinically significant maladaptive behavior or psychological changes, for example, inappropriate sexual or aggressive behavior, mood lability, impaired judgment, slurred speech, incoordination, unsteady gait, nystagmus, impaired attention and memory finally resulting in stupor or coma.

Withdrawal syndrome: In persons who have 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. Withdrawal symptoms begin within 6 to 48 hours and peak about 24 to 35 hours after the last drink. During this period, the inhibition of brain activity caused by alcohol is abruptly reversed. Stress hormones are overproduced, and the central nervous system becomes overexcited.

These are discussed below:

- *Simple withdrawal syndrome:* It is characterized by mild tremors, nausea, vomiting, weakness, irritability, insomnia and anxiety.
- *Delirium tremens:* It occurs usually within 2–4 days of complete or significant abstinence from heavy alcohol drinking. The course is short, with recovery occurring within 3–7 days. It is characterized by:

- A dramatic and rapidly changing picture of disordered mental activity, with clouding of consciousness and disorientation in time and place
- Poor attention span
- Vivid hallucinations which are usually visual; tactile hallucinations can also occur
- Severe psychomotor agitation, shouting and evident fear
- Grossly tremulous hands which sometimes pick-up imaginary objects; truncal ataxia
- Autonomic disturbances such as sweating, fever, tachycardia, raised blood pressure, pupillary dilatation
- Dehydration with electrolyte imbalances
- Reversal of sleep-wake pattern or insomnia
- Blood tests reveal leukocytosis and impaired liver function
- Death may occur due to cardiovascular collapse, infection, hyperthermia or self-inflicted injury.

Alcohol-induced amnestic disorders: Chronic alcohol abuse associated with thiamine (vitamin B) deficiency is the most frequent cause of amnestic disorders. This condition is divided into:

- *Wernicke's syndrome:* This is characterized by prominent cerebellar ataxia, palsy of the 6th cranial nerve, peripheral neuropathy and mental confusion.
- *Korsakoff's syndrome:* The prominent symptom in Korsakoff's syndrome is gross memory disturbance. Other symptoms include:
 - Disorientation
 - Confusion
 - Confabulation
 - Poor attention span and distractibility
 - Impairment of insight

Alcohol-induced psychiatric disorders

- *Alcohol-induced dementia:* It is a long-term complication of alcohol abuse,

characterized by global decrease in cognitive functioning (decreased intellectual functioning and memory). This disorder tends to improve with abstinence, but most of the patients may have permanent disabilities.

- *Alcohol-induced mood disorders:* Excess drinking may induce persistent depression or anxiety.
- *Suicidal behavior:* Suicidal rates are higher in alcoholics when compared to non-alcoholics of the same age. The risk factors for suicidal behavior are continued drinking, comorbid major depression, serious medical illness, unemployment and poor social support.
- *Alcohol-induced anxiety disorder:* Alcoholics report panic attacks during acute withdrawal, similarly during the first 4 to 6 weeks of abstinence.
- *Impaired psychosexual function:* Erectile dysfunction and delayed ejaculation are common in chronic alcoholics.
- *Pathological jealousy:* Excessive drinkers may develop an overvalued idea or delusion that the partner is being unfaithful.
- *Alcoholic seizures (rum fits):* Generalized tonic clonic seizures occur usually within 12–48 hours after a heavy bout of drinking. Sometimes, status epilepticus may be precipitated.
- *Alcoholic hallucinosis:* This is characterized by the presence of hallucinations (auditory) during abstinence, following regular alcohol intake. Recovery occurs within 1 month.

Complications of Alcohol Abuse

Alcoholism reduces life expectancy by about 10–12 years. The earlier people begin drinking heavily, the greater their chance of developing serious illnesses later on. Alcohol damages body tissues by irritating them directly, through changes that occur during its

Box 9.1: Complications of alcohol abuse

Cardiopulmonary complications	Neurologic complications
» Arrhythmias	» Alcohol dementia
» Cardiomyopathy	» Alcoholic hallucinosis
» Essential hypertension	» Alcohol withdrawal delirium
» Chronic obstructive pulmonary disease	» Korsakoff's syndrome
» Pneumonia	» Peripheral neuropathy
» Increased risk of tuberculosis	» Seizure disorders
Gastrointestinal (GI) complications	» Subdural hematoma
» Chronic diarrhea	» Wernicke's encephalopathy
» Esophagitis	Psychiatric complications
» Esophageal cancer	» Amotivational syndrome
» Esophageal varices	» Depression
» Gastric ulcers	» Impaired social and occupational functioning
» Gastritis	» Multiple substance abuse
» GI bleeding	» Suicide
» Malabsorption	Other complications
» Pancreatitis	» Beriberi
Hepatic complications	» Fetal alcohol syndrome
» Alcoholic hepatitis	» Hypoglycemia
» Cirrhosis	» Leg and foot ulcers
» Fatty liver	» Prostatitis
	» Higher rate of death from injury or violence
	» Accidents, suicide and crime
	» Domestic violence

metabolism, by interacting with other drugs, by aggravating existing disease, or through accidents brought on by intoxication. Tissue damage can lead to a host of complications (Box 9.1).

Alcohol abusers who need surgery have an increased risk of postoperative complications, including infections, bleeding, insufficient heart and lung functions and hinders wound healing. Alcohol withdrawal symptoms after surgery may impose further stress on the patient and hinder recuperation.

Alcohol interacts with many drugs used by people with diabetes. It interferes with drugs

that prevent seizures or blood clotting. It increases the risk for gastrointestinal bleeding in people taking aspirin or other nonsteroidal inflammatory drugs (NSAIDs) including ibuprofen and naproxen.

Diagnosis

- Carbohydrate deficient transferrin (CDT) is a marker for heavy drinking and can be helpful in monitoring patients for progress towards abstinence. It is the only biologic marker approved by the FDA to help detect chronic heavy drinking.

- Gamma-glutamyl transferase (GGT) a liver enzyme it is very sensitive to alcohol and can be elevated after moderate alcohol intake and in chronic alcoholism.
- Testosterone is a male hormone. Its levels are low in men with alcoholism.
- Estimation of mean corpuscular volume (MCV). This blood test measures the size of red blood cells, which increase in alcoholics with vitamin deficiencies.
- Urine toxicology to reveal use of other drugs.
- Serum electrolyte analysis revealing electrolyte abnormalities associated with alcohol use.
- Liver function studies demonstrating alcohol related liver damage.
- Hemotologic workup possibly revealing anemia, thrombocytopenia.
- Echocardiography and electrocardiography (ECG) demonstrating cardiac problems
- Based on ICD10 criteria.

Treatment

The immediate goal of treatment is to calm the patient as quickly as possible.

- *Detoxification:* Detoxification is the treatment for alcohol withdrawal symptoms. The drugs of choice are benzodiazepines. The most commonly used drugs from this class are chlordiazepoxide 80–200 mg/day and diazepam 40–80 mg/day, in divided doses.
- *Treating delirium tremens:* People with symptoms of delirium tremens must be treated immediately. Untreated delirium tremens has a fatality rate that can be as high as 20%. Treatment usually involves intravenous administration of anti-anxiety medications and IV fluids. Restraints may be necessary to prevent injury to the patient or to others.
- *Treating seizures:* Seizures are usually self-limited and treated with a benzodiazepine. Intravenous phenytoin (Dilantin) along

with a benzodiazepine may be used in patients who have a history of seizures, who have epilepsy, or in those with ongoing seizures. Because phenytoin may lower blood pressure, the patient's blood pressure should be monitored during treatment.

- *Psychosis:* For hallucinations or extremely aggressive behavior antipsychotic drugs particularly haloperidol (Haldol) may be administered. Korsakoff's psychosis (Wernicke-Korsakoff syndrome) is caused by severe vitamin B₁ (thiamine) deficiency, which cannot be replaced orally. Rapid and immediate injection of the B vitamin thiamin is necessary.
- *Others:* For vitamin B deficiency a preparation of vitamin B containing 100 mg of thiamine should be administered parenterally, twice daily for 3 to 5 days. This should be followed by oral administration of vitamin B for at least 6 months.
 - Administration of anticonvulsants is necessary, maintaining fluid and electrolyte balance, strict monitoring of vitals, level of consciousness and orientation. Close observation is essential, especially during the first five days.
 - Symptomatic treatment, may involve respiratory support, fluid replacement, IV glucose to prevent hypoglycemia, correction of hypothermia or acidosis, and emergency measures for trauma, infection or GI bleeding.

Inpatient versus outpatient treatment

Inpatient treatment may be performed in a general or psychiatric hospital or in a de-addiction center. Factors that indicate a need for inpatient treatment include:

- Delirium tremens
- Potential harm to self or others
- Failure to respond to conservative treatments
- Coexisting medical or psychiatric disorder
- Disruptive home environment

Inpatient treatment includes:

- A physical examination and other tests to uncover medical problems
- Psychiatric work-up for any mental disorders
- Detoxification—Involves initiating abstinence, managing withdrawal symptoms and complications
- On-going treatment with medications in some cases
- Psychotherapy, usually cognitive behavioral therapy
- An introduction to AA

People with mild-to-moderate withdrawal symptoms are usually treated as outpatients.

Outpatient treatment includes:

- Medications
- Psychotherapy or counseling
- Social support groups such as AA
- Involvement of family and other significant people in patient's life.

Medications:

Three drugs are specifically approved to treat alcohol dependence:

- Naltrexone (ReVia, Vivitrol) (anticraving drug)
- Acamprosate (Campral) (anticraving drug)
- Disulfiram (Antabuse)
- Other types of medications, such as antidepressants, may also be used to treat patients with alcoholism.

Anticraving Medications

Anticraving drugs are opioid antagonists. These drugs reduce the intoxicating effects of alcohol and the urge to drink.

Naltrexone: It is available in oral (ReVia, Vivitrol) and injectable (Vivitrol) forms. This helps reduce alcohol dependence in the short term for people with moderate-to-severe alcohol dependency. ReVia, a pill is taken daily by mouth while vivitrol injection is taken once-a-month. This drug should be prescribed along with psychotherapy or other supportive medical management.

The common side effects are nausea, vomiting, headache, fatigue and stomach pain, which are usually mild and temporary. Some patients suffer adverse injection-site reactions, including spreading of skin infections and abscesses. Patients should be monitored for injection site for pain, swelling, tenderness, bruising, or redness, if symptoms do not improve within 2 weeks inform the physician. High doses can cause liver damage. The drug should not be given to anyone who has used narcotics in the last 7–10 days.

Acamprosate (Campral): It calms the brain and reduces cravings by inhibiting the transmission of the neurotransmitter gamma aminobutyric acid (GABA). Studies indicate that it reduces the frequency of drinking and, in combination with psychotherapy, improves quality of life even in patients with severe alcohol dependence. The drug may cause occasional diarrhea, headache and impair certain memory functions but does not alter short term working memory or mood. People with kidney problems should use acamprosate cautiously. For some patients, combination therapy with naltrexone or disulfiram may provide greater benefit than acamprosate alone.

Aversion medications (Disulfiram): Some drugs have properties that interact with alcohol to produce distressing side effects. Disulfiram (Antabuse) causes flushing, headache, nausea, and vomiting if a person drinks alcohol while taking the drug. The symptoms may be triggered after drinking half a glass of wine or half a shot of liquor and may last from half an hour to 2 hours depending on dosage of the drug and the amount of alcohol consumed. One dose of disulfiram is usually effective for 1–2 weeks. Overdose can be dangerous, causing low blood pressure, chest pain, shortness of breath, and even death.

Other drugs: Topiramate (Topamax) is an anti-seizure drug used to treat epilepsy. It also helps control impulsivity. Studies indicate that it may help treat alcohol dependence.

Side effects included burning and itching skin sensations, change in taste sensation, loss of appetite, and difficulty concentrating.

Baclofen (Lioresal) is a muscle relaxant and antispasmodic drug. It is being investigated for its benefits in helping maintain abstinence, particularly in patients with alcoholic cirrhosis.

Psychological Therapies

Commonly used therapies are cognitive behavioral therapy, combined behavioral interventions, interactional group therapy, motivational interviewing, family therapy, aversive conditioning, relapse prevention techniques, cue exposure technique.

Cognitive behavioral therapy (CBT): This therapy uses a structured teaching approach, patients are given instructions and homework assignments intended to improve their ability to cope with basic living situations, control their behavior and change the way they think about drinking. For example, patients might write a history of their drinking experiences and describe what they consider to be risky situations. They are then assigned activities to help them cope when exposed to 'cues' (situations or places that trigger their desire to drink). Patients may also be given tasks that are designed to replace drinking. CBT may be effective when used in combination with opioid antagonist, such as naltrexone.

Combined behavioral interventions: This therapy combines elements from cognitive behavioral therapy, motivational enhancement therapy, and a 12-step program, patients are taught how to cope with drinking triggers, learn strategies for refusing alcohol so that patients can achieve and maintain abstinence.

Family intervention: Among the various treatment modalities, family intervention is the most notable current advance in the area of psychosocial treatment of alcoholism.

The ingredients of family intervention include:

- Increasing cohesion within the family members
- Highlighting the positive aspects in the marriage
- Enhancing communication and conflict resolution skills with in the family
- Reducing adverse family atmosphere
- Enhancing problem-solving capacity of family members
- Maintaining reasonable expectations for patient performance
- Achieving changes in family members' behavior and belief system.

Motivational interviewing: This involves providing feedback to the patient on the personal risks that alcohol poses, together with a number of options for change.

Group therapy: Group therapy enables the patients to observe their own problems mirrored in others and to work out better ways of coping with them.

Aversive conditioning: This therapy is based on classical conditioning. In alcoholism the behavior patterns are self-reinforcing and pleasurable, but are maladaptive for reasons outside the control of the patient. In this technique, the patient is exposed to chemically-induced vomiting or shock when he takes alcohol.

Relapse prevention technique: This technique helps the patient to identify high-risk relapse factors and develop strategies to deal with them. It also enables the patient to learn methods to cope with cognitive distortions.

Cue exposure technique: This technique aims through repeated exposure to desensitize drug abusers to drug effects, and thus improve their ability to remain abstinent.

Other therapies include assertiveness training, behavior counseling, supportive psychotherapy and individual psychotherapy.

Agencies Concerned with Alcohol-related Problems

Alcoholics Anonymous

Alcoholics anonymous (AA) is a self-help organization founded in the USA by two alcoholic men, Dr Bob Smith and Bill Wilson, a stockbroker on the 10th of June, 1935. It has since then spread to many countries in the world. AA considers alcoholism as a physical, mental and spiritual disease, a progressive one, which can be arrested but not cured. It remains the most well-known program for helping people with alcoholism. AA offers a very strong support network using group meetings open 7 days a week in locations all over the world. A companion system, group understanding of alcoholism, and forgiveness for relapses are AA's standard methods for building self-worth and alleviating feelings of isolation. 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 other alcoholics to achieve sobriety.

Al-Anon

Al-Anon is a group started by Mrs Anne, wife of Dr Bob to support the spouses of alcoholics.

Al-Ateen

Provides support to their teenage children.

Hostels

These are intended mainly for those rendered homeless due to alcohol-related problems. They provide rehabilitation and counseling. Usually, abstinence is a condition of residence.

Nursing Management

Nursing Assessment

- Recognition of alcohol abuse: The CAGE questionnaire may be adopted for this purpose:
 - 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?
- Be suspicious about 'at-risk' factors: Problems in the marriage and 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.
- If at-risk factors raise suspicion, the next step is to ask tactful but persistent questions to confirm the diagnosis.
- Certain clinical signs lead to the suspicion that drugs are being injected: Needle tracks and thrombosed veins, wearing garments with long sleeves, etc. IV use should be suspected in any patient who presents with subcutaneous abscesses or hepatitis.
- Behavioral changes: Absence from school or work, negligence in appearance, minor criminal offences, isolation from former friends and adoption of new friends in a drug culture.

- Laboratory tests:
 - Raised Gamma-Glutamyl Transpeptidase (GGT)
 - Raised mean corpuscular volume
 - Blood alcohol concentration
 - Most drugs can be detected in urine, the notable exception being LSD
- Nervous system
 - Orientation
 - Level of consciousness
 - Co-ordination, gait
 - Memory (short and long term)
 - Signs of depression or anxiety
 - Tremors or decreased reflexes
 - Pupils (constricted or dilated)
- Cardiovascular and respiratory
 - Vital signs
 - Peripheral pulses
 - Dyspnea on exertion
 - Abnormal breath sounds
 - Arrhythmias
 - Fatigue
 - Peripheral edema
- Gastrointestinal
 - Nausea/vomiting
 - Changes in weight or appetite
 - Signs of malnutrition
 - Color and consistency of stool
- Integumentary
 - Skin lesions
 - Needle tracks on scarring on arms, legs, fingers, toes, under the tongue, or between gums and lips
- Emotional behavior
 - Affect
 - Rate of speech
 - Suspiciousness, anger, agitation
 - Occurrence of hallucinations, blackouts
 - History of violent episodes
 - Support system.

When assessing the patient who abuses substances it is first important to remember that underneath the surface of denial and rationalization are the feelings of fear, insecurity, anxiety and low self-esteem.

- Identify the type of substance the person has been using, the amount, frequency, method of administration and the length of time the substance has been abused.
- Note for any suicidal ideation or intent with drained symptoms
- Assess for level of motivation for treatment
- Identify reason for admission
- A baseline physical and emotional nursing assessment is done to determine admission status and provide baseline from which to determine progress towards an expected outcome.

Nursing Diagnosis I

Risk for injury related to hallucinosis, acute intoxication evidenced by confusion, disorientation, inability to identify potentially harmful situations.

Objective: Patient will not harm self.

Intervention: See Table 9.1.

Nursing Diagnosis II

Impaired health maintenance related to inability to identify, manage or seek out help to maintain health, evidenced by various physical symptoms, exhaustion, sleep disturbances, etc.

Objective: The patient will maintain optimum health status.

Intervention: See Table 9.2.

Nursing Diagnosis III

Ineffective denial related to weak, underdeveloped ego, evidenced by lack of insight, rationalization of problems, blaming others, failure to accept responsibility for his behavior.

Objective: Patient will understand the effect of his behavior on others and verbalize acceptance of responsibility and desire for change.

Intervention: See Table 9.3.

Table 9.1: Nursing interventions during acute intoxication

<i>Nursing interventions</i>	<i>Rationale</i>
Place the patient in a room near the nurse's station or where the staff can observe the patient closely	Patient's safety is nursing priority
Monitor the patient's sleep pattern; he may need to be restrained at night if confused or if he wanders or attempts to climb out of bed	- do -
Decrease environmental stimuli (bright lights, television, visitors) when the patient is restless, irritable or tremulous	Too many stimuli in the environment may increase misperceptions and restlessness
Institute seizure precautions (padded tongue blade and airway at bedside, raised side-rails, etc.)	Seizures can occur during withdrawal, precautions can minimize chances of injury
Reorient the patient to person, time, place and situation as needed	The patient is often confused and needs to be reoriented
Talk to the patient in simple, direct, concrete language	Patient's ability to deal with complex or abstract ideas is limited

Table 9.2: Nursing interventions to improve health status of alcoholics

<i>Nursing interventions</i>	<i>Rationale</i>
Monitor the patient's health status. Administer medications as prescribed by physician. Observe the patient for any behavioral changes and inform physician when necessary	To evaluate the patient's progress accurately
Maintain fluid and electrolyte balance	Patients with alcohol abuse are at high risk for fluid and electrolyte imbalances
Provide food or nourishing fluids as soon as the patient can tolerate eating (bland food usually is tolerated best at first)	Many patients who use alcohol heavily experience gastritis, anorexia and so forth. Therefore, bland foods are tolerated most easily. It is important to re-establish nutritional intake as soon as possible
Ensure that amount of protein in the diet is appropriate for individual patient condition	Diseased liver may be incapable of metabolizing proteins properly resulting in an accumulation of ammonia in the blood that circulates to the brain leading to altered consciousness
Provide small frequent feedings of patient's favorite foods. Supplement with vitamins and minerals	To correct malnutrition
Assist the patient in self-care activities; it may be necessary to provide complete physical care, depending on the severity of the patient's withdrawal	The level of patient independence is determined by the severity of withdrawal symptoms. The patient's needs should be met with the greatest degree of independence he can attain

Nursing Diagnosis IV

Ineffective individual coping related to impairment of adaptive behavior and problem-solving abilities, evidenced by use of substances as coping mechanisms.

Objective: Patient will be able to use adaptive coping mechanisms, instead of abusing drugs/alcohol, in response to stress.

Intervention: See Table 9.4.

Table 9.3: Nursing interventions to improve adaptive behavior

<i>Nursing interventions</i>	<i>Rationale</i>
Develop trust, convey an attitude of acceptance. Ensure that patient understands it is not him but his behavior that is unacceptable	Unconditional acceptance promotes dignity and self-worth
Identify recent maladaptive behaviors or situations that have occurred in the patient's life and discuss how use of drugs/alcohol may be a contributing factor	The first step in decreasing denial and rationalization is for patient to see the relationship between substance use and personal problems
Do not allow patient to rationalize or blame others for behaviors associated with substance use	This only serves to prolong the denial
Provide positive reinforcement when the patient shows insight into his behavior	Enhances repetition of desirable behavior

Table 9.4: Nursing interventions to improve adaptive coping skills among alcoholics

<i>Nursing interventions</i>	<i>Rationale</i>
Encourage patient to explore options available to deal with stress, rather than resorting to substance use. Practice these techniques	To develop desirable ways of coping with stress
Give positive reinforcement for ability to delay gratification and respond to stress with adaptive coping strategies	Because of weak ego, patient needs a lot of positive feedback to enhance self-esteem
Teach patient and family that alcoholism is a disease that requires long-term treatment and followup. Refer to AA, Al-Anon and other support groups as indicated	Family and significant others are also affected by the patient's substance use and need help
Teach the patient about prevention of HIV transmission	Patients with alcohol/drug use may involve in high risk behaviors which increase the risk of HIV transmission
Maintain frequent contact with the patient, even if it is only by a brief telephone call	Patient will not feel left alone to deal with his problems
If drinking occurs, discuss the events that led to the incident with the patient in a non-judgmental manner. Discuss ways to avoid similar circumstances in the future	The patient may be able to see the relatedness of the event or a pattern of behavior while discussing the situation. Anticipatory planning may prepare the patient to avoid similar circumstances in future
Assist the patient to plan weekly or even daily schedules of purposeful activities, such as appointments, taking walks, etc.	Scheduled events provide the patient with something to look forward to

Evaluation

The following questions can be useful in evaluating the nursing care:

- Has detoxification occurred without complications?

- Has a correlation been made between personal problems and the use of substances?
 - Does he accept responsibility for own behavior?
- Acute withdrawal outcomes are achieved when the patient no longer exhibits any signs

or symptoms of substance intoxication or withdrawal. As the patient gains insight into the illness he expresses willingness to admit and take responsibility for his own substance problem.

OTHER SUBSTANCE USE DISORDERS

The National Household Survey of Drug Use (2001) in the country is the first systematic effort to document the nation-wide prevalence of drug use. It was estimated that the prevalence of alcohol 21.4% is the primary substance used (apart from tobacco) followed by cannabis 3.0%, Heroin 0.2%, Opium 0.4% and other opiates 0.1%. About 17 to 26% of alcohol users qualified for ICD 10 diagnosis of dependence, translating to an average prevalence of about 4%. There was a marked variation in alcohol use prevalence in different states of India (current use ranged from a low of 7% in the Western State of Gujarat (officially under Prohibition) to 75% in the North-eastern State of Arunachal Pradesh). Tobacco use prevalence was high at 55.8% among males, with maximum use in the age group 41–50 years.

Opioid Use Disorders

In the last few decades, the use of opioids has increased markedly world over. India, surrounded on both sides by routes of illicit transport, namely Golden Triangle (Burma, Thailand, Laos) and Golden Crescent (Iran, Afghanistan, Pakistan), is particularly affected. The most important dependence producing derivatives are morphine and heroin.

The commonly abused opioids (narcotics) in our country are heroin (*brown sugar, smack*) and synthetic preparations like pethidine, fortwin (pentazocine) and tidigesic (buprenorphine). The drugs that are injected through needle are heroin, buprenorphine and pentazocine. Though most opiate users had begun chasing (inhaling the smoke or *chasing the dragon*) heroin they gradually shifted to

needle use. These 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 and pinpoint pupils. Later delayed reflexes, thready pulse and coma can occur.

Withdrawal Syndrome

Narcotic withdrawal rarely produces a life-threatening situation. Common symptoms include watery eyes, running nose, yawning, loss of appetite, irritability, tremors, sweating, cramps, nausea, diarrhea, insomnia, raised body temperature, piloerection and anorexia.

Withdrawal symptoms begin within 12 hours of the last dose, peak in 24 to 36 hours and disappear in 5 to 6 days.

Complications

- Complications due to illicit drug use: Parkinsonism, peripheral neuropathy, transverse myelitis
- Complications due to intravenous use: Skin infection, thrombophlebitis, pulmonary embolism, endocarditis, septicemia, AIDS, viral hepatitis and tetanus
- Involvement in criminal activities.

Treatment

Treatment of opioid overdose: Opioid overdose can be treated with narcotic antagonists, for example, naloxone, naltrexone.

Detoxification: Withdrawal symptoms can be managed by methadone, clonidine, naltrexone, buprenorphine, etc.

Maintenance therapy: After the detoxification phase is over, the patient is maintained on one of the following regimens:

- Methadone maintenance
- Opioid antagonists
- Psychological methods like individual psychotherapy, behavior therapy, group therapy and family therapy.

Cannabis Use Disorder

Cannabis is 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 is characterized by mild impairment of consciousness and orientation, tachycardia, a sense of floating in the air, euphoria, dream-like states, 'flashback' phenomena, alteration in psychomotor activity, tremors, photophobia, lacrimation, dry mouth and increased appetite. Severe intoxication causes perceptual disturbances like depersonalization, derealization, synesthesia and hallucinations.

Withdrawal Symptoms

They are mostly found in the first 72–96 hours and include increased salivation, hyperthermia, insomnia, decreased appetite and loss of weight.

Complications

- Transient or short-lasting psychiatric disorders such as acute anxiety, paranoid psychosis, hysterical fugue-like states, hypomania, schizophrenia-like state
- A motivational syndrome
- Memory impairment.

Treatment

- Supportive and symptomatic treatment.

Cocaine Use Disorder

Common street name is 'crack'. It can be administered orally, intranasally by smoking, or parenterally.

Acute Intoxication

It is characterized by pupillary dilatation, tachycardia, hypertension, sweating and nausea and hypomanic picture.

Withdrawal Syndrome

Agitation, depression, anorexia, fatigue and sleepiness.

Complications

Acute anxiety reaction, uncontrolled compulsive behavior, seizures, respiratory depression, cardiac arrhythmias.

Treatment

Management of intoxication: Amyl nitrite is an antidote; diazepam or propranolol is also used.

For withdrawal symptoms: Antidepressants (imipramine or amitriptyline) and psychotherapy.

Amphetamine Use Disorder

Amphetamines are powerful CNS stimulants with peripheral sympathomimetic effects. Commonly used amphetamines are pemoline and methylphenidate.

Acute Intoxication

It is characterized by tachycardia, hypertension, cardiac failure, seizures, tremors, hyperpyrexia, pupillary dilation, panic, insomnia, restlessness, irritability, paranoid hallucinatory syndrome and amphetamine-induced psychosis.

Withdrawal Syndrome

It is characterized by depression, apathy, fatigue, hypersomnia or insomnia, agitation and hyperphagia.

Complications

Seizures, delirium, arrhythmias, aggressive behavior, coma.

Lysergic Acid Diethylamide Use Disorder

Lysergic acid diethylamide (LSD) is a powerful hallucinogen, and was first synthesized in 1938. It presumably produces its effects by acting on 5-HT levels in brain. A common pattern of LSD use is 'trip' (occasional use followed by a long period of abstinence).

Intoxication

It is characterized by perceptual changes occurring in clear consciousness, for example, depersonalization, derealization, illusions, synesthesias (colors are heard, sounds are felt), autonomic hyperactivity, marked anxiety, paranoid ideation and impairment of judgment.

Withdrawal Syndrome

Flashbacks (brief experiences of the hallucinogenic state).

Complications

Anxiety, depression, psychosis or visual hallucinosis.

Treatment

Symptomatic treatment with antianxiety, antidepressant or antipsychotic medications.

Barbiturate Use Disorder

The commonly abused barbiturates are secobarbital, pentobarbital and amobarbital.

Intoxication

Acute intoxication characterized by irritability, lability of mood, disinhibited behavior, slurring

of speech, incoordination, attention and memory impairment.

Complications

Intravenous use can lead to skin abscesses, cellulitis, infections, embolism and hypersensitivity reactions.

Withdrawal Syndrome

It is characterized by marked restlessness, tremors, and seizures 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 or Volatile Solvent Use Disorder

The commonly used volatile solvents include petrol, aerosols, thinners, varnish remover and industrial solvents.

Intoxication

Inhalation of a volatile solvent leads to euphoria, excitement, belligerence, slurring of speech, apathy, impaired judgment and neurological signs.

Withdrawal Symptoms

Anxiety, depression.

Complications

Irreversible damage to the liver and kidneys, peripheral neuropathy, perceptual disturbances and brain damage.

Treatment

Reassurance and diazepam for intoxication.

GENERAL NURSING INTERVENTIONS FOR A PATIENT WITH ACUTE DRUG INTOXICATION

- Care for a substance-abuse patient starts with an assessment to determine which substance he is abusing. Signs and symptoms vary with the substance and dosage
- During the acute phase of drug intoxication and detoxification, care focuses on maintaining the patient's vital functions, ensuring his safety, and easing discomfort
- During rehabilitation, caregivers help the patient acknowledge his substance abuse problem and find alternative ways to cope with stress. Healthcare professionals can play an important role in helping patients achieve recovery and stay drug-free
- These general nursing interventions are appropriate for patients during and after acute intoxication with most types of psychoactive drugs.

During an Acute Episode

- Continuously monitor the patient's vital signs and urine output; watch for complications of overdose and withdrawal, such as cardiopulmonary arrest, seizures, and aspiration
- Maintain a quiet, safe environment
- Take appropriate measures to prevent suicide attempts and assaults, according to facility policy; remove harmful objects from the room, and use restraints 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 and record their effectiveness.

During Drug Withdrawal

- Administer medications, as ordered, to decrease withdrawal symptoms; monitor and record their effectiveness
- Maintain a quiet, safe environment because excessive noise may agitate the patient.

When the acute episode has resolved

- Carefully monitor and promote adequate nutrition
- Administer drugs carefully to prevent hoarding; check the patient's mouth to ensure that he has swallowed oral medication, and closely monitor visitors who might supply him with drugs
- Refer the patient for rehabilitation as appropriate; give him a list of available resources
- Encourage family members to seek help regardless of whether the abuser seeks it; suggest private therapy or community mental health clinics
- Use the episode to develop personal self-awareness and an understanding and positive attitude toward the patient; control reactions to his undesirable behaviors; commonly, psychological dependence, manipulation, anger, frustration, and alienation
- Set limits when dealing with demanding, manipulative behavior.

PREVENTION OF SUBSTANCE USE DISORDER

Primary Prevention

- Reduction of over prescribing by doctors (especially with benzodiazepines and other anxiolytic drugs).
- Identification and treatment of family members who may be contributing to the drug abuse.
- Introduction of social changes is likely to affect drinking patterns in the population as a whole. This is made possible by:

- Putting up the price of alcohol and alcoholic beverages
- Controlling or abolishing the advertising of alcoholic drinks
- Controls on sales (by limiting hours or banning sales in supermarkets)
- Restricting availability and lessening social deprivation (Governmental measures)
- Other approaches are to strengthen the individual's personal and social skills to increase self-esteem and resistance to peer pressure.
- Health education to college students and the youth about the dangers of drug abuse through the curriculum and mass media. Health education should also include certain specific groups where a substance like alcohol may be culturally accepted. For instance, certain tribal communities such as the *Lambani* group manufacture arrack, and its intake is considered normal. Some communities use it in the postnatal period, as alcohol is believed to strengthen the pelvic muscles and also speed up retroversion of the uterus. Such attitudes should be addressed and corrected.
- An overall improvement in the socio-economic condition of the population.

Secondary Prevention

- Early detection and counseling.
- Brief intervention in primary care (simple advice by a general practitioner plus an educational leaflet).
- Motivational interviewing which involves providing feedback to the patient on the personal risks that alcohol poses, together with a number of options for change.
- A full assessment including an appraisal of current medical, psychological and social problems. Assessment also includes ascertaining whether alcoholism is the primary or secondary problem. For example, a

patient with diabetic neuropathy may be using alcohol to numb pain. Alcohol is also used by some to relieve asthmatic symptoms. In such instances, treatment of the medical problem can help to control alcoholism.

- Detoxification with benzodiazepines (diazepam, chlordiazepoxide).

Tertiary Prevention

Specific measures include:

- Alcohol deterrent therapy (Disulfiram or Antabuse).
- Other therapies include assertiveness training (to prevent yielding to peer pressure), teaching coping skills (some take drugs to combat stress), behavior counseling, supportive psychotherapy and individual psychotherapy.
- Agencies concerned with alcohol-related problems: Alcoholics Anonymous (AA), Al-Anon, Al-Ateen, etc.
- Some practical issues under relapse prevention include:
 - Motivation enhancement, including education about health consequences of alcohol use
 - Identifying high-risk situations and developing strategies to deal with them (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 and 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, is to enable him to leave the drug sub-culture and to develop new social contacts, in this, patients first engage in work and social activities in sheltered surroundings and 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 and living.

GERIATRIC CONSIDERATIONS

Onset of initial drinking problems after the age of 50 years is not uncommon. Risk factors for late-onset substance abuse in elders include chronic illness, life stress, social isolation, grief, depression, etc. Some elders with alcohol use problems are those who had a drinking problem early in life, had a significant period of abstinence and then resumed drinking again in later life. Elders may experience physical problems associated with substance abuse rather quickly, especially if their overall medical health is compromised by other illnesses.

FOLLOW-UP AND HOME CARE

Some patients with drug problems complete treatment the first time and remain sober, while other patients have to repeat treatment several times. Some patients do not succeed in staying sober. Nurses remain hopeful and appropriately supportive but realistic when treating patients.

Patient and Family Teaching

- Teach the patient/family about the physical, psychological and social complications of drug and alcohol use.
- Inform the patient/family that psychoactive substances 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 or alcohol use and avoid treatment.
- Teach the patient/family that drug overdose or withdrawal can result in a medical emergency and even death, give the family emergency resources for help.
- Caution the patient that sharing dirty or used needles 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) and behavior modification to strengthen the recovery process.
- Teach the patient/family how to recognize psychosocial stressors that may exacerbate substance abuse problem and how to avoid or prevent them.
- Emphasize to the patient the importance of changing lifestyle, friendships, and habits that promote drug use to remain sober.
- Teach the patient/family about the availability of local self-help programs (AA, Al-Anon) to strengthen the patient's recovery and support the family's assistance.
May 31st of every year is observed as World No-Tobacco Day.

REVIEW QUESTIONS

Long Essays

1. Role of a nurse in prevention of drug abuse.
2. Nursing management for substance use disorder.
3. Outline rehabilitation program for an alcoholic patient who is on antabuse therapy.

Short Essays

1. Alcohol anonymous

2. Korsakoff's syndrome
3. Delirium tremens
4. Etiology of substance use
5. Complications of alcohol abuse
6. Psychological treatments for alcohol related problems
7. Follow-up and home care for alcoholics.

Short Answers

1. Drug addiction
2. What are the drugs commonly used for addiction?
3. Drug abuse
4. Dependence
5. Esperol.

MULTIPLE CHOICE QUESTIONS

1. Drug dependence means:

- a. Physiological and psychological dependence on drugs
- b. Maladaptive pattern of substance use
- c. Experiencing psychotic symptoms
- d. Developing complications

2. Substance abuse means:

- a. Physiological and psychological dependence on drugs
- b. Maladaptive pattern of substance use
- c. Experiencing withdrawal symptoms
- d. Developing tolerance

3. Which of the following is NOT a criteria for diagnosis of dependence syndrome in ICD-10 classification?

- a. A strong desire to take the substance
- b. Physiological withdrawal state
- c. Development of tolerance
- d. Episodic use of substances

4. Which of the following drug is a deterrent agent in the treatment of alcohol dependence syndrome?

- a. Acamprosate
- b. Naltrexone
- c. Disulfiram
- d. Bupropion

5. Which of the following is an anticraving drug?

- a. Disulfiram
- b. Acamprosate
- c. Chlordiazepoxide
- d. Diazepam

6. Delirium tremens is associated with all the following, except:

- a. Clouding of consciousness
- b. Vivid hallucinations
- c. Trembling hands
- d. Hypothermia

7. Detoxification means:

- a. Alcohol induced disorder
- b. Treatment for alcohol withdrawal symptoms
- c. Treatment for alcohol complications
- d. Removal of toxins from body

8. Which of the following nursing interventions is most appropriate for a patient during acute intoxication?

- a. Decrease in environmental stimuli
- b. Education on ill effects of alcoholism
- c. Educate family members on how to control alcohol behavior
- d. Encourage the use of positive coping skills

9. The following are all nursing interventions to improve adaptive behavior, except:

- a. Convey an attitude of acceptance
- b. Provide positive reinforcement when patient shows insight to his problem
- c. Do not allow patient to rationalize
- d. Educate family members on ill effects of alcoholism

10. Korsakoff's syndrome occurs due to the intake of:

- a. Cannabis
- b. Opium
- c. Amphetamine
- d. Alcohol

11. Korsakoff's syndrome results due to the deficiency of:

- a. Thiamine
- b. Vitamin B12

- c. Riboflavin
- d. Biotin

12. Alcohol induced amnestic disorder is termed as:

- a. Wernicke's syndrome
- b. Peripheral neuropathy
- c. Alcohol hallucinosis
- d. Delirium tremens

13. A nurse refers a patient with 20-year history of alcohol abuse to alcoholic anonymous (AA). The primary function of AA is to:

- a. Teach ill effects of alcoholism
- b. Help members to maintain sobriety
- c. Encourage the use of positive coping skills
- d. Provide membership to alcohol patients

14. Which of the following is derived from the plant 'Cannabis sativa'?

- a. Morphine
- b. Cocaine
- c. Opium
- d. Ganja

15. Watery eyes, running nose, yawning, loss of appetite, irritability are characteristics of:

- a. Cannabis withdrawal syndrome

- b. Opium withdrawal syndrome
- c. Cocaine withdrawal syndrome
- d. Alcohol withdrawal syndrome

16. "Flash back phenomenon" is common with:

- a. Opium
- b. Cannabis
- c. Nicotine
- d. Alcohol

17. The drug's of choice in the management of alcohol withdrawal is/are:

- a. Antidepressants
- b. Benzodiazepines
- c. Disulfiram
- d. Acamprosate

18. Which of the following is NOT a cannabis preparation?

- a. Smack
- b. Ganja
- c. Hashish
- d. Bhang

19. "Chasing the dragon" refers to the smoking of:

- a. Nicotine
- b. Heroin
- c. LSD
- d. Cocaine.

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. a | 2. b | 3. d | 4. c | 5. b | 6. d | 7. b | 8. a | 9. d | 10. d |
| 11. a | 12. a | 13. b | 14. d | 15. b | 16. b | 17. b | 18. a | 19. b | |

Chapter 10

Nursing Management of Patient with Personality, Sexual and Eating Disorder

PERSONALITY DISORDER

The term personality refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances. Personality disorders result when personality traits become abnormal, i.e. become inflexible and maladaptive and cause significant social or occupational impairment or significant subjective distress. In ICD10, they are listed under the section on Disorders of Adult Personality and Behavior (F6).

Definition (ICD9)

Personality disorder reflects adaptive failure involving impaired sense of self-identity or failure to develop effective interpersonal functioning.

The definition of abnormal personality given by ICD9 is as follows:

An abnormal personality is one in which there are, "deeply ingrained maladaptive patterns of behavior recognizable by the time of adolescence or earlier and continuing through most of adult life. Because of this the patient suffers or others have to suffer, and there is an adverse effect on the individual or on society."

Incidence

The prevalence of personality disorders in the general population is 5 to 10%. Occurrence of mixed personality disorders is more

common than a single personality disorder in an individual.

Classification

F60–F69 : Disorders of adult personality and behavior

- F60 : Specific personality disorders
- F60.0 : Paranoid personality disorder
- F60.1 : Schizoid personality disorder
- F60.2 : Dissocial personality disorder
- F60.3 : Emotionally unstable personality disorder
- F60.4 : Histrionic personality disorder
- F60.5 : Anankastic personality disorder
- F60.6 : Anxious personality disorder
- F60.7 : Dependent personality disorder
- F61 : Mixed and other personality disorders
- F62 : Enduring personality changes, not attributable to brain damage and disease
- F63 : Habit and impulse disorders
- F64 : Gender identity disorders
- F65 : Disorders of sexual preference.

DSM Classification

In DSMIV, personality disorders are coded on axis II and have been divided into three clusters:

- Cluster A (odd and eccentric): paranoid, schizoid, schizotypal personality disorders.

- Cluster B (dramatic, emotional and erratic): Antisocial, histrionic, narcissistic personality disorders.
- Cluster C (anxious and fearful): Avoidant, dependent and obsessive-compulsive personality disorders.

DSMV classified personality disorders under five categories: Antisocial/psychopathy, avoiding, borderline, obsessive-compulsive and schizotypal personality disorders.

Etiology

The exact cause of personality disorder is unknown; most likely, they represent a combination of genetic, biological, social, psychological, developmental and environmental factors.

Genetic factors: Genetic factors influence the biological basis of brain function as well as basic personality structure. Genetic predisposition can be responsible for a psychopathic personality.

Biological factors: Some researchers suspect that poor regulation of the brain circuits that control emotion increases the risk for a personality disorder when combined with such factors as abuse, neglect or separation. For a biologically predisposed person, the major developmental challenges of adolescence and early adulthood (such as separation from the parents, identity and independence) may trigger a personality disorder.

Psychodynamic theories: These theories propose that personality disorders stem from deficiencies in ego and superego development. These deficiencies may relate to mother-child relationships marked by unresponsiveness, over protectiveness or early separation.

Other factors:

- Maternal deprivation, especially in *antisocial* personality
- *Borderline* personalities are more likely to report physical and sexual abuse in childhood

- *Histrionic* personality is said to occur as a result of failure to resolve oedipal complex and excessive use of repression as a mechanism of defense
- *Dependent* personality may be due to fixation in the oral stage of development
- *Paranoid* personality is due to absence of trust, which results from lack of parental affection in childhood and persistent rejection by parents leading to low self-esteem.

Clinical Features of Abnormal Personalities

According to DSMV the four core features of all personality disorders are:

1. Distorted thinking patterns
2. Problematic emotional responses
3. Over or under regulated impulse control
4. Interpersonal difficulties

Paranoid Personality Disorder

This disorder is marked by a distrust of other people and a constant unwarranted suspicion that others have sinister motives. Persons with paranoid personality disorder search for hidden meanings and hostile intentions in everything others say and do. The signs and symptoms are:

- Suspicious
- Mistrustful
- Sensitive
- Argumentative
- Stubborn
- Self-important
- Hypersensitive
- Jealous and irritable

Schizoid Personality Disorder

Schizoid personality disorder is characterized by detachment and social withdrawal. People with this disorder are commonly described as loners, with solitary interests and occupations and no close friends; typically they maintain a social distance even from

family members and seem unconcerned about other's praise or criticism. The signs and symptoms are:

- Emotionally cold
- Aloof
- Detached
- Humorless
- Introspective
- No desire for or enjoyment of close relationship
- Inability to experience pleasure

Schizotypal Disorder

This disorder is marked by odd thinking and behavior, a pervasive pattern of social and interpersonal deficits and acute discomfort with others. The signs and symptoms are:

- Inappropriate affect
- Odd beliefs or magical thinking
- Social withdrawal
- Odd, eccentric or peculiar behavior
- Lack of close relationships
- Social isolation
- Not fitting easily with others.

Antisocial (Dissocial) Personality Disorder (Sociopath, Psychopath)

Antisocial personality disorder is characterized by chronic antisocial behavior that violates others rights or social norms which predisposes the affected person to criminal behavior. The person is unable to maintain consistent, responsible functioning at work, school or as a parent. The signs and symptoms are:

- Failure to sustain relationships
- Disregard for the feelings of others
- Impulsive actions
- Low tolerance to frustration
- Tendency to cause violence
- Lack of guilt
- Failure to learn from experience
- Reckless disregard for own or others safety
- Impulsivity and failure to plan ahead
- Manipulative behavior for self-gratification
- Inability to maintain close personal or sexual relationship.

Nursing Interventions for Antisocial Personality Disorder

- Convey an accepting attitude towards the patient. Be honest, keep all promises and convey the message that it is not him but his behavior which is unacceptable.
- Maintain low level of stimuli in the environment to decrease agitation and aggressive behavior; remove all dangerous objects from the environment.
- Help the patient to identify the true object of his hostility and encourage him to gradually verbalize hostile feelings. This may help him to come to terms with unresolved issues.
- Explore with patient alternative ways of handling frustration to relieve pent-up tensions (for example, large motor skills that channel hostile energy into socially acceptable behavior).
- Staff should maintain a calm attitude. Have sufficient staff available to present a show of strength to patient if necessary. It also provides some physical security for the staff.
- Administer tranquilizing medications as prescribed.
- Mechanical restraints may be necessary if the patient is not calmed by 'talking down' or by medication.
- Explain consequences if limits are violated. A consequence must involve something of value to the patient, and all staff must be consistent in enforcing these limits.
- Provide positive feedback for acceptable behavior which will encourage repetition of desirable behaviors.
- Help patient to gain insight into his own behavior. He must understand that certain behaviors will not be tolerated within the society and that severe consequences will be imposed upon those individuals who refuse to comply.
- Talk about his past behaviors. Help him identify ways in which he has exploited others. Encourage him to explore how he would feel if the circumstances were reversed.

Histrionic Personality Disorder

Patients with this disorder characteristically have a pervasive pattern of excessive emotionality and attention seeking behavior and are drawn to momentary excitements and fleeting adventures. This disorder is more common in females. People with this disorder need to be the center of attention at all times. The signs and symptoms are:

- Dramatic emotionality (Emotional blackmail, angry scenes, demonstrative suicide attempts, etc.)
- Craving for novelty and excitement
- Shallow and labile affectivity
- Attention-seeking behavior
- Over concern with physical attractiveness
- Exaggerated, vague speech
- Self-dramatization
- Impulsivity
- Suggestibility
- Ego-centricity, self-indulgence and lack of consideration for others.

Narcissistic Personality Disorder

Patient with narcissistic personality disorder is self-centered, self-absorbed and lacking in empathy for others. He typically takes advantage of people to achieve his own ends, and uses them without regard to their feelings. The signs and symptoms are:

- Inflated sense of self-importance
- Attention-seeking, dramatic behavior
- Unable to face criticism
- Lack of empathy
- Exploitative behavior
- Arrogance
- Preoccupation with fantasies of success, power, beauty, brilliance or ideal love

Borderline Personality Disorder

Borderline personality disorder is marked by a pattern of instability in interpersonal relationships, mood, behavior and self-image. The four main categories of signs and symptoms are:

- Unstable relationships
- Unstable self-image

- Unstable emotions
- Impulsivity

Other symptoms include:

- Lack of control on anger
- Recurrent suicidal threats or behavior
- Uncertainty about personal identity
- Chronic feelings of emptiness
- Efforts to avoid abandonment
- Transient stress-related paranoid or dissociative symptoms
- Acting out of feelings instead of expressing them appropriately or verbally.

Nursing Interventions for Borderline Personality Disorder

- Observe patient's behavior frequently. Do this during routine activities and interaction; avoid appearing watchful and suspicious.
- Secure a verbal contract from patient that he will seek out staff members for help when urge for self-mutilation is felt.
- If self-mutilation occurs, care for patient's wounds in matter-of-fact manner. Do not give positive reinforcement to this behavior by offering sympathy or additional attention. Assign staff on a one-to-one basis if need arises.
- Encourage patient to talk about feelings he was having just prior to this behavior. Act as a role model for appropriate expression of angry feelings. Give positive reinforcement when attempts to conform are made.
- Set limits on acting out behavior.
- Rotate staff who works with the patient to prevent developing dependence on particular staff member.
- Explore feelings that relate to fears of abandonment. Help patient understand that these fears are causing his clinging and distancing behaviors. Help patient understand how these behaviors interfere with satisfactory relations.

Anxious (Avoidant) Personality Disorder

Anxious personality disorder is marked by feelings of inadequacy, extreme social anxiety,

social withdrawal and hypersensitivity to others' opinions. People with this disorder have low self-esteem and poor self-confidence; they dwell on the negative and have difficulty viewing situations and interactions objectively. The signs and symptoms are:

- Persistent feeling of tension and apprehension
- Inferiority complex
- Fear of criticism, disapproval or rejection
- Unwillingness to become involved with people
- Excessive preoccupation with being criticized or rejected in social situations.

Many people with avoidant personality disorder have other psychiatric disorders like social phobia, anxiety disorder, obsessive-compulsive disorder, depressive disorders, somatoform disorders, dissociative disorder and schizophrenia.

Dependent Personality

This disorder is characterized by an extreme need to be taken care of, which leads to submissive, clinging behavior and fear of separation or rejection. People with this disorder let others make important decisions for them and have a strong need for constant reassurance and support. The signs and symptoms are:

- Subordination of one's own needs
- Unwillingness to make even reasonable demands on other people
- Inability to take decision
- Feeling uncomfortable or helpless when alone
- Low self-esteem and lack of self-confidence
- Hypersensitivity to criticism.

Obsessive-Compulsive (Anankastic) Personality Disorder

This disorder is marked by a pervasive desire for perfection and order at the expense of openness, flexibility and efficiency. The individual places a great deal of pressure on

himself and others not to make mistakes. May have a constant sense of righteous indignation and feelings of anger and contempt for anyone who disagrees with him, believes his way of doing something is the only right way, may force himself and others to follow right moral principles and to conform to extremely high standards of performance and insist on literal compliance with authority and rules.

The signs and symptoms are:

- Feeling of excessive doubt and caution
- Preoccupation with details, rules, lists, order or schedule
- Perfectionism
- Rigidity and stubbornness
- High standards

Treatment Modalities

Personality disorder is often difficult to treat. Drug treatment has a very limited role and may be used if associated mental illness like depression or psychosis is present. Individual and group psychotherapy, therapeutic community and behavioral therapy may be beneficial. Manipulation of the social environment can be tried.

- Group therapy helps patients improve interaction skills in addition to gaining an understanding of how they are perceived by others. Patients can learn how to ventilate anxiety and trust others in a safe environment. Problem-solving methods can be practiced within the group to resolve community issues. Individual therapy helps patients gain insight into their thinking and behavior. Ways can be explored for them to modify their behavior to a more functional level.
- Occupational therapy allows patients to increase their level of functioning so that they become more independent. Task completion skills can also be evaluated and enhanced by these activities.
- Recreation therapy can assist patients to ventilate feelings and increase socialization skills.

- Interaction and guidance by the therapist can provide patients with constructive ways to deal with anger and other self-destructive behaviors.
- Medications if needed.

Nursing Interventions for Patients with Personality Disorders

Providing care for people with personality disorders is very challenging for nurses. The nurse must identify personal feelings about the patient's behaviors and maintain a continuous awareness to provide appropriate interventions. Nursing actions may include the following:

- Show acceptance of the person at all times by separating the person from the behaviors
- Provide a safe environment, especially important for patients who exhibit self-mutilating behavior
- Set and maintain limits with consequences
- Explain all unit rules and enforce them fairly and consistently
- Require the patient to take responsibility for his or her own behavior
- Identify inappropriate behavior and discuss possible alternative behavior with the patient
- Do not make exceptions or show favoritism
- Encourage the patient to openly express feelings and thoughts
- Identify triggers of acting-out behaviors
- Maintain alertness to manipulative behaviors of patients
- Communicate problems with manipulative patients to other team members
- Provide positive feedback to patients who are making efforts to change behavior
- Approach patients from the front and speak clearly. This is especially true for the patient with paranoia
- Monitor medication
- Encourage the patient to participate in unit activities
- Assess for suicidal ideation

- Develop a no-harm contract with the patient with self-destructive tendencies
- Assist and educate the patient in the problem-solving process
- Demonstrate a matter-of-fact attitude when patients act-out or exaggerate events
- Point out 'all or none' behavior to the patient when it occurs
- Encourage the patient to keep a private journal of thoughts and feelings
- Discuss with the patient how his or her behavior affects others and assist to explore alternative actions
- Observe and intervene before escalation of behavior occurs
- Use time-out for curbing acting-out behavior if patient is resistant to redirection.

Geriatic Considerations

They are not first diagnosed in elderly persons but may persist from young adulthood into older age. Some persons with personality disorders tend to stabilize and experience fewer difficulties in late life. Others are described as 'aging badly', i.e. they are unable or unwilling to acknowledge limitations that come with aging, they refuse to accept help when needed, and they do not make reasonable decisions about their healthcare, finances, or living situation. These individuals seem chronically angry, unhappy, or dissatisfied, resulting in strained relationships and even alienation from family, friends, caregivers and healthcare providers.

Follow-up, Homecare and Rehabilitation for Personality Disorders

Because of the long-term, deeply ingrained patterns of maladaptive perceptions, feelings, cognitions, and behaviors that accompany personality disorders, the prognosis for these patients is generally poor and at best is guarded. It is difficult to change a person's lifelong patterns of living.

Patient and family teaching

- Explain to the family that the patient may challenge them and test their limits
- Inform the family that the patient may self mutilate or attempt to injure self or others, requiring safety precautions and professional interventions
- Teach the family to recognize manipulative and splitting behaviors and how to set limits on negative behaviors in a simple, direct way
- Instruct the patient/family to verbalize their anger rather than use aggressive or passive-aggressive behaviors
- Advise the family to reinforce the patient's realistic self-perceptions and realistic appraisal of others
- Inform the patient/family that the patient needs opportunities to practice simple decision-making skills
- Teach the patient/family to identify stressors and how to recognize, manage and prevent symptoms
- Teach the patient/family about the importance of medication compliance.

SEXUAL DISORDERS

In ICD10 gender identity disorders, disorders of sexual preference and sexual development and orientation disorders are listed under Disorders of Adult Personality and Behavior (F6), while sexual dysfunctions are listed under Behavioral Syndromes associated with Physiological Disturbances and Physical Factors (F5).

Classification

- Gender identity disorders
- Psychological and behavioral disorders associated with sexual development and maturation
- Disorders of sexual preference (paraphilic)
- Sexual dysfunctions.

Gender Identity Disorders (F6)

In these disorders, the sense of one's masculinity or femininity is disturbed. They include:

- **Transsexualism:** In this, there is a persistent and significant sense of discomfort regarding one's anatomic sex and a feeling that it is inappropriate to one's perceived gender. The person will be preoccupied with the wish to get rid of one's genitals and secondary sex characteristics and to adopt the sex characteristics of the other sex.
Treatment
 - Counseling to help the individual reconcile with the anatomic sex.
 - Sex change to the desired gender [sex reassignment surgery (SRS)] in selected cases.
- **Gender identity disorder of childhood:** This is a disorder similar to transsexualism, with a very early age of onset.
- **Dual-role transvestism:** It is characterized by wearing clothes of the opposite sex in order to enjoy the temporary experience of membership of the opposite sex but without any desire for permanent sex change.
- **Intersexuality:** The patients have gross anatomical or physiological features of the other sex. For example, pseudohermaphroditism, Turner's syndrome, congenital adrenal hypoplasia.

Psychological and Behavioral Disorders Associated with Sexual Development and Maturation (F6)

Homosexuality: In this, sexual relationships are maintained between persons of the same sex. Female homosexuals are called as 'lesbians' and male homosexuals are called 'gay.'

Treatment

- Behavior therapy: Aversion therapy, covert sensitization, systematic desensitization

- Supportive psychotherapy
- Psychoanalytic psychotherapy.

Disorders of Sexual Preference (ICD10–F6) or Paraphilias (DSMV)

In paraphilias, sexual arousal occurs persistently and significantly in response to objects, which are not a part of normal sexual arousal. These disorders include:

- **Fetishism:** Sexual arousal occurs with a non-living object which is usually intimately associated with the human body. The fetish object may include bras, underpants, shoes, gloves, etc.
- **Transvestism:** Sexual arousal occurs by wearing clothes of the opposite sex.
- **Sexual sadism:** The person is sexually aroused by physical and psychological humiliation, suffering or injury of the sexual partner.
- **Sexual masochism:** Here the person is sexually aroused by physical or psychological humiliation or injury inflicted on self by others.
- **Exhibitionism:** In this, the person is sexually aroused by the exposure of one's genitalia to an unsuspecting stranger.
- **Voyeurism:** This is a persistent or recurrent tendency to observe unsuspecting persons naked (usually of the other sex) and engaged in sexual activity.
- **Frotteurism:** This is a persistent or recurrent involvement in the act of touching and rubbing against an unsuspecting, non-consenting person.
- **Pedophilia:** It is characterized by persistent or recurrent involvement of an adult in sexual activity with prepubertal children.
- **Zoophilia (Beastiality):** Involving in sexual activity with animals.
- **Other paraphilias:** Sexual arousal occurs with urine, feces, enemas, etc.

Treatment

- Behavior therapy: Aversion therapy

- Psychoanalysis
- Drug therapy: Antipsychotics have been used for severe aggression, associated with paraphilias.

Sexual Dysfunctions (F5)

Sexual dysfunction is a significant disturbance in the sexual response cycle, which is not due to an underlying organic cause.

The common dysfunctions are:

- **Frigidity:** Absence of desire for sexual activity.
- **Impotence:** This disorder is characterized by an inability to have or sustain penile erection till the completion of satisfactory sexual activity.
- **Premature ejaculation:** Ejaculation before the completion of satisfactory sexual activity for both partners.
- **Non-organic vaginismus:** An involuntary spasm of lower 1/3rd of vagina, interfering with coitus.
- **Non-organic dyspareunia:** Pain in the genital area of either male or female during coitus.

Treatment

- Psychoanalysis
- Hypnosis
- Group psychotherapy
- Behavior therapy.

Nursing Intervention for Patient with Sexual Disorder

- Assess patient's sexual history and previous level of satisfaction in sexual relationships; also assess patient's perception of the problem.
- Note cultural, social, ethnic, racial and religious factors that may contribute to conflicts regarding variant sexual practices.
- Assess for any medications which might be affecting libido.
- Provide information regarding sexuality and sexual functioning, correct any misconceptions if necessary. Teach patient that

sexuality is a normal human response and that it involves complex inter-relationships among one's self-concept, body image, family and cultural influences.

- Both the patient and his/her partner may need additional assistance if problems in sexual relationship are severe or remain unresolved.
- Refer for additional counseling or sex therapy if required.
- Assist therapist as necessary in plan of behavior modification to help decrease variant behavior.
- In all cases, an accepting and non-judgmental attitude on the part of the nurse is highly essential for successful resolution of these problems as these are highly sensitive issues and may be causing significant distress to the patient.

PSYCHOPHYSIOLOGICAL/ PSYCHOSOMATIC DISORDERS

The word 'psychosomatic' means mind and body. Psychosomatic disorders are those disorders in which the psychic elements are significant for initiating chemical, physiological or structural alterations, which in turn create the physical symptoms in the person.

The term 'psychosomatic' has now been replaced with 'psychophysiological'. Following three factors must be present simultaneously for a person to develop a psychosomatic disorder:

1. Biological predisposition
2. Personality vulnerability
3. Significant psychosocial stress in his/her susceptible personality area

Common Examples of Psychophysiological Disorders

Franz Alexander, the father of psychosomatic medicine, described seven classical psychosomatic illnesses.

Cardiovascular disorders

- Essential hypertension

- Coronary artery disease
- Post-cardiac surgery delirium
- Migraine
- Mitral valve prolapse syndrome

Endocrine disorders:

- Diabetes mellitus
- Hyperthyroidism
- Cushing's syndrome
- Pre-menopausal syndrome
- Amenorrhea
- Menorrhagia

Gastrointestinal disorders:

- Esophageal reflux
- Peptic ulcer
- Ulcerative colitis
- Crohn's disease

Immune disorders:

- Autoimmune disorders, for example, systemic lupus erythematosus
- Allergic disorders, like bronchial asthma and hay fever
- Viral infections

Musculoskeletal disorders:

- Rheumatoid arthritis

Respiratory disorders:

- Bronchial asthma
- Hay fever
- Rhinitis

Skin disorders:

- Psoriasis
- Pruritus
- Urticaria
- Acne vulgaris
- Warts.

Treatment

1. Relaxation techniques: This is one of the most important methods aimed at reducing anxiety or restlessness. They include:
 - Jacobson's progressive relaxation technique
 - Yoga
 - Auto hypnosis

- Meditation
 - Biofeedback
2. Behavior modification techniques
 3. Individual therapy
 4. Group therapy.

Nursing Management

Assessment

- Perform thorough physical assessment
- Monitor laboratory values, vital signs, intake and output and other assessments necessary to maintain an accurate ongoing appraisal
- Assess patient's level of anxiety
- Assess patient's level of knowledge regarding effects of psychological problems on the body.

Nursing Diagnoses

- Ineffective individual coping related to repressed anxiety and inadequate coping methods, evidenced by initiation or exacerbation of physical illness
- Knowledge deficit related to psychological factors affecting physical condition, evidenced by various physical problems.

Interventions

- Encourage patient to discuss current life situations that he perceives as stressful, and the feelings associated with each.
- Provide positive reinforcement for adaptive coping mechanisms identified or used. Suggest alternative coping strategies but allow patient to determine which can most appropriately be incorporated into his lifestyle.
- Help patient to identify a resource person within the community (friend or significant others) to use as a support system for the expression of feelings.
- Have patient keep a diary of appearance, duration, and intensity of physical symptoms. A separate record of situations that the patient finds especially stressful should be kept.

- Help patient identify needs that are being met through the sick role. Together, formulate more adaptive means for fulfilling these needs, practice by role-playing.
- Provide instruction in assertive techniques, especially the ability to recognize the differences among passive, assertive, and aggressive behaviors and the importance of respecting the rights of others while protecting one's own basic rights.
- Discuss adaptive methods of stress management, such as relaxation techniques, physical exercises, meditation and breathing exercises.

EATING DISORDERS

The two most important eating disorders are:

- Anorexia nervosa, and
- Bulimia nervosa

Anorexia Nervosa

Anorexia nervosa is characterized by highly specific behavioral and psychopathological symptoms and significant somatic signs. Majority are females and the onset is during adolescence. The core psychopathological feature is the dread of fatness, weight phobia and a drive for thinness.

Etiology

- *Genetic causes:* Among female siblings of patients with established anorexia nervosa, 6–10% suffer from the condition compared to the 1–2% found in the general population of the same age (Strober, 1995).
- *A disturbance in hypothalamic function.*
- *Social factors:* There is a high prevalence of anorexia nervosa among female students and in occupational groups particularly concerned with weight (for example,

dancers). Influence of mass media, beauty contests are other important social causes.

- *Individual psychological factors:* A disturbance of body image, a struggle for control and a sense of identity are important factors in the causation of anorexia nervosa. Traits of low self-esteem and perfectionism are often found.
- *Causes within the family:* Disturbance in family relationships, over-protection, family members having an unusual interest in food and physical appearance.

Clinical Features

- There is an intense fear of becoming obese. This fear does not decrease even if the person loses weight grossly and becomes very thin.
- The body weight is 15% below the standard weight.
- There is a body image disturbance. The patient is unable to perceive the body size accurately.
- The pursuit of thinness may take several forms. Patients generally eat little and set themselves daily calorie limits (often between 600 and 1000 calories). Some try to achieve weight loss by inducing vomiting, excessive exercise, and misusing laxatives.
- Other signs and symptoms are secondary to starvation and include sensitivity to cold, delayed gastric emptying, constipation, low blood pressure, bradycardia, hypothermia and amenorrhea in females.
- Vomiting and abuse of laxatives may lead to a variety of electrolyte disturbances, the most serious being hypokalemia.
- Hormonal abnormalities also may be seen.
- Psychological findings—preoccupation with body size, distorted body image, description of herself as fat.

Complications

- Resulting from the malnutrition, dehydration and electrolyte imbalances caused

by prolonged starvation, vomiting and laxative abuse

- Increased susceptibility to infection
- Hypoalbuminemia
- Chronic inflammatory bowel disease (due to laxative abuse)
- Esophageal erosion, ulcers, tears, bleeding, gum erosion, dental caries (due to frequent vomiting)
- Amenorrhea
- Life-threatening cardiovascular complications.

Course and Prognosis

Anorexia nervosa often runs a fluctuating course with periods of exacerbations and partial remissions. Outcome is very variable.

Diagnosis

- Complete physical examination including laboratory tests to rule out endocrine, metabolic and central nervous system abnormalities; cancer; malabsorption syndrome and other disorders that cause physical wasting
- Complete blood testing—hemoglobin levels, platelet count, cholesterol level, total protein, sodium, potassium, chloride, calcium and fasting blood glucose and serum amylase levels and blood urea nitrogen
- ECG readings irregular
- Differential diagnosis to rule out other psychiatric disorders like substance abuse, anxiety disorder, body dysmorphic disorder, mood disorders, schizophrenia
- Based on ICD10 criteria

Treatment Modalities

Pharmacotherapy

- Neuroleptics
- Appetite stimulants
- Antidepressants

Psychological therapies

- Individual psychotherapy
- Behavioral therapy

- Cognitive behavior therapy
- Family therapy

Nursing Interventions

- Maintain a strict intake and output chart
- Monitor status of skin and oral mucous membranes
- Encourage the patient to verbalize feelings of fear and anxiety related to achievement, family relationships and intense need for independence
- Encourage family to participate in education regarding connection between family process and the patient's disorder
- Avoid discussions that focus on food and weight
- Short-term management is focused on ensuring weight gain and correcting nutritional deficiencies. Maintaining normal weight and preventing relapses are long-term goals to be achieved
- Hospitalization is usually required and successful treatment depends on good nursing care, with clear aims and understanding on the part of the patient as well as the nurse
- Eating must be supervised by the nurse and a balanced diet of at least 3000 calories should be provided in 24 hours
- In the early stages of treatment, it is best for the patient to remain in bed in a single room while the nurse maintains close observation. The goal should be to achieve a weight gain of 0.5 to 1 kg per week
- Weight should be checked regularly. Monitor serum electrolyte levels and signs and symptoms like amenorrhea, constipation, hypoglycemia, hypotension, etc.
- Control vomiting by making the bathroom inaccessible for at least 2 hours after food
- In extreme cases, when the patient refuses to eat and comply with the treatment, gavage feedings may need to be instituted.

Bulimia Nervosa

Bulimia nervosa is characterized by episodes of binge-eating followed by feelings of guilt,

humiliation, depression, and self-condemnation.

- Includes frequent binging (consuming abnormally large portions of food within a specific time period); in severe cases, can have several binge episodes in one day
- Involves recurrent use of compensatory measures to prevent weight gain (such as self-induced vomiting, diuretic or laxative use, dieting, fasting, or a combination of these measures).

Etiology

- More common in first-degree, biological relatives of people with bulimia
- Specific area of chromosome 10p linked to families with history of bulimia
- Possible role of altered serotonin levels in brain
- Society's emphasis on appearance and thinness
- Family disturbances or conflict
- Sexual abuse
- Learned maladaptive behavior
- Struggle for control or self-identity

Clinical Features

- Persistent sore throat, heartburn
- Callused or scarring on back of hands and knuckles
- Tooth staining or discoloration, loss of dental enamel, and increased dental caries
- History of eating amount of food larger than what most people would eat
- During binge-eating episodes, sense of lack of control
- Thin, normal, or slightly overweight appearance, with history of frequent weight fluctuations
- Abdominal and epigastric pain
- Amenorrhea
- Fluid and electrolyte imbalances
- Perfectionism
- Distorted body image
- Exaggerated sense of guilt

- Feelings of alienation
- Poor impulse control
- Low tolerance for frustration
- Peculiar eating habits or rituals
- Excessive exercise regimen
- Withdrawal from friends and usual activities
- Frequent weighing.

Complications

- Gastric rupture during periods of binge-eating
- Dental caries, erosion of tooth enamel, parotitis, and gum infections
- Dehydration or electrolyte imbalances
- Chronic, irregular bowel movements and constipation from laxative use
- Increased risk of suicide and psychoactive substance abuse.

Diagnosis

- Medical evaluation to rule out upper gastrointestinal disorder
- Psychological evaluation and Beck Depression Inventory
- History
- Laboratory tests (serum electrolytes, blood glucose, baseline ECG)
- Confirmed, if ICD10 criteria met.

Treatment Modalities

- Psychotherapy
- TCAs or SSRIs
- Self-help groups
- Hospitalization

Nursing Interventions

- Engage patient in therapeutic alliance to obtain commitment to treatment
- Establish contract with patient that specifies amount and type of food she must eat at each meal
- Set a time limit for each meal

- Identify patient's elimination patterns
- Teach patient to keep journal to monitor high-risk situations that cue binging and purging behaviors
- Encourage patient to recognize and verbalize her feelings about her eating behavior
- Explain risks of laxative, emetic, and diuretic abuse
- Provide assertiveness training
- Assess and monitor patient's suicide potential.

SLEEP DISORDERS

Sleep can be regarded as a physiological reversible reduction of conscious awareness.

Sleep disorders are divided into subtypes:

1. Dyssomnias
 - Insomnia
 - Hypersomnia
 - Disorders of sleep-wake schedule.
2. Parasomnias
 - Stage IV disorders
 - Other disorders.

Insomnia

Insomnia refers to disorder of initiation and maintenance of sleep. This includes frequent awakening during the night and early morning awakening.

Causes

Medical illnesses

- Any painful or uncomfortable illness
- Heart disease
- Respiratory diseases
- Brain stem or hypothalamic lesions
- Delirium
- Rheumatic and other musculoskeletal diseases
- Periodic movements in sleep
- Old age

Alcohol and drug use

- Delirium tremens
- Amphetamines or other stimulants
- Chronic alcoholism.

Psychiatric disorders

- Mania (due to decreased need for sleep)
- Major depression (early morning awakening or *late insomnia*)
- Dysthymia or neurotic depression (difficulty in initiating sleep or *early insomnia*)
- Schizophrenia and other psychoses (due to psychotic symptoms)
- Anxiety disorder (difficulty in initiating sleep due to worrying thoughts).

Social causes

- Financial loss
- Separation or divorce
- Death of spouse or a close relative
- Retirement
- Stressful life situations.

Behavioral causes

- Naps during the day
- Irregular sleeping hours
- Lack of physical exercise
- Excessive intake of beverages in the evening, for example, coffee
- Disturbing environment (heat, cold, noise).

Treatment

- A thorough medical and psychiatric assessment; polysomnography may be needed in some cases
- Treatment of underlying physical or psychiatric disorder
- Withdrawal of current medications, if any
- Transient insomnia can be treated initially with hypnotics.

Non-drug treatment for insomnia

- Progressive relaxation
- Autosuggestion
- Meditation, yoga
- Stimulus control therapy: Do not use the bed for reading or chatting—go to bed for sleep only.

Sleep hygiene

- Regular, daily physical exercises in the evening
- Avoid fluid intake and heavy meals just before bedtime
- Avoid caffeine intake (for example, tea, coffee, cola drinks) before sleeping hours
- Avoid reading or watching television while in bed
- Back rubs, warm milk and relaxation exercises
- Sleep in a comfortable environment.

Hypersomnia

Hypersomnia is known as Disorder of Excessive Somnolence (DOES). It includes excessive daytime sleepiness, sleep attacks during daytime, sleep drunkenness (person needs much more time to awaken, and during this period he is confused or disoriented).

Causes

1. **Narcolepsy:** Excessive daytime sleepiness characterized by:
 - Sleep attacks
 - Cataplexy—Sudden decrease or loss of (sleep paralysis) muscle tone, often generalized and may lead on to sleep
 - Sleep paralysis—It occurs either at awakening in morning or at sleep onset. The person is conscious but unable to move his body
 - Hypnagogic hallucinations
2. **Sleep apnea:** Repeated episodes of apnea during sleep.
3. **Kleine-Levin syndrome:** Periodic episodes of hypersomnia.

Disorder of Sleep-wake Schedule

The person with this disorder is not able to sleep when he wishes to, although at other time he is able to sleep adequately.

Causes

- Work shifts
- Unusual sleep phases.

3. Voyeurism

4. Sexual perversion

Stage IV Sleep Disorders

- Sleep walking (somnambulism)
- Night terrors
- Sleep-related enuresis
- Bruxism (tooth-grinding)
- Sleep talking (somniloquy).

Other Sleep Disorders

- Nocturnal angina
- Nocturnal asthma
- Nocturnal seizures
- Sleep paralysis.

REVIEW QUESTIONS**Long Essays**

1. What are the causes of antisocial personality? Explain nursing management for antisocial personality.
2. List various psychosomatic disorders and explain nursing interventions for psychosomatic disorders.
3. What is anorexia nervosa? Explain clinical features and nursing interventions.

Short Essays

1. Classification of personality disorders
2. Antisocial personality disorder
3. Psychopathic personality
4. Etiology of personality disorders
5. Sexual disorders
6. Bulimia nervosa
7. Causes of insomnia

Short Answers

1. Classification of sexual disorders
2. Transsexualism

MULTIPLE CHOICE QUESTIONS

- 1. Following are all core features of personality disorder, except:**
 - a. Interpersonal difficulties
 - b. Distorted thinking
 - c. Problematic emotional response
 - d. Occupational impairment
- 2. In which of the following personality disorders mistrust and suspiciousness are the main clinical features?**
 - a. Paranoid personality disorder
 - b. Antisocial personality disorder
 - c. Anxious personality disorder
 - d. Histrionic personality disorder
- 3. Ideas of reference, odd eccentric behavior and magical thinking are the main features in which of the following personality disorders?**
 - a. Paranoid personality disorder
 - b. Antisocial personality disorder
 - c. Schizotypal personality disorder
 - d. Histrionic personality disorder
- 4. Which of the following is the most prominent characteristic of borderline personality disorder?**
 - a. Suspiciousness
 - b. Magical thinking
 - c. Instability in personal relationships
 - d. Unlawful behavior
- 5. When assessing a patient with histrionic personality disorder, the nurse might identify which of the following characteristic behaviors?**
 - a. Odd eccentric and magical thinking
 - b. Excessive emotionality and attention seeking behavior
 - c. Self-centered and self-absorbed
 - d. Preoccupation with orderliness and rigidity

- 6. Which of the following is a characteristic of antisocial personality disorder?**
- Argumentative
 - Loss of cognitive function
 - Violates social norms
 - Not capable of carrying on regular activities
- 7. Anankastic personality is also known as:**
- Obsessional personality
 - Histrionic personality
 - Narcissistic personality
 - Borderline personality
- 8. The following features are characteristic of an antisocial (dissocial) personality, except:**
- Pleasure seeking
 - Inability to work under supervision
 - Deep emotional relationship
 - Drug abuse and alcohol dependence
- 9. Sexual arousal with the help of a non-living object is called:**
- Fetishism
 - Transvestism
 - Exhibitionism
 - Frotteurism
- 10. Sexual arousal by wearing clothes of opposite sex is called:**
- Fetishism
 - Transvestism
 - Exhibitionism
 - Frotteurism
- 11. Persistant or recurrent tendency to observe unsuspecting persons, naked and engaged in sexual activity is termed as:**
- Exhibitionism
 - Sadism
 - Voyeurism
 - Frotteurism
- 12. Bestiality is also termed as:**
- Pedophilia
 - Zoophilia
- 13. Sexual gratification by rubbing against an unsuspecting, non-consenting person is termed as:**
- Frotteurism
 - Fetishism
 - Exhibitionism
 - Voyeurism
- 14. A condition in which the person seeks sexual excitement by giving pain to the partner is termed as:**
- Masochism
 - Fetishism
 - Sadism
 - Transvestism
- 15. In which of the following disorders psychic elements are significant for initiating chemical, physiological or structural changes which in turn create physical symptoms?**
- Somatoform disorders
 - Conversion disorders
 - Dissociative disorders
 - Psychophysiological disorders
- 16. Following are all core features of anorexia nervosa disorder, except:**
- Fear of becoming obese
 - Body image disturbance
 - Excess body weight
 - Drive for thinness
- 17. Following are all core features of bulimia nervosa, except:**
- Binge eating
 - Use of diuretics or laxatives
 - Dieting or fasting
 - Fear of thinness
- 18. Which of the following investigations is specifically related to sleep disorders?**
- CT Scan
 - Galvanic Skin Response (GSR)

- c. Dexamethasone Suppression Test (DST)
- d. Polysomnography

19. Klien-Levin syndrome is characterized by:

- a. Hypersomnia
- b. Hyperphagia
- c. Hypersexuality
- d. Hyperesthesia

20. Sleep walking is also known as:

- a. Somniloquy
- b. Enuresis
- c. Somnambulism
- d. Seizures

21. Narcolepsy means:

- a. Excessive daytime sleepiness
- b. Sleep-related enuresis
- c. Sleep apnea
- d. Sleep drunkenness

22. Which of the following finding requires hospitalization of an anorexia patient?

- a. Pulse rate of 90–100 per minute
- b. Hyperthermia
- c. Blood pressure of 84/50 mm Hg
- d. Amenorrhea.

KEY

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- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. d | 2. a | 3. c | 4. c | 5. b | 6. c | 7. a | 8. c | 9. a | 10. b |
| 11. c | 12. b | 13. a | 14. c | 15. d | 16. c | 17. d | 18. d | 19. a | 20. c |
| 21. a | 22. c | | | | | | | | |

Chapter 11

Nursing Management of Childhood and Adolescent Disorders Including Mental Deficiency

Child psychiatry is concerned with the assessment and treatment of children's emotional and behavioral problems. Psychological disturbance in childhood causes abnormality in emotions or behavior or relationships. Several factors rather than one contribute to the development of disturbance. Child psychotherapy begins with Sigmund Freud's case of Little Hans, a 5-year-old phobic boy. In 1935, Leo Kanner published the first text book on Child Psychiatry in English. The major contributors to child psychiatry are Donald Winnicott, Anna Freud and Melanie Klein.

In 1954, the first graduate program in child psychiatric nursing was introduced. Advocates for Child Psychiatric Nursing, a professional organization for this nursing specialty was established in 1971, and the first American Nurses Association (ANA) certification of child psychiatry nurses took place in 1979. The ANA's standards of child and adolescent psychiatric and mental health nursing practice were published in 1985.

The child psychiatric nurse uses a wide range of treatment modalities, including milieu therapy, behavior modification, cognitive behavior therapy, therapeutic play, group and family therapy and pharmacological agents.

Child psychiatric nursing is different from adult psychiatric nursing in the following ways:

- It is seldom that children initiate a consultation with the clinician. Instead, they are brought by adults, usually the parents,

who think that some aspect of behavior or development is abnormal

- The child's stage of development determines whether behavior is normal or abnormal. For instance, bedwetting is normal at the age of 3 years but abnormal when the child is 7. Thus, greater attention should be paid to the stage of development of the child and duration of the disorder
- Children are generally less able to express themselves in words; therefore, evidence of disturbance is based more on observations of behavior made by parents, teachers and others
- The treatment of children makes less use of medications or other methods of individual treatment. Main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with family and coordinating the efforts of others who can help children, especially at school.

Classification (ICD10)

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 disorders with onset usually occurring in childhood and 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 and adolescence
- F95 : Tic disorders
- F98 : Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

MENTAL RETARDATION (F7) (MENTALLY CHALLENGED INDIVIDUALS)

Definition

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

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

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 and

could be extended to 75 or more, depending on the reliability of the intelligence test used.

Adaptive behavior is defined as the degrees with which the individual meets the standards of personal independence and social responsibility expected of his age and 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 and childhood

- Sensory and motor skill development
- Communication skill (including speech and language)
- Self-help skills
- Socialization.

During childhood and adolescence

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

During late adolescence

- Vocational and social responsibilities and performance

Developmental period is defined as the period of time between conception and 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 March 2001*). Mental retardation is more common in boys than girls. With severe and profound mental retardation, mortality is high due to associated physical diseases.

Etiology

Genetic factors:

Chromosomal abnormalities

- Down's syndrome

- 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 diseases of brain

- Tuberous sclerosis
- Neurofibromatosis
- Epilepsy

Prenatal factors:

Infections

- Rubella
- Cytomegalovirus
- Syphilis
- Toxoplasmosis, herpes simplex

Endocrine disorders

- Hypothyroidism
- Hypoparathyroidism
- Diabetes mellitus

Physical damage and disorders

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

Intoxication

- Lead
- Certain drugs
- Substance abuse

Placental dysfunction

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

Perinatal factors:

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

Postnatal factors:

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

Environmental and sociocultural factors

- Cultural deprivation
- Low socioeconomic status
- Inadequate caretakers
- Child abuse.

Classification

Intelligence quotient (IQ) is the ratio between mental age (MA) and chronological age (CA). While the chronological age is determined from the date of birth, mental age is determined by intelligence tests (Table 11.1).

Behavioral Manifestations

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.

Table 11.1: Classification of mental retardation based on intelligence quotient

Type	Intelligence quotient (IQ)
Mild (Educable)	50–70
Moderate (Trainable)	35–50
Severe (Dependent retarded)	20–35
Profound (Life support)	< 20

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 and absent or markedly delayed speech and 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 and supervision. Associated physical disorders are common (Table 11.2).

Table 11.2: Behavioral manifestations of mentally retarded children

Type of retardation/ behavioral manifestations	Mild retardation	Moderate retardation	Severe retardation	Profound retardation
Self-care ability	The child may be able to live somewhat independently with monitoring or assistance with life changes, challenges, or stressors (such as personal illness or the death of a loved one)	The child requires close supervision and must be supervised when performing certain independent activities	The child requires complete supervision but may be able to perform simple hygiene skills, such as brushing teeth and washing hands	The child requires constant assistance and supervision
Education level	The child can achieve reading skills up to the level of primary school and master vocational training	The child can achieve skills up to second class and may be trained in skills to participate in a workshop setting	May learn a few simple skills	The child cannot benefit from academic training
Social skills	The child can learn and use social skills in structured settings	The child has certain speech limitations and difficulty following expected social norms	The child has limited verbal skills and tends to communicate needs non-verbally or by acting them out	The child has little speech development and lacks social skills
Psychomotor skills	The child can develop average to good skills but may experience minor coordination problems	The child may have difficulty with gross motor skills and may have limited vocational opportunities	The child has poor psychomotor skills, with limited ability to perform simple tasks even under direct supervision	The child lacks both fine and gross motor skills
Economic situation	The child can perform a job under close supervision and manage money with proper guidance	The child may learn to handle a small amount of pocket money as well as how to make change	The child may be taught how to use money and supervised while shopping	The child must depend on others for money management

Signs and Symptoms

- Failure to achieve developmental milestones
- Deficiencies in cognitive functioning such as inability to follow commands or directions
- Reduced ability to learn or to meet academic demands
- Expressive or receptive language problems
- Psychomotor skill deficits
- Difficulty performing self-care activities
- Neurologic impairments
- Medical problems, such as seizures
- Low self-esteem, depression and labile moods
- Irritability when frustrated or upset
- Acting-out behavior
- Lack of curiosity.

Diagnosis

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

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

$$\frac{\text{Mental Age (MA)}}{\text{Chronological Age (CA)}} \times 100$$

Prognosis

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

Treatment Modalities

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

Prevention

Primary Prevention

Preconception

- Genetic counseling, which is an attempt to determine risks of occurrence or recurrence of specific genetic or chromosomal disorders; parents can then make an informed decision as to the risks of having a retarded child

- Immunization for maternal rubella
- Blood tests for marriage licenses can identify the presence of venereal diseases
- Adequate maternal nutrition can lay a sound metabolic foundation for later childbearing
- Family planning in terms of size, appropriate spacing, and age of parents can also affect a variety of specific causal agents.

During gestation

Two general approaches to prevention are associated with this period:

- Prenatal care
 - Adequate nutrition, fetal monitoring and protection from disease
 - Avoidance of teratogenic substances like exposure to radiation and consumption of alcohol and drugs
- Analysis of fetus for possible genetic disorders
 - By amniocentesis, fetoscopy, fetal biopsy and ultrasound.

At delivery

- Delivery conducted by expert doctors and staff, especially in cases of high-risk pregnancy (for example, maternal conditions of diabetes, hypertension, etc.)
- Apgar scoring done at 1 and 5 minutes after the birth of the child
- Close monitoring of mother and child
- Injection of gamma globulin, which can prevent Rh-negative mothers from developing antibodies that might otherwise affect subsequent children.

Childhood

- Proper nutrition throughout the developmental period and particularly during the first 6 months after birth
- Dietary restrictions for specific metabolic disorders until no longer needed
- Avoidance of hazards in the child's environment to avert brain injury from causes such as lead poisoning, ingestion of chemicals, or accidents.

Secondary Prevention

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

Tertiary Prevention

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

Legal aspects concerning persons with mental disabilities

- Mentally retarded are treated as persons with disabilities under Section 2 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Participation) Act, 1995 (PWD Act)
- The statutory provisions for the welfare of mentally retarded persons are: (i) PWD Act, 1995 and; (ii) National Trust Act, 1999
- Indian Railways and some State Governments have schemes for travel facility for persons with disability
- The Income-Tax Act allows deduction in respect of maintenance including medical treatment of a dependent who is a person with disability which includes mental retardation and mental illness under Section 80DD.

Care and Rehabilitation of the Mentally Retarded

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

- Early detection and early stimulation of mental handicaps

- Regular assessment of the mentally retarded person's attainments and disabilities
- Advice, support, and practical measures for families
- Provision for education, training, occupation, or work appropriate for each handicapped person
- Housing and social support to enable self-care
- Medical, nursing, and other services for those who require them as outpatients, day patients, or inpatients
- Psychiatric and psychological services.

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

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

The severely retarded: In case of children, some require special services throughout their lives, which may include a sitting service, day respite during school holidays, or overnight stays in a foster family or residential care. In case of adults, provisions are required for work, occupation, housing, adult education, etc. The main principle now guiding the provision of resources is that the retarded person should be given sufficient help to be able to use the usual community services, rather than to provide specialist segregated services.

Education and training: The aim is to educate as many mentally retarded children as possible in ordinary schools either in normal classes or in special classes. There is now an

increasing use of more specialist teaching and a variety of innovative procedures for teaching language and other methods of communication. Before leaving school, these children require reassessment and vocational guidance.

Hints for Successful Skill Training

- Divide each training activity into small steps and demonstrate.
- Give the mentally retarded person repeated training in each activity.
- Give the training regularly and systematically. Do not let parents get impatient.
- Start the training with what the child already knows and then proceed to the skill that needs to be trained. By this the child will have a feeling of success and achievement.
- Reward his effort even if the child attains near success, by appreciation or with something that he likes.
- Reduce the reward gradually as he masters a skill and takes up another skill for training.
- Use the training materials which are appropriate, attractive and locally available.
- Remember, children learn better from children of the same age. Therefore, try and involve normal children of the same age in training the mentally retarded child, after orienting the normal child appropriately.
- Remember, there is no age limit for training a mentally retarded person.
- Assess the child periodically, preferably once in 4 or 6 months.
- Remember, a mentally retarded child learns very slowly. Tell the parents not to be dejected at the slow progress, nor feel threatened by the child's failure.

Vocational training: The activities included in vocational training are work preparation, selective placement, post placement and follow up. For example, MITRA Special School and Vocational Training Center for the Mentally Retarded, Bengaluru, Karnataka.

Help for families: Help for families is needed from the time that the diagnosis is

first made; adequate time must be allowed to explain the prognosis; indicate what help can be provided, and discuss the part that the parents can play in helping their child to achieve full potential.

When the child starts school, the parents should not only be kept informed about his progress, but should feel involved in the planning and provision of care.

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

Stages in parent counseling

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

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

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

Parents are taught behavior modification techniques to decrease or eliminate problematic behavior, increase adaptive behavior and develop new skills. Some of these techniques include positive reinforcement, shaping, prompting, modeling, extinction procedures, etc. (Refer Chapter 5, Page 151 for a detailed description on above technique).

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

Frequently asked questions

1. Is mental retardation same as mental illness?

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

2. Is mental retardation curable?

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

3. Can marriage solve the problems of mental retardation?

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

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

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

5. Is mental retardation an infectious disease?

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

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

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

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

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

Residential care: Parents should be supported in caring for their retarded children at home, or if they are too heavy a burden for their parents, the child should be cared for in day care centers, halfway homes, etc.

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

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

Nursing Management

Assessment

- Assessment of early infant behavior for cognitive disability among high-risk children should be closely done (for example, children born to elderly primiparas, birth trauma, etc.); Early infant behaviors that may indicate a cognitive disability include non-responsiveness to contact, poor eye contact during feeding, slow feeding, diminished spontaneous activity, decreased responsiveness to surroundings, decreased alertness to voice or movement, and irritability
- Documentation of daily living skills
- A careful family assessment for information on:
 - The family's response to the child
 - Presence of other members with impaired cognition in the family
 - Degree of independence encouraged at home
 - Stability of the family unit
- Psychological assessment—This is directed at the interaction between the individual and people who are closely involved in

care, and determining the correct needs and wishes for the future. It should examine opportunities for learning new skills, making relationships, and achieving maximum choice about the way of life.

Intervention

- The long-term goals for these children are highly individualized and are dependent on the level of mental retardation. Parents should be involved in establishing realistic goals for their child. Some of these goals can be:
 - The child dresses himself
 - The child maintains continence of stool and urine
 - The child demonstrates acceptable social behavior
 - The adolescent participates in a structured work program.
- Early intervention programs are essential to maximize the children's potential development. This necessitates early recognition and referral. Nurses have an opportunity to evaluate children in the nursery, in the clinic during well-baby healthcare, in schools, and during acute management. The potential of each child will vary according to the degree of mental retardation. The key for success is that the child's strengths and potential abilities are emphasized rather than deficits
- The nurse can participate in programs that teach infant stimulation, activities of daily living and independent self-care skills. A successful technique in treatment of the mentally retarded is called operant conditioning. It focuses on changing or modifying the individual's response to the environment by reinforcing certain desirable patterns of behavior or eliminating undesirable patterns
- In addition, learning social skills and adaptive behavior assists the child in building a positive self-image. For older children and adolescents, assistance is needed to prepare them for a productive work life

- Sexuality becomes a major concern, as these children may form emotional attachment to those of the opposite sex and have normal sexual desires. However, their decision-making skills are limited. Teaching contraceptive methods are important to emphasize with both the child and family
- In all instances it is important for the nurse to maintain a non-threatening approach. Very often, these children do not understand why physical assessment, therapeutic approaches and evaluative measures are needed. Proper explanation and relevant information should be given to the parents and their help should be enlisted in bringing out the best out of the child. Close collaboration with all members of the team involved in the care of the child is highly essential for a successful outcome. To a large extent the nurse is responsible for the emotional climate of the setting in which she is employed.

(Also refer 'Care and rehabilitation of the mentally retarded' on page 283)

Prevention of exploitation and abuse of persons with mental disabilities

- Persons with mental disabilities are one of the vulnerable groups likely to be exploited.
- Female persons with mental disabilities are the most vulnerable of the group. Therefore, the legal services institutions shall come to the assistance of these people in preventing their exploitation including sexual abuse and also for taking legal action against the abusers and exploiters.

DISORDERS OF PSYCHOLOGICAL DEVELOPMENT (F8)

Specific Developmental Disorders of Speech and Language

These are disorders in which normal patterns of language acquisition are disturbed from the

early stages of development. The conditions are not directly attributable to neurological or speech mechanism abnormality or mental retardation.

It includes developmental language disorder or dysphasia, developmental articulation disorder or phonological disorder or dyslalia, expressive language disorder, receptive language disorder and other developmental disorders of speech and language.

Specific Developmental Disorders of Scholastic Skills

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

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

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

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

Specific Developmental Disorders of Motor Function

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

Pervasive Developmental Disorder

The term pervasive developmental disorder (PDD) refers to a group of disorders characterized by abnormalities in communication and social interaction and by restricted repetitive activities and interests. These abnormalities occur in a wide range of situations. Usually, development is abnormal from infancy and most cases are manifest before the age of 5 years.

PDD includes childhood autism, atypical autism, Rett's syndrome, Asperger's syndrome, childhood disintegrative disorder, and other pervasive developmental disorders.

Epidemiology

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

Childhood Autism

In 1908, Heller from Austria reported 6 cases of a disintegrative psychosis with onset in the 3rd or 4th year of life in children whose previous development was normal. Leo Kanner (1943) identified a relatively homogenous group of children with onset of psychosis in the 1st and 2nd year of life whom he designated early 'infantile autism' and 'autistic disturbance of affect contact.' Lauretta Bender first used the term 'childhood schizophrenia' to characterize psychotic children. Now all these terms have been replaced and the condition is currently known as Childhood Autism in ICD10, or Autism Spectrum Disorder (ASD) in DSMV.

Meaning

Autism is a complex neurobehavioral disorder that includes impairments in social interaction, verbal and non-verbal communication combined with restricted and repetitive behavior. Parents usually notice signs in the first two years of their child's life (Box 11.1).

Box 11.1: Characteristics of autistic disorder

- » Inappropriate responses to environment
- » Pronounced impairments in language, communication, and social interaction
- » Repetitive interests and behaviors
- » Disordered thinking
- » Difficulty understanding feelings of others and world around him
- » Repetitive, self-injurious, or other abnormal behaviors

Etiology

Genetic factors: The higher concordance in monozygotic than dizygotic twins (36% vs 0%) suggests a genetic factor. Siblings of autistic children show a prevalence of autistic disorder of 2% (50 times over expected prevalence).

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

Medical factors: There is an elevated incidence of early developmental problems such as postnatal neurological infections (meningitis, encephalitis), congenital rubella and cytomegalovirus, phenylketonuria and rarely perinatal asphyxia. The other inborn errors of metabolism associated with autism are tuberous sclerosis and neurofibromatosis. About 2–5% appear to have fragile X chromosome syndrome. Neurological abnormalities are present in about one-quarter of cases.

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

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

deviant parental personality characteristics, family break-up, family stress, insufficient stimulation and faulty communication patterns (Schreibman and Charlop, 1989).

Kanner (1973) in his studies, described the parents of autistic children as well educated upper class individuals, involved in career and intellectual pursuits, who were aloof, obsessive and emotionally cold. The term 'refrigerator parents' was coined to describe their lack of warmth and affectionate behavior.

Mahler and associates (1975) suggested that the autistic child is fixed in the presymbiotic phase of development. In this phase, the child creates a barrier between self and others. The normal symbiotic relationship between mother and child followed by the progression to separation/individualization does not occur. Ego development is inhibited and the child fails to achieve a sense of self.

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

Electrophysiological changes: Brain stem Auditory Evoked Responses (BAERs) of autistic children showed impairment in sensory modulation at brainstem level.

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

Clinical Picture

Behavioral characteristics

- Autistic aloofness (unresponsiveness to parent's affectionate behavior, by smiling or cuddling)
- Gaze avoidance or lack of eye-to-eye contact
- Dislikes being touched or kissed
- No separation anxiety on being left in an unfamiliar environment with strangers

- No or abnormal social play. Failure to play with peers and unable to make friends
- Failure to develop empathy
- Marked lack of awareness of the existence or feelings of others
- Anger or fear without apparent reason and absence of fear in the presence of danger.

Communication and language

- Gross deficits and deviances in language development
- No mode of communication such as babbling, facial expression, gestures, mime, etc.
- Absence of imaginative activity such as play acting of adult roles, fantasy characters of animals, lack of interest in imaginative stories
- Marked abnormality in the production of speech (volume, pitch, stress, rhythm, rate, etc.)
- Marked abnormalities in the form or content of speech including stereotyped or repetitive use of speech, use of "you" when "I" is meant, idiosyncratic use of phrases
- Marked impairment in the ability to initiate or sustain a conversation with others despite adequate speech.

Activities

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

Other features

- More than half of autistic children have moderate to profound mental retardation, whereas about 25% have mild mental retardation

- Autistic children are resistant to transition and change
- Over-responsive or under-responsive to sensory stimuli
- May have a heightened pain threshold or an altered response to pain
- Other behavioral problems like hyperkinesis, aggression, temper tantrums, self-injurious behavior, head banging, biting, scratching and hair pulling are common
- Idiot Savant Syndrome: Inspite of a pervasive or abnormal development of functions, certain functions may remain normal, for example, calculating ability, prodigious remote memory, musical abilities, etc.
- Absence of hallucinations, delusions, loosening of associations as in schizophrenia
- Kanner's "Autistic triad"—Kanner said autistic aloofness, speech and language disorder and obsessive desire for sameness constitute a triad characteristic of infantile autism
- Autism identifying methods by an autism specialist
 - Standardized rating scale to help evaluate the child's social behavior and language
 - Tests for certain genetic and neurologic problems may be ordered
 - Interviews with the parents to seek information about the child's behavior and early development
- Developmental screening to reveal behaviors suggestive of autism
 - Failure to babble, coo, or gesture (point, wave, or grasp) by age 12 months
 - Failure to say single words by age 16 months and to say two-word phrases on his own by age 24 months
 - Loss of language or social skills at any age
- After evaluation and testing, diagnoses is based on clear evidence of poor or limited social relationships; underdeveloped communication skills; and repetitive behaviors, activities, and interests.

Course and Prognosis

- Autistic disorder has a long course and guarded prognosis
- About 10–20% autistic children begin to improve between 4 and 6 years of age and eventually attend on ordinary school and obtain work
- 10–20% can live at home, but need to attend a special school or training center and cannot work
- About 60% improve little and are unable to lead an independent life, mostly needing long-term residential care
- Those who improve may continue to show language problem, emotional coldness and odd behavior.

Diagnosis

- No definitive diagnostic tool; usually diagnosed by age 3—after first ruling out other disorders that resemble autism (neurologic disorders, hearing loss, speech problems, and mental retardation)

- Autism identifying methods by an autism specialist
 - Standardized rating scale to help evaluate the child's social behavior and language
 - Tests for certain genetic and neurologic problems may be ordered
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 - Loss of language or social skills at any age
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Treatment

- *Pharmacotherapy* is a valuable treatment for associated symptoms like aggression, temper tantrums, self-injurious behavior, hyperactivity and stereotypic behavior. Some drugs that have been used are risperidone, serotonin specific reuptake inhibitors, clomipramine and lithium. Antiepileptic medication is used for generalized seizures.
- *Behavioral methods:* Contingency management may control some of the abnormal behavior of autistic children. The term contingency management refers to a group of procedures based on the principle that, if any behavior persists, certain of its consequences are reinforcing it. If these consequences can be altered, the behavior will change. The parents instructed and supervised by a clinical psychologist often carry out this method at home. Contingency management has the following stages:

- First the behavior to be changed is defined, and another person (usually a nurse, spouse or parent) is trained to record it; for example, a mother might count the number of times a child with learning difficulties shouts loudly
- Second, the events that immediately follow (and therefore are presumed to reinforce the behavior) are identified; for example, the parents may pay attention to the child when he shouts, but ignore him at other times
- Third, reinforcements are devised for alternative behaviors, for example, being approved or earning points by refraining from shouting for an agreed time. Staff or relatives are trained to provide the chosen reinforcements immediately after the desired behavior, and to withhold them at other times
- As treatment progresses, records are kept of the frequency of the problem behaviors and of the desired behaviors
- Although treatment is mainly concerned with the consequences of behavior, attention is also given to changing any events that might be provoking the behavior. For example, in a psychiatric ward, the abnormal behavior of one child may be provoked on each occasion by the actions of another child
- *Special schooling:* Most autistic children require special schooling and older adolescents many need vocational training.
- *Counseling and supportive therapy:* The family of an autistic child needs considerable help to cope with the child's behavior, which is often distressing.
- Home care to assist with the child's physical or behavioral management at home; if the child's disruptive behavior persists, alternative residential placement may be necessary.
- *Others:* Development of a regular routine, positive reinforcements to teach self-care skills, speech therapy or sign language teaching, behavior techniques to encourage interpersonal interactions.

Nursing Management

Assessment

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

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

Intervention

- Work with the child on a one-to-one basis.
- Protect the child when self-mutilative behavior occurs. Devices such as a helmet, padded mittens or arm covers may be used
- Try to determine if self-mutilative behavior occurs in response to increasing anxiety, and if so, to what the anxiety may be attributed. Intervene with diversion or replacement activities as anxiety level starts to rise. These activities may provide needed feelings of security and substitute for self-mutilative behavior
- Assign limited number of caregivers to the child. Ensure that warmth, acceptance and availability are conveyed
- Provide child with familiar objects such as familiar toys or a blanket. Support child's attempts to interact with others
- Give positive reinforcement for eye contact with something acceptable to the child (for example, food, familiar object). Gradually replace with social reinforcement (for example, touch, hugging)
- Anticipate and fulfill the child's needs until communication can be established
- Slowly encourage him to express his needs verbally. Seek clarification and validation
- Give positive reinforcement when eye contact is used to convey nonverbal expressions or when the child tries to speak

- Teach simple self-care skills by using behavior modification techniques
- Language training plays a big part in teaching autistic children. At first, they have to learn the names of things by linking the name with the actual object. When teaching the word 'table' they must see and feel a real table, and lots of different tables, otherwise they may think that table refers to only that particular object. Look at child's face and pronounce simple words. Ask the child to repeat the words. Show picture books and name the objects. Verbs like sitting, walking, running can be acted to show the child what these words mean.
- Autistic children have personal identity disturbance and need to be assisted to recognize separateness during self-care activities, such as dressing and feeding. The child should be helped to name own body parts. This can be facilitated with the use of mirrors, drawings and pictures of himself. Encourage appropriate touching of, and being touched by others
- The role of the parent is crucial for any intervention with the autistic child; the parent, generally, acts as a co-therapist and plays an integral role in treatment. The behavior of their autistic child is often very distressing and parental counseling begins with clarification of the diagnosis and an explanation of the characteristics of the disorder. To effectively participate in the treatment program, the parents must have acknowledged the extent of their child's handicap and be able to work with him at the appropriate developmental level.

Atypical Autism

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

Rett's Syndrome

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

Asperger's Syndrome

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

BEHAVIORAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE (F9)

Hyperkinetic Disorder

Hyperkinetic disorder (Attention-Deficit Hyperactivity Disorder or ADHD in DSMIV) is a persistent pattern of inattention and/or hyperactivity more frequent and severe than is typical of children at a similar level of development. The syndrome was first described by Heinrich Hoff in 1854.

Characteristics of ADHD

- Neurobiological disorder
- Marked by developmentally inappropriate inattention, impulsiveness and, in some cases, hyperactivity
- May progress to conduct disorder.

Epidemiology

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

Etiology

Biological influences

Genetic factors

- There is greater concordance in monozygotic than in dizygotic twins
- Siblings of hyperactive children have about twice the risk of having the disorder as does the general population
- Biological parents of children with the disorder have a higher incidence of ADHD than do adoptive parents.

Biochemical theory

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

Pre, peri and postnatal factors

- Prenatal toxic exposure, prenatal mechanical insult to the fetal nervous system
- Prematurity, fetal distress, precipitated or prolonged labor, perinatal asphyxia and low Apgar scores
- Postnatal infections, CNS abnormalities resulting from trauma, etc.

Environmental influences

- Environmental lead
- Food additives, coloring preservatives and sugar have also been suggested as possible causes of hyperactive behavior but there is no definite evidence.

Psychosocial factors

- Prolonged emotional deprivation
- Stressful psychic events
- Disruption of family equilibrium.

Risk Factors for ADHD

- Drug exposure in utero
- Birth complications
- Low birth weight
- Lead poisoning.

Clinical Features

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

- At times, the reverse occurs and the children are flaccid and limp, sleep more and the growth and development is slow in the first month of life
- More commonly active in crib, sleep little
- General coordination deficit
- Short attention span, easily distractable
- Failure to finish tasks
- Impulsivity
- Memory and thinking deficits
- Specific learning disabilities.

In school

- Often fidgets with hands or feet or squirms in seat
- Answers only the first two questions; often blurts out answers to questions before they have been completed
- Unable to wait to be called on in school and may respond before everyone else
- Has difficulty awaiting turn in games or group situations
- Often loses things necessary for tasks or activities at school.

Home

- Explosive or irritable
- Emotionally labile and easily set off to laughter or tears
- Mood is unpredictable
- Impulsiveness and an inability to delay gratification
- Often talks excessively
- Often engages in physically dangerous activities without considering possible consequences (for example, runs into street without looking).

Types

ADHD: Predominantly hyperactive-impulsive type

ADHD: Predominantly inattentive type

ADHD: Combined type.

Diagnosis

- Complete medical evaluation, with emphasis on a neurologic examination, hearing, and vision

- A psychiatric evaluation to assess intellectual ability, academic achievement, and potential learning disorder problem
- Detailed prenatal history and early developmental history
- Direct observation, teacher's school report (often the most reliable), parent's report.

Treatment

Pharmacotherapy

- CNS stimulants: Dextroamphetamine, methylphenidate, pemoline
- Tricyclic antidepressants
- Antipsychotics
- Serotonin specific reuptake inhibitors
- Clonidine.

Psychological therapies

- Behavior modification techniques
- Cognitive behavior therapy
- Social skills training
- Family education.

Nursing Intervention

- Develop a trusting relationship with the child. Convey acceptance of the child, separate from the unacceptable behavior
- Ensure that patient has a safe environment. Remove objects from immediate area in which patient could injure self due to random hyperactive movements. Identify deliberate behaviors that put the child at risk for injury. Institute consequences for repetition of this behavior. Provide supervision for potentially dangerous situations
- Since there is non-compliance with task expectations, provide an environment that is as free of distractions as possible
- Ensure the child's attention by calling his name and establishing eye contact, before giving instructions
- Ask the patient to repeat instructions before beginning a task
- Establish goals that allow patient to complete a part of the task, rewarding each

- step completion with a break for physical activity
- Provide assistance on a one-to-one basis, beginning with simple concrete instructions
- Gradually decrease the amount of assistance given to task performance, while assuring the patient that assistance is still available if deemed necessary
- Offer recognition for successful attempts and positive reinforcement for attempts made. Give immediate positive feedback for acceptable behavior
- Provide quiet environment, self-contained classrooms, and small group activities. Avoid over stimulating places such as cinema halls, bus stops and other crowded places
- Help him learn how to take his turn, wait in line and follow rules
- Assess parenting skill level, considering intellectual, emotional and physical strengths and limitations. Be sensitive to their needs as there is often exhaustion of parental resources due to prolonged coping with a disruptive child
- Provide information and materials related to the child's disorder and effective parenting techniques. Give instructional materials in written and verbal form with step-by-step explanations
- Explain and demonstrate positive parenting techniques to parents or caregivers, such as time-in for good behavior, or being vigilant in identifying the child's behavior and responding positively to that behavior
- Educate child and family on the use of psychostimulants and anticipated behavioral response
- Coordinate overall treatment plan with schools, collateral personnel, the child and the family.

Conduct Disorders

Conduct disorders are characterized by a persistent and significant pattern of conduct in which the basic rights of others are violated or

Box 11.2: Characteristics of conduct disorders

- » Aggressive behavior is the hallmark
 - Fights, bullies, intimidates, and assaults others physically or sexually
 - Has poor relationships with peers and adults
 - Violates others' rights and society's rules
- » A child with conduct disorder rarely performs at the level predicted by IQ or age, causing academic, social and developmental problems
 - May perform poorly at school or work
 - May be expelled from school and have problems with law
- » A child with conduct disorder is also at risk for sexually transmitted diseases, rape, teenage pregnancy, injuries, substance abuse, depression, suicidal thoughts, suicide attempts and suicide

rules of society are not followed. The diagnosis is only made when the conduct is far in excess of the routine mischief of children and adolescents. The onset occurs much before 18 years of age, usually even before puberty. The disorder is much more (about 5 to 10 times) common in boys (Box 11.2).

Etiology

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

Biochemical factors: Various studies have reported a possible correlation between elevated plasma levels of testosterone and aggressive behaviors.

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

Psychosocial factors

- Parental rejection
- Inconsistent management with harsh discipline
- Frequent shifting of parental figures
- Large family size
- Absent father
- Parents with antisocial personality disorder or alcohol dependence
- Parental permissiveness
- Marital conflict and divorce in parents
- Associations with delinquent subgroups
- Inadequate/inappropriate communication patterns in the family.

Clinical Features

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

Diagnosis

- Complete team approach (including medical and psychiatric evaluations, feedback from parents, a school consultant's recommendations, a case manager's plan, and a probation officer's report) is important because antisocial behaviors tend to be underreported
- Educational assessments to determine if there are cognitive deficits, learning disabilities, or problems in intellectual functioning

- A neurologic examination if there's a history of head trauma or seizures

Treatment Modalities

- The treatment is difficult. The most common mode of management is placement in a corrective institution. Behavioral, educational and psychotherapeutic measures are employed for changing the behavior.
- Drug treatment may be indicated in the presence of epilepsy (anticonvulsants), hyperactivity (stimulant medication), impulse control disorder and episodic aggressive behavior (lithium, carbamazepine) and psychotic symptoms (antipsychotics).
- Parental instruction to teach how to deal with the child's demands.
 - May need to learn to reinforce appropriate behaviors and use harsh punishment for inappropriate behaviors
 - Should be encouraged to find ways to bond more strongly with child
- Juvenile justice system, if needed, to provide structured rules and a means for monitoring and controlling the child's behavior.

Nursing Intervention

- The nurse should bear in mind that there is always the risk of violence in these children. She should, therefore, observe the child's behavior frequently during routine activities and interactions. She should be aware of behavior that indicates a rise in agitation.
- Redirect violent behavior with physical outlets for suppression of anger and frustration.
- Ensure that a sufficient number of staff is available to indicate a show of strength if necessary. Administer tranquilizing medication as prescribed. Use of mechanical restraints or isolation should be used only if the situation cannot be controlled by less restrictive means.

- Explain to the patient the correlation between feelings of inadequacy and the need for acceptance from others, and how these feelings provoke aggression or defensive behavior such as blaming others for own faulty behavior. Practice more appropriate responses through role play.
- Set limits on manipulative behavior, and identify the consequences of manipulative behavior. Administer the consequences matter-of-factly and in a non-threatening manner if such behavior occurs.
- Provide immediate positive feedback for acceptable behavior.
- Encourage the child to maintain a log book and make daily entries of his behavior. The entry should consist of a brief statement of an incident when the patient was angry or disagreed with another person, what the patient thought about the incident afterwards (in his own words), what the patient thought about doing, and what he actually did, and the outcome. This provides opportunity for the child to identify his predominant patterns of thinking and behaving in different situations, and recognize new and acceptable ways of responding in situations which provoke such behaviors.
- Review the log with the patient before discharge. Provide feedback regarding improved behavioral responses and areas where continued work is needed. Encourage patient to continue the log after discharge.
- Social skills training: The key steps for teaching social skills are:
 - Presenting the target skill to the child by describing it and discussing when it is relevant
 - Demonstrating the skill by modeling
 - Asking the child to rehearse the skill and providing feedback
 - Role playing example situations that call for use of the skill
 - Giving the child an assignment involving practice of the skill in real life situations outside the clinical setting

- Guidance and support for parents: In parent training programs, the nurse should emphasize to the parents that reconnecting with their children as positive, nurturing caregivers, comes first. However, management of difficult behavior is a key component in the program, and certain guidelines for discipline include:
 - Develop disciplinary alternatives (such as time out or removal of privileges) to spanking
 - Spend scheduled time with your child that would foster a more positive relationship with him
 - Agree on the rules about behavior and consequences, make them clear and stick with them
 - Do not give a direction unless you are willing to make sure it is followed
 - Encourage parents to verbalize feelings of guilt and helplessness in dealing with the child. Involve siblings in family discussions and planning for more effective family interactions
- Working with the school: Aggressive children often display problems across settings, including school, or even only in a particular classroom. The nurse should emphasize on close collaboration between parents and school personnel likely to come into contact with the child (principal, assistant principal, guidance counselors, school psychologists, etc.). Children who see their parents and teachers working together find it easier to control their behavior both at home and school.
- Truancy requires separate consideration. Pressure should be brought upon the child to return to school, and if possible, the support of the family should be enlisted. At the same time, an attempt should be made to resolve educational or other problems at school. In all this, it is essential to maintain good communication between the nurse, parents and teachers.

Juvenile Delinquency

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

Recently, there was a clarification made by the Supreme Court in the existing Juvenile Justice Act, that a regular court would try a juvenile if he is arrested after crossing the age of 16 though he might have committed the crime when he was under the age of 16 (The Hindu, 15th May 2000).

Causes

Social Causes

- Defects in the family structure, like broken families, uncaring attitude of parents, bad conduct of parent, etc.
- Defects in the school system, like harsh punishment by teachers, weakness in some subjects, a level of education that is above the child's capacity
- Children living in crime-dominated areas
- Absent or defective recreation
- War and post-war conditions.

Psychological Causes

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

Economic Causes

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

Reformatory Measures

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

- Institutions like reformatory schools, remand homes, certified schools, auxiliary homes provide for all-round progress of the delinquent.
- Psychological therapies like play therapy, finger-painting, psychodrama.
- Governmental measures: The Children's Act of 1977 under which remand homes and borstal schools were made available; vocational training and follow-up services. Under the Care Program sponsored by the Central Government, 5 borstal schools, 15 boy's clubs and 5 probation hostels have been established.

Separation Anxiety Disorder

In these disorders, there is excessive anxiety concerning separation from those individuals to whom the child is attached.

Clinical Features

- An unrealistic worry about possible harm befalling major attachment figures or fears that they will leave and not return
- Persistent reluctance or refusal to go to sleep, without being near or next to a major attachment figure
- Persistent inappropriate fear of being alone
- Repeated nightmares
- Repeated occurrence of physical symptoms, for example, nausea, stomachache, headache, etc., on occasions that involve separation from a major attachment figure, such as leaving home to go to school
- Excessive tantrums, crying and apathy immediately following separation from a major attachment figure.

Treatment

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

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

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

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

Phobic Anxiety Disorder

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

Treatment

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

Social Anxiety Disorder

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

Sibling Rivalry Disorder

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

Management

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

Elective Mutism

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

Management

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

Tic Disorders

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

1. Motor tics, characterized by repetitive motor movements.

2. Vocal tics, characterized by repetitive vocalizations.

Tic disorders can be either transient or chronic. A special type of chronic tic disorder is Gilles de la Tourette's syndrome or Tourette's disorder. This is characterized by: multiple motor and vocal tics, with duration of more than 1 year. Onset is usually before 11 years of age and almost always before 21 years of age.

The disorder is more common (about 3 times) in males and has a prevalence rate of about 0.5 per 1000.

Motor Tics

Motor tics can be simple or complex.

Simple Motor Tics

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

Complex Motor Tics

These are facial gestures, stamping, jumping, hitting self, squatting, twirling, echokinesis (repetition of observed acts), and copropraxia (obscene acts).

Motor tics are often the earliest to appear, beginning in the head region and progressing downwards. These are followed by vocal tics.

Vocal Tics

Vocal tics also can be simple or complex.

Simple Vocal Tics

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

Complex Vocal Tics

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

Etiology of Tourette's syndrome: The etiology of Tourette's syndrome is not known but the presence of learning difficulties, neurological soft signs, hyperactivity, abnormal EEG record, abnormal evoked potentials and

abnormal CT brain findings in some patients point towards a biological basis. There is some evidence to suggest that Tourette's syndrome may be inherited as autosomal dominant disorder with variable penetrance.

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

Nonorganic Enuresis

It is a disorder characterized by involuntary voiding of urine by day and/or night which is abnormal in relation to the individual's mental age and which is not a consequence of a lack of bladder control due to any neurological disorder, epileptic attacks or any structural abnormality of urinary tract. Enuresis would not ordinarily be diagnosed in a child under the age of 5 years or with a mental age less than 4 years.

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

Factors Associated with Enuresis

- Faulty training: If toilet training is started too early, and especially if coercive, produces confusion and resentment rather than compliance. Also, if it is begun too late, loss of bladder control can result.
- Emotional disturbances: Emotional problems or conflicts can manifest in the form of disturbed bladder control. These conflicts may be due to such factors like dominating parents, harsh punishments and other problems in the family, causing the child to feel neglected and isolated. As the children grow older, they become sensitive about their habit of bed-wetting. They develop feelings of inferiority and a sense of being different from other
- children, which aggravates the problem even further.
- Physical diseases and anatomic defects (for example, congenital anomalies of the genitourinary tract, diseases involving the central nervous system) are relatively rare causes for enuresis.

Management

- Exclude any physical basis for enuresis by history, examination and if necessary, investigation of the renal tract.
- Explain to the child and parents about the maturational basis of the problem and the likelihood of spontaneous improvement.
- The child should be encouraged to keep a diary of the pattern of night time dryness/wetness, which can be done with a star chart. This consists of a record of dry nights with a star placed on the sheet for each dry night. The star chart system has three functions:
 - It provides an accurate record of the problem
 - It tests motivation and cooperation of the child and the family
 - It acts as a positive reinforcement for the desired behavior
- Fluid restriction after 6 O' clock in the evening.
- Interruption of child's sleep and emptying bladder in the toilet.
- Bell and pad technique: It is based on classical conditioning principle. A bell is attached to the napkin or panties and when the child passes urine, the alarm goes off, the child then has to wake up, change his napkin, bed sheets, etc. Reinforcement is given for dry nights.
- Medications: Tricyclic antidepressants like imipramine or amitriptyline, 25–50 mg at night. The mechanism of action is unknown, but results have demonstrated its effectiveness.
- The parents should be instructed not to blame the child in any way. On no account should the child be embarrassed

or humiliated, which will only serve to aggravate the problem.

Nonorganic Encopresis

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

Management

- Family tensions regarding the symptoms must be reduced and a non-punitive atmosphere must be created. Parental guidance and family therapy often is needed.
- Behavioral techniques, for example, star charts, in which the child places a star on a chart for dry or continent nights.
- Individual psychotherapy to gain the cooperation and trust of the child.

Feeding Disorder of Infancy and Childhood

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

Pica

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

Stereotyped Movement Disorders

These disorders are characterized by voluntary, repetitive, stereotyped, non-functional,

often rhythmic movements that do not form part of any recognized psychiatric or neurological condition. The movements include body rocking, head rocking, hair plucking, hair twisting, finger flicking, mannerisms and hand flapping.

Management

- Individual and family interventions
- Behavioral strategies

Stuttering (Stammering)

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

FOLLOW-UP, HOME CARE AND REHABILITATION FOR CHILDHOOD PSYCHIATRIC DISORDERS

- Educate the parents about age-appropriate developmental tasks, and explain how their child's disorder may disrupt these important milestones.
- Teach the parents about the specific disorder, symptoms, behaviors, treatment and management strategies.
- Emphasize to the parents the importance of reinforcing the child's strengths, capabilities and positive qualities.
- Educate the family in identifying stressors that may provoke the patient's disruptive or aggressive behaviors and teach strategies to avoid or modify them.
- Inform the parents about the availability of local support groups for children and adolescents with mental disorders.

REVIEW QUESTIONS

Long Essays

1. Role of a nurse in the prevention of mental retardation.
2. Nursing management of childhood psychiatric disorders.
3. Nursing management of a mentally retarded child.
4. Nursing management of an autistic child.
5. Nursing management of a child with hyperkinetic disorder.

Short Essays

1. Classification of childhood psychiatric disorders.
2. Definition and etiology of mental retardation.
3. Classification of mental retardation.
4. Autism
5. ADHD
6. Conduct disorder
7. Juvenile delinquency

Short Answers

1. Enuresis
2. Mutism
3. Tic disorder
4. Separation anxiety disorder

MULTIPLE CHOICE QUESTIONS

- 1. All the following features are characteristic of MR, except:**
 - a. Impairment in adaptive behavior
 - b. Subaverage intellectual ability
 - c. Manifested during developmental period
 - d. Significant medical problems
- 2. Which of the following chromosomal abnormalities cause mental retardation?**
 - a. Down's syndrome
 - b. Toxemia of pregnancy

- c. Kernicterus
- d. Septicemia during infancy
- 3. Which of the following perinatal factor causes mental retardation?**
 - a. Lead poisoning during infancy
 - b. Hypothyroidism of the mother
 - c. Herpes simplex infection in the mother
 - d. Birth asphyxia
- 4. A child with an IQ score 30 would be categorized under which of the degrees of mental retardation?**
 - a. Mild
 - b. Moderate
 - c. Severe
 - d. Profound
- 5. Following are all primary preventive measures of MR, except:**
 - a. Genetic counseling
 - b. Immunization for maternal rubella
 - c. Proper nutrition throughout the developmental period
 - d. Reduction of disability by rehabilitation
- 6. When developing a care plan for a child with an IQ score 47, the nurse would expect the child to be capable of:**
 - a. Performing an intellectual job
 - b. Money budgeting
 - c. Performing certain self care activities
 - d. Living independently
- 7. Which of the following is an example of specific developmental disorder of speech and language?**
 - a. Dysphasia
 - b. Dyslexia
 - c. Autism
 - d. Rett's syndrome
- 8. Which of the following is an example of specific developmental disorder of scholastic skills?**
 - a. Dysphasia
 - b. Dyslexia
 - c. Autism
 - d. Rett's syndrome

- 9. Which of the following is an example of pervasive developmental disorder?**
- Dysphasia
 - Dyslexia
 - Childhood autism
 - Hyperkinetic disorder
- 10. Following are all characteristics of childhood autism, except:**
- Unresponsiveness to parent's affection
 - Gross deficits in language development
 - Stereotype body movements
 - Attention deficit and hyperactivity
- 11. Autism mainly involves**
- Over activity and inattention
 - Poor eating skills
 - Poor intelligence
 - Poor communication
- 12. Which of the following measures is a priority for the parents of an autistic child who engages in head banging?**
- Stimulant administration
 - Home safety measures
 - Face-to-face communication
 - Regular routines
- 13. Which of the following nursing interventions is most appropriate to develop language skills among autistic children?**
- Teach the names of the objects by linking them with the actual object
 - Assign limited number of care givers
 - Provide child with familiar toys
 - Encourage child to talk
- 14. Which of the following characteristics is the nurse most likely to observe in ADHD children?**
- More attentive, less focused, impulsive
 - Sensitive to stimuli, more attentive and focused
 - More attentive, hyperactive, unable to wait
 - Less attentive, hyperactive, impulsive
- 15. What nursing action would be most effective in changing the behavior of a child diagnosed with Attention Deficit Hyperactivity Disorder (ADHA)?**
- Sedate the child for hyperactive behavior
 - Reward appropriate behavior
 - Use aggressive punishment to control undesired behavior
 - Use seclusions and restraints
- 16. Which of the following drugs is commonly prescribed for ADHD child?**
- Methylphenidate
 - Diazepam
 - Clozapine
 - Chlorpromazine
- 17. Which of the following features are not likely to be observed by the nurse in a child with ADHD?**
- Organized behavior and accomplishing tasks
 - Blurting out answers even before questions have been asked
 - Difficulty engaging in learning activities
 - Failure to follow instructions
- 18. Following are all conduct disorders, except:**
- Aggressive behavior
 - Violating others rights
 - Poor performance in school
 - Poor communication skills
- 19. Sudden occurrence of abnormal involuntary movement, purposeless in nature is termed as:**
- Social anxiety disorder
 - Elective mutism
 - Tic disorder
 - Mannerisms
- 20. An elimination disorder in which the child suffers from incontinence of urine during sleep is termed as:**
- Enuresis

- b. Encopresis
- c. Dyspareunia
- d. Pseudocyesis

21. Craving and eating of non-food substances, such as paint and clay is termed as:

- a. Binge eating
- b. Verbigeration

- c. Polyphagia
- d. Pica

22. Which classification of drugs may be used to treat enuresis in children?

- a. Tricyclic antidepressants
- b. Major tranquilizers
- c. Anti-anxiety agents
- d. Hypnotics

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. d | 2. a | 3. d | 4. c | 5. d | 6. c | 7. a | 8. b | 9. c | 10. d |
| 11. d | 12. b | 13. a | 14. d | 15. b | 16. a | 17. a | 18. d | 19. c | 20. a |
| 21. d | 22. a | | | | | | | | |

Chapter 12

Nursing Management of Organic Brain Disorders

Organic mental disorders are behavioral or psychological disorders associated with transient or permanent brain dysfunction. These disorders have a demonstrable and independently diagnosable cerebral disease or disorder. They are classified under F0 in ICD10.

CLASSIFICATION OF ORGANIC MENTAL DISORDERS

- 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 and dysfunction and physical disease
 - F07 : Personality and behavioral disorders due to brain disease, damage and dysfunction.

DEMENTIA IN ALZHEIMER'S DISEASE (CHRONIC ORGANIC BRAIN SYNDROME)

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

Alzheimer's-type dementia is an irreversible disease marked by global, progressive impair-

ment of cognitive functioning, memory, and personality.

Incidence

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

Etiology

- Significant loss of neurons and volume in brain regions devoted to memory and higher mental functioning
- Neurofibrillary tangles (twisted nerve cell fibers that are the damaged remains of microtubules—Support structures that permit nutrients to flow through neurons)
- Buildup of amyloid
- Accumulation of beta amyloid, an insoluble protein, which form sticky patches (neuritic plaques) surrounded by debris of dying neurons
- Environmental factors: Infection, metals, and toxins
- Excessive amounts of metal ions, such as zinc and copper, in brain
- Other possible factors being researched are:
 - Deficiencies of vitamins B₆, B₁₂, and folate: Possible risk factor due to increased

- levels of homocysteine (amino acid that may interfere with nerve cell repair)
- Early depression: Common genetic factors seen in those with early depression and Alzheimer's disease
- Serious head injury: Possible link between injury in early adulthood and later development of Alzheimer's disease
- Education level: Increased risk in those with less education than in those who remain mentally active (possibly because learning may stimulate increased neuron growth, resulting in greater brain reserve).

Untreatable and Irreversible Cause of Dementia

- Degenerating disorders of CNS
- Alzheimer's disease (this is the most common of all dementing illnesses)
- Pick's disease
- Huntington's chorea
- Parkinson's disease.

Treatable and Reversible Causes of Dementia

- Vascular—Multi-infarct dementia
- Intracranial space occupying lesions
- Metabolic disorders—Hepatic failure, renal failure
- Endocrine disorders—Myxedema, Addison's disease
- Infections—AIDS, meningitis, encephalitis
- Intoxication—Alcohol, heavy metals (lead, arsenic), chronic barbiturate poisoning
- Anoxia—Anemia, post-anesthesia, chronic respiratory failure
- Vitamin deficiency, especially deficiency of thiamine, and nicotine
- Miscellaneous—Heatstroke, epilepsy, electric injury.

Stages of Dementia

Stage I: Early Stage (2 to 4 years)

- Forgetfulness
- Declining interest in environment

- Hesitancy in initiating actions
- Poor performance at work.

Stage II: Middle Stage (2 to 12 years)

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

Stage III: Final Stage (up to a year)

- Marked loss of weight because of inadequate intake of food
- Unable to communicate
- Does not recognize family
- Incontinence of urine and feces
- Loses the ability to stand and walk
- Death is usually caused by aspiration pneumonia.

Warning Signs of Alzheimer's Dementia

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

Clinical Features (for Alzheimer's Type)

- *Personality changes:* Lack of interest in day-to-day activities, easy mental fatigability, self-centered, withdrawn, decreased self-care.
- *Memory impairment:* Recent memory is prominently affected.

- *Cognitive impairment:* Disorientation, poor judgment, difficulty in abstraction, decreased attention span.
- *Affective impairment:* Labile mood, irritability, depression.
- *Behavioral impairment:* Stereotyped behavior, alteration in sexual drives and activities, neurotic/psychotic behavior.
- *Neurological impairment:* Aphasia, apraxia, agnosia, seizures, headache.
- *Catastrophic reaction:* Agitation, attempt to compensate for defects by using strategies to avoid demonstrating failures in intellectual performances, such as changing the subject, cracking jokes or otherwise diverting the interviewer.
- *Sundowner syndrome:* It is characterized by drowsiness, confusion, ataxia; accidental falls may occur at night when external stimuli, such as light and interpersonal orienting cues are diminished.

Course and Prognosis

Insidious onset but slow progressive deterioration occurs.

Diagnosis

Based on ICD10 criteria.

Following tests are used for diagnosis:

- Cognitive assessment evaluation—mini-mental status examination (MMSE)—shows cognitive impairment
- Functional dementia scale (to indicate degree of dementia)
- Magnetic resonance image (MRI) of the brain shows structural and neurologic changes
- Spinal fluid analysis shows increased beta amyloid deposits.

Treatment Modalities

Medications used in the treatment of Alzheimer's disease are:

- Tacrin hydrochloride (cognex)

- Donepezil hydrochloride (aricept)—Both drugs inhibit the enzyme acetylcholinesterase in the CNS, increasing the level of acetylcholine. The drug may temporarily improve cognitive function in patients with Alzheimer's disease. Most common side effects are headache, blurred vision, insomnia, nausea, diarrhea, urinary frequency, muscle cramps, dizziness, urticaria
- Antipsychotic medications such as risperidone (risperdal) and haloperidol (Haldol) may be used to decrease verbal and physical aggressiveness to alleviate hallucinations and delusions
- Benzodiazepines for insomnia and anxiety
- Antidepressants for depression
- Anticonvulsants to control seizures
- Agents under investigation for treating Alzheimer's disease: Estrogen, non-steroidal anti-inflammatory agents, vitamin E, selegiline (Carbex, Eldepryl), and ginkgo biloba; a vaccine is being studied in mice
- Alzheimer's disease prevention, targeting individuals at increased genetic risk; may involve prophylactic nutritional agents (such as vitamin E) or cholinergic or amyloid-targeting interventions.

Brief psychotherapy techniques, such as reality orientation and memory retraining, to aid patients during certain stages.

Nursing Management

Nursing care for patients of Alzheimer's disease is most important. Whether at home, in an acute hospital environment, a day-care center or in a long-term stay institution. Care givers must be trained to promote the patient's remaining intellectual abilities; help them maintain their independence in attending to their usual functions and avoid injuries; and provide for a good quality of life.

Nursing Assessment

Assessment data for the patient with dementia should include a past health and medication history (Box 12.1).

Box 12.1: Data to be included for nursing assessment

- » Disorientation
- » Mood changes
- » Fear
- » Suspiciousness
- » Self-care deficit
- » Social behavior
- » Level of mobility, wandering behavior
- » Judgment ability
- » Sleep disturbance
- » Speech or language impairment
- » Hallucinations, illusions or delusions
- » Bowel and bladder incontinence
- » Apathy
- » Any decline in nutritional status
- » Recognition of family members
- » Identify primary care giver, support system and the knowledge base of the family members

Nursing Interventions

Daily Routine

Maintaining a daily routine includes drawing up a fixed timetable for the patient for waking up in the morning, toilet, exercise and meals. This gives the patient a sense of security.

Patients often deteriorate after dark, a phenomenon known as 'sun downing'. Additional care must be taken during the evening and at night. Orient the patient to reality in order to decrease confusion; clock with large faces aid in orientation to time. Use calendar with large writing and a separate page for each day. Provide newspapers which stimulate interest in current events. Orientation of place, person and time should be given before approaching the patient.

Nutrition and Body Weight

Patient should be provided a well-balanced diet, rich in protein, high in fiber, with adequate amount of calories. Allow plenty of time for meals. Tell the patient which meal it is and what is there to eat; food served should neither be too hot nor too cold. Many patients have

sugar craving. Care should be taken that such patients do not gain weight. The diet should take into account other medical illnesses which require diet modification, such as diabetes or high blood pressure. Semi-solid diet is the safest while liquids are the most dangerous as these can be easily aspirated into the lungs.

Personal Hygiene

Particular care should be taken about the patient's personal hygiene, including brushing of teeth, bathing, keeping the skin clean and dry, particularly in areas prone to perspiration, such as the armpits and groin. Caustic substances such as spirit or antiseptic solutions should not be used routinely on the skin. Remember to check finger and toe nails regularly, cut them if the person cannot do it by himself.

People with dementia may have problem with the lock on the bathroom door; if this happens it is advisable to remove the lock. Compliment the patient when he/she looks good.

Toilet Habits and Incontinence

Toilet habits should be established as soon as possible and maintained as a rigid routine. This includes conditioned behavior such as going for bowel movement immediately after a cup of tea. The patient should be taken to urinate at fixed interval, depending on the season and amount of fluid intake. Prostate trouble common in elderly men leads to discomfort as it causes urgency and frequency of urination particularly in winters. A doctor should check this.

Incontinence is very distressing to the patient and family. Once incontinence sets in, the undergarments, pants of the patient and the house in general start reeking of foul smell. Toilet habits, established in healthy years must be maintained as long as possible by gently persuading the patient to go to the toilet and use it. When the first sign of incontinence appears doctor should check for an underlying cause if any, such as urinary infection or urinary tract damage.

Constipation is a frequent cause of discomfort to the patient. The quantity of feces passed each morning should be checked to ensure that the patient is not constipated. Constipation can be avoided by adding fiber supplements and roughage to the diet on a daily basis.

Accidents

Great care should be taken to avoid accidents caused by tripping over furniture, falling down the stairs or slipping in the bathroom. The reasons for falling include loose and poorly fitting footwear and wrinkled carpets. Ideally, patients should be made to wear soft slip-on shoes with straps which fit securely. Any floor covering must be firmly secured.

Older people have been driving for years and in modern cities many people are dependent on their personal cars for transportation. Once early signs of the disease appear, patients should be gently persuaded to stop driving as this can pose a hazard to them and others.

Make sure that lights are bright enough. Keep matches, bleach, and paints out of reach. Do not allow the patient to take medication alone.

Fluid Management

The patients require as much fluid as normal people and this depends on the season. Ideally, sufficient fluid should be given during the day and only the minimum essential amount of fluid (some water with dinner) after 6 pm. The last cup of tea should be given around 5 pm. After that no beverages, including tea, coffee, cocoa or any other caffeine containing drinks, should be given, as all these promote urination. Proper fluid management will reduce bed-wetting and also reduce the number of times the patient will need to get up during the night.

Moods and Emotions

Some patients of Alzheimer's disease have abrupt change in their moods and emotions. These changes can be unpredictable. Mood changes are best controlled by keeping a

calm environment with fixed daily routine. The patients should not be questioned repeatedly or given too many choices, such as what they want to eat or what they want to wear. Mood changes are also amenable to distraction, particularly if topics related to the past are discussed or favorite pieces of music played. For example, if music that reminds the patients of their childhood is played, the pleasant associations put them in a nostalgic mood. If patient behavior and emotions are distressing to the family members the doctor may prescribe some medications to calm the patient.

Wandering

Patients of Alzheimer's disease often lose their geographic orientation and can get lost even in familiar surroundings. They may be found wandering aimlessly either in the neighborhood or far away. It is advisable to have some identification bracelet or card always in their possession. The doors of the house should be securely locked so that the patients cannot leave unnoticed. The patient should always be accompanied while going for walks or for simple chores outside the house.

Disturbed sleep

Sleep disturbances are extremely distressing to the family. If the patient is restless at night or wanders and talks at night, the entire family is disturbed. Sleep patterns must be maintained. Napping during the day should be avoided. Sleeping pills are best avoided as their effect is temporary and frequently unpredictable in patients of Alzheimer's disease. Causes of discomfort at night, such as pain, uncomfortable temperature or prostate trouble, should be checked.

Interpersonal relationship

Verbal communication should be clear and unhurried. Questions that require 'yes' or 'no' answers are best. Reinforce socially acceptable skills. Give necessary information repeatedly. Focus on things the person does

well rather than on mistakes or failures. Try to make sure that each day has something of interest for the patient—it might be going for a walk, listening to music; talk about the day's activities. Try to involve him with old friends for a chat, reminiscing about the past.

Follow-up, Home Care and Rehabilitation

Family members should be aware of early warning signs which may suggest that one of the older members may be on the verge of developing Alzheimer's disease. Early diagnosis and early intervention can be beneficial both to the patient and the family. As the disease progresses, the family remains the main pillar of support for the patient.

Programs and services for patients with dementia and their families have increased with the growing awareness of Alzheimer's disease. Home care is available through home health agencies, public health agencies and visiting nurses. These services offer assistance with bathing, medication management and transportation as well as with other support. Residential facilities are available for patients who do not have home caregivers or whose needs have progressed beyond the care that could be provided at home. These patients usually require assistance with activities of daily living, such as eating and taking medications.

Role of the Caregiver

Caregivers need to know about dementia and the required patient care as well as how patient care will change as the disease progresses. Many caregivers have other demands on their time, such as their own families, careers, and personal lives. Caregivers must deal with their feelings of loss and grief as the health of their loved ones continually declines.

Caring for patients with dementia can be emotionally and physically exhausting and stressful. Caregivers may need to drastically change their own lives, such as quitting a job,

to provide care. Role strain is identified when the demands of providing care threaten to overwhelm a caregiver.

Supporting the caregivers is an important component of providing care at home to patients with dementia. Caregivers need outlets for dealing with their own feelings. Support groups can help them to express frustration, sadness, anger, guilt or ambivalence. All these feelings are common. Nurses should offer hope to the family and avoid false reassurance when possible. Teach the family/caregiver strategies that promote the patient's existing memory, for example, reminiscence activities, environmental cues, familiar songs, pictures, pets, etc.

Rehabilitative Services

Alzheimer's associations around the world provide practical and emotional help and information to families, healthcare professionals and the community. Alzheimer's and Related Disorders Society of India (ARDSI) started in 1992, a national organization dedicated to dementia care, support and research.

VASCULAR DEMENTIA (MULTI-INFARCT DEMENTIA)

Vascular dementia is a condition characterized by an irreversible alteration in brain function that results from damage or destruction of brain tissue such as blood clots that block small vessels in the brain.

Etiology

- Small focal deficits—typically caused by a series of small strokes
- Contributing factors
 - Advanced age
 - Cerebral emboli or thrombosis
 - Diabetes
 - Heart disease
 - High blood cholesterol level
 - Hypertension (leading to stroke)
 - Transient ischemic attacks.

Signs and Symptoms

Occur more abruptly than associated with Alzheimer's disease:

- Confusion
- Wandering or getting lost in familiar places
- Leg or arm weakness
- Neurologic symptoms lasting only a few days
- Slurred speech
- Problems with recent memory
- Loss of bladder or bowel control
- Inappropriate emotional reactions such as laughing or crying inappropriately
- Problem in handling money
- Difficulty following instructions
- Depression
- Dizziness.

Diagnosis

- Cognitive assessment scale (shows deterioration in cognitive ability)
- Global deterioration scale (indicates degenerative dementia)
- MMSE (reveals disorientation and difficulty with recall)
- MRI or Computed Tomography scan (shows structural, vascular, and neurologic changes in the brain)
- An abbreviated mental examination to detect memory problems and aid differential diagnosis, treatment, and rehabilitation
- Based on criteria established in ICD 10.

Treatment Modalities

- Carotid endarterectomy
- Drug therapy such as aspirin.

Nursing Interventions

- Reduce unnecessary stimulation
- Make environment as stable as possible
- Avoid changing patient's room and moving furniture or possessions
- Minimize factors that may contribute to confusion

- Orient patient to his surroundings to ease his anxiety.

September 21st of every year is observed as World Dementia Day.

DELIRIUM (ACUTE ORGANIC BRAIN SYNDROME)

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

Incidence

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

Etiology

- *Vascular*: Hypertensive encephalopathy, cerebral arteriosclerosis, intracranial hemorrhage
- *Infections*: Encephalitis, meningitis
- *Neoplastic*: Space occupying lesions
- *Intoxication*: Chronic intoxication or withdrawal effect of sedative-hypnotic drugs
- *Traumatic*: Subdural and epidural hematoma, contusion, laceration, post-operative, heatstroke
- *Vitamin deficiency*: For example, thiamine
- *Endocrine and metabolic*: Diabetic coma and shock, uremia, myxedema, hyperthyroidism, hepatic failure
- *Metals*: Heavy metals (lead, manganese, mercury), carbon monoxide and toxins
- *Anoxia*: Anemia, pulmonary or cardiac failure.

Clinical Features

- Impairment of consciousness: Clouding of consciousness ranging from drowsiness to stupor and coma

- Impairment of attention: Difficulty in shifting, focusing and sustaining attention
- Perceptual disturbances: Illusions and hallucinations, most often visual
- Disturbance of cognition: Impairment of abstract thinking and comprehension, impairment of immediate and recent memory, increased reaction time
- Psychomotor disturbance: Hypo or hyperactivity, aimless groping or picking at the bed clothes (flocculation), enhanced startle reaction
- Disturbance of the sleep-wake cycle: Insomnia or in severe cases total sleep loss or reversal of sleep-wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams or nightmares, which may continue as hallucinations after awakening
- Emotional disturbances: Depression, anxiety, fear, irritability, euphoria, apathy.

Course and Prognosis

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

Treatment

- Identification of cause and its immediate correction, for example, 50 mg of 50% dextrose IV for hypoglycemia, O₂ for hypoxia, 100 mg of B₁ IV for thiamine deficiency, IV fluids for fluid and electrolyte imbalance
- Symptomatic measures: Benzodiazepines (10 mg diazepam or 2 mg lorazepam IV) or antipsychotics (5 mg haloperidol or 50 mg chlorpromazine IM) may be given.

Nursing Intervention

Providing Safe Environment

- Restrict environmental stimuli, keep unit calm and well-illuminated
- There should always be somebody at the patient's bedside reassuring and sup-

- porting
- As the patient is responding to a terrifying unrealistic world of hallucinatory illusions and delusions, special precautions are needed to protect him from himself and to protect others

Alleviating Patient's Fear and Anxiety

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

Meeting the Physical Needs of the Patient

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

Facilitate Orientation

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

ORGANIC AMNESTIC SYNDROME

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

Etiology

- Thiamine deficiency, the most common cause being chronic alcoholism. It is also called as “Wernicke-Korsakoff syndrome.” Wernicke’s encephalopathy is an acute phase of delirium preceding amnestic syndrome, while Korsakoff’s syndrome is a chronic phase of amnestic syndrome
- Head trauma
- Bilateral temporal lobectomy
- Hypoxia
- Brain tumors
- Herpes simplex encephalitis
- Stroke.

Clinical Features

- Recent memory impairment
- Anterograde and retrograde amnesia
- There is no impairment of immediate memory.

Management

- Treatment for underlying cause.

MENTAL DISORDERS DUE TO BRAIN DAMAGE, DYSFUNCTION AND PHYSICAL DISEASE

These are mental disorders, which are causally related to brain dysfunction due to primary cerebral disease, systemic disease or toxic substances.

Primary cerebral diseases: Epilepsy, encephalitis, head trauma, brain neoplasms, vascular cerebral disease and cerebral malformations.

Systemic diseases: Hypothyroidism, Cushing’s disease, hypoxia, hypoglycemia, systemic lupus erythematosus and extracranial neoplasms.

Drugs: Steroids, antihypertensives, antimalarials, alcohol and psychoactive substances. The following mental disorders come under this category:

- Organic hallucinosis

- Organic catatonic disorder
- Organic delusional disorder
- Organic mood disorder
- Organic anxiety disorder.

PERSONALITY AND BEHAVIORAL DISORDERS DUE TO BRAIN DISEASE, DAMAGE AND DYSFUNCTION

These disorders are characterized by significant alteration of the premorbid personality due to underlying organic cause. There is no disturbance of consciousness and global intellectual function. The personality change may be characterized by emotional lability, poor impulse control, apathy, hostility or accentuation of earlier personality traits.

Etiology

- Complex partial seizures (temporal lobe seizures)
- Cerebral neoplasms
- Cerebrovascular disease
- Head injury.

Management

- Treatment for the underlying cause
- Symptomatic treatment with lithium, carbamazepine or with antipsychotics.

GERIATRIC CONSIDERATIONS

Elderly people are more prone to develop delirium than younger people. It is usually associated with other physical illnesses like pneumonia, metabolic disorders, cardiac failure, etc. or after surgery. Mortality increases as age advances. When reversible disease conditions are corrected delirium subsides. As age advances, the prevalence rate of dementia also rises. The two major causes of dementia are Alzheimer’s disease and vascular disorders in the elderly.

REVIEW QUESTIONS

Long Essays

- What is dementia? List various causes for Alzheimer's disease. Describe nursing management for dementia patient.
- Describe nursing interventions for delirium.

Short Essays

- Amnestic syndrome.
- Follow-up home care and rehabilitation for dementia patient.

Short Answers

- Classification of organic mental disorders.
- Delirium.
- Diagnosis of dementia.

MULTIPLE CHOICE QUESTIONS

1. Following are all organic brain disorders, except:

- a. Amnestic disorder
- b. Dementia
- c. Delirium
- d. Mental retardation

2. An acquired global impairment of intellect, memory and personality without impairment of consciousness is:

- a. Delirium
- b. Dementia
- c. Amnestic syndrome
- d. Parkinson's disease

3. Which of the following is untreatable and irreversible cause of dementia?

- a. Alzheimer's disease
- b. Addison's disease
- c. Multi-infarct dementia
- d. Lead poisoning

4. Which of the following is treatable and reversible cause of dementia?

- a. Myxedema
- b. Pick's disease

- c. Parkinson's disease
- d. Huntington's chorea

5. Which of the following neurotransmitter is implicated in the development of Alzheimer's disease?

- a. Acetylcholine
- b. Dopamine
- c. Serotonin
- d. Epinephrine

6. The most common cause of dementia is:

- a. Multiple sclerosis
- b. General paresis of insane
- c. Alzheimer's disease
- d. Multi-infarct lesion

7. Catastrophic reaction means:

- a. Attempts to compensate for defects
- b. Drowsiness and confusion
- c. Stereotyped behavior
- d. Labile mood

8. A 75-year-old patient is diagnosed with Alzheimer's dementia and confabulates. The nurse understands that this patient:

- a. Fills in memory gaps with false description of events
- b. Rationalizes his behavior
- c. Denies confusion by using jokes
- d. Pretends to be someone else

9. Which of the following will the nurse use when communicating with a patient who has a cognitive impairment?

- a. Provide detailed explanation with examples
- b. Use gestures instead of words
- c. Use short words and simple sentences
- d. Use stimulating words and sentences to capture the patient attention

10. The following are features of early stage of Alzheimer's dementia, except:

- a. Loss of recent memory
- b. Lack of interest in day-to-day activities
- c. Poor performance at work
- d. Unable to recognize family members

11. The following are features of middle stage of Alzheimer's dementia, except:

- a. Wandering

- b. Neglect of personal hygiene
 - c. Labile mood
 - d. Incontinence of urine and feces
- 12. Sundowner syndrome means:**
- a. Restlessness and confusion worsening in the evenings
 - b. Unconsciousness filling of memory gaps
 - c. Attempts to compensate for defects
 - d. Stereotyped behavior and activities
- 13. Which of the following is an acute organic psychiatric disorder?**
- a. Dementia
 - b. Delirium
 - c. Amnestic disorder
 - d. Organic mood disorder
- 14. Which of the following nursing interventions is most appropriate to reduce accidents among dementia patients?**
- a. Do not allow him to walk in the house
 - b. Remove sharp items from the patient environment
 - c. Provide well-fitted shoes with straps
 - d. Provide help to walk at all times
- 15. Which of the following nursing intervention is most appropriate to control mood changes among dementia patients?**
- a. Questioning repeatedly with too many choices
 - b. Keeping a calm environment with fixed daily routine
 - c. Administration of mood stabilizers
 - d. Engaging in one or other activity continuously
- 16. Which of the following verbal communication techniques is appropriate to improve inter-personal relationship with a dementia patient?**
- a. Use close-ended questions
 - b. Questioning repeatedly with too many choices
 - c. Communication should be quick and clear
 - d. Use long sentences with explanation
- 17. Which of the following interventions will improve orientation among dementia patients?**
- a. Use calendar with larger writings
 - b. Clock with large dial
 - c. Provide news papers with current events
 - d. All of the above
- 18. The following are nutritional interventions for a dementia patient, except:**
- a. Provide high protein and fiber diet
 - b. Provide adequate calories
 - c. Provide semi-solid diet
 - d. Provide clear liquid diet
- 19. Which of the following drugs is prescribed to an older patient with Alzheimer's type dementia?**
- a. Donepezil
 - b. Haloperidol
 - c. Risperidone
 - d. Alprazolam
- 20. Clouding of consciousness is characteristic of:**
- a. Schizophrenia
 - b. Dementia
 - c. Hysteria
 - d. Delirium
- 21. A 65-year-old male patient has been admitted to the psychiatric unit with symptoms of fatigue, inability to concentrate, inability to complete everyday tasks and preferring to sleep all the day; one of the most important intervention for this patient is:**
- a. Encourage him to perform regular activities
 - b. Explain causes of fatigue
 - c. Encourage him to join in ward activities
 - d. Develop a structured routine for him to follow

- 22. Which of the following is an appropriate nursing intervention for a patient with dementia who develops a catastrophic reaction?**
- a. Employ negative responses to behavior
 - b. Use touch to communicate
 - c. Eliminate or reduce environmental stimuli
 - d. Maintain close personal boundaries.

KEY

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|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. d | 2. b | 3. a | 4. a | 5. a | 6. c | 7. a | 8. a | 9. c | 10. d |
| 11. d | 12. a | 13. b | 14. c | 15. b | 16. a | 17. d | 18. d | 19. a | 20. d |
| 21. d | 22. c | | | | | | | | |

Chapter 13

Psychiatric Emergencies and Crisis Intervention

Psychiatric emergency is a condition wherein the patient has disturbances of thought, affect and psychomotor activity leading to a threat to his existence (suicide), or threat to the people in the environment (homicide). This condition needs immediate intervention to safeguard the life of the patient, bring down the anxiety of the family members and enhance emotional security to others in the environment.

Initial Approach during Emergency

- The initial approach to the patient should be warm, direct and concerned
- A quick evaluation to identify the nature of the condition and to institute care on the basis of seriousness is essential
- The emergency staff should have basic knowledge of handling psychiatric emergencies
- Medicolegal cases need to be registered separately and informed to the concerned officer
- Hospital security must be adequate to control violent and dangerous patients
- History and clinical findings should be recorded clearly in the emergency file
- Patient's condition and plans of management should be explained in simple language to the patient and family members.

TYPES OF PSYCHIATRIC EMERGENCIES AND THEIR MANAGEMENT

Suicidal Threat

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

Etiology

Psychiatric Disorders

- Major depression
- Schizophrenia
- Drug or alcohol abuse
- Dementia
- Delirium
- Personality disorder.

Physical Disorders

- Patients with incurable or painful physical disorders like, cancer and 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 for Suicide

- Age
 - Males above 40 years of age
 - Females above 55 years of age
- Sex
 - Men have greater risk of completed suicide
 - Suicide is three times more common in men than in women
 - Women have higher rate of attempted suicide
- Being unmarried, divorced, widowed or separated
- Having a definite suicidal plan
- History of previous suicidal attempts
- Recent losses.

Suicidal Tendency in Psychiatric Wards

Certain psychiatric disorders where the patient may develop suicidal tendencies include:

- *Major depression*: This is one of the commonest conditions associated with a high risk of suicide. Suicide in a major depressive episode is due to pervasive and persistent sadness; pessimistic cognitions concerning the past, present and future; delusions of guilt, helplessness, hopelessness and worthlessness; and derogatory voices urging him to take his life. The risk of suicide is more when the acute phase has passed and the characteristic psychomotor retardation has improved. This is so because the patient has more energy to carry out his suicidal plans now, though he might have been harboring them for quite some time.
- *Schizophrenia*: The major risk factors among schizophrenics include the presence of associated depression, young age and high levels of premorbid functioning (especially during college education). People in this risk group are more likely to realize the devastating significance of their illness more than

other groups of schizophrenic patients do, and see suicide as a reasonable alternative.

- *Mania*: Manic patients may occasionally commit suicide. This is usually the result of grandiose ideation. The patient may believe that he is a great person, or wish to prove his supernatural powers. With this intent in mind, he may carry out some dangerous activity that can cost him his life.
- *Drug or alcohol abuse*: Suicide among alcoholics can be due to depression in the withdrawal phase. Also, the loss of friends and family, self-respect, status, and a general realization of the havoc alcohol has created in his life can cause the individual to wish to die.
- *Personality disorder*: Individuals with histrionic and borderline traits may occasionally attempt suicide.
- *Organic conditions*: Conditions such as delirium and dementia due to changes of mood like anxiety and depression may also induce suicidal tendency.

Management

- Be aware of certain signs which may indicate that the individual may commit suicide, such as:
 - Suicidal threat
 - Writing farewell letters
 - Giving away treasured articles
 - Making a will
 - Closing bank accounts
 - Appearing peaceful and happy after a period of depression
 - Refusing to eat or drink
- Monitoring the patient's safety needs:
 - Take all suicidal threats or attempts seriously and notify psychiatrist
 - Search for toxic agents such as drugs/ alcohol
 - Do not leave the drug tray within reach of the patient, make sure that the daily medication is swallowed

- Remove sharp instruments such as razor blades, knives, glass bottles from his environment
- Remove straps and clothing such as belts, neckties
- Do not allow the patient to bolt his door on the inside, make sure that somebody accompanies him to the bathroom
- Patient should be kept in constant observation and should never be left alone
- Have good vigilance, especially during morning hours
- Spend time with him, talk to him, and allow him to ventilate his feelings
- Encourage him to talk about his suicidal plans/methods
- If suicidal tendencies are very severe, sedation should be given as prescribed.
- Encourage verbal communication of suicidal ideas as well as his/her fear and depressive thoughts. A 'no suicidal' pact may be signed, which is a written agreement between the patient and the nurse, that patient will not act on suicidal impulses, but will approach the nurse to talk about them.
- Enhance self-esteem of the patient by focusing on his strengths rather than weaknesses. His positive qualities should be emphasized with realistic praise and appreciation. This fosters a sense of self-worth and enables him to take control of his life situation.

Management of Attempted Suicide in the In-patient Unit

- Assess for vital signs, check airway, if necessary clear airway
- If pulse is weak, start IV fluids
- Turn patient's head and neck to one side to prevent regurgitation and swallowing of vomitus
- Emergency measures to be instituted in case of self-inflicted injuries.

Management of Shock

- Transfer the patient to medical center immediately
- If there is no evidence of life leave the body in the same position/room in which it was found (move the patient in case of suicide from a common living area for example, dining room or TV room)
- In case the patient has attempted suicide by jumping, do not leave the body in a place which is visible to other patients of the ward
- Inform authorities, record the incident accurately
- Contact local guardian and inform them
- Place an attendant outside the room where the body is kept
- Once the patient is transferred to mortuary or police custody clean the place with disinfectant solution
- Hand over the patient's properties to the concerned authorities/relatives
- Carry out the institutional formalities for death certificate
- The senior staff should discuss the incident in detail with all the staff and reassure them. The discussion should include possible lapses and preventive measures that need to be undertaken
- The care for other patients should include the following:
 - Transfer all the patients away from the incident location
 - Keep the patients in the center engaged by games and other recreational activities
 - Serve food and medication to the patients earlier than schedule
 - Observe for any change in the behavior, inform the psychiatrist.

VIOLENT OR AGGRESSIVE BEHAVIOR OR EXCITEMENT

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

Etiology

- Organic psychiatric disorders like, delirium, dementia, Wernicke-Korsakoff's psychosis
- Other psychiatric disorders like, schizophrenia, mania, agitated depression, withdrawal from alcohol and drugs, epilepsy, acute stress reaction, panic disorder and personality disorders.

Management

- An excited patient is usually brought tied up with a rope or in chains. The first step should be to remove the chains. A large proportion of aggression and violence is due to the patient feeling humiliated at being tied up in this manner
- Talk to the patient and see if he responds. Firm and kind approach by the nurse is essential
- Usually sedation is given. Common drugs used are: diazepam 10–20 mg IV; haloperidol 10–20 mg; chlorpromazine 50–100 mg IM
- Once the patient is sedated, collect history carefully from relatives; rule out the possibility of organic pathology. In particular check for history of convulsions, fever, recent intake of alcohol, fluctuations of consciousness
- Carry out complete physical examination
- Send blood specimens for hemoglobin, total cell count, etc.
- Look for evidence of dehydration and malnutrition. If there is severe dehydration, IV drip may be started
- Have less furniture in the room and remove sharp instruments, ropes, glass items, ties, strings, match boxes, etc. from patient's vicinity
- Keep environmental stimuli, such as lighting and noise levels to a minimum; assign a single room; limit interaction with others
- Remove hazardous objects and substances; caution the patient when there is possibility of an accident
- Stay with the patient as hyperactivity increases to reduce anxiety level and foster a feeling of security
- Redirect violent behavior with physical outlets such as exercise, outdoor activities
- Encourage the patient to 'talk out' his aggressive feelings, rather than acting them out
- If the patient is not calmed by talking down and refuses medication, restraints may become necessary
- Following application of restraints, observe patient every 15 minutes to ensure that nutritional and elimination needs are met. Also observe for any numbness, tingling or cyanosis in the extremities. It is important to choose the least restrictive alternative as far as possible for these patients
- Guidelines for self-protection when handling an aggressive patient:
 - Never see a potentially violent person alone
 - Keep a comfortable distance away from the patient (arm length)
 - Be prepared to move, a violent patient can strike out suddenly
 - Maintain a clear exit route for both the staff and patient
 - Be sure that the patient has no weapons in his possession before approaching him
 - If patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away
 - Keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon
 - Distract the patient momentarily to remove the weapon (throwing water in the patient's face, yelling, etc.)
 - Give prescribed antipsychotic medications.

PANIC ATTACKS

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

Management

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

CATATONIC STUPOR

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

Management

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

HYSTERICAL ATTACKS

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

- Hysterical fits
- Hysterical ataxia
- Hysterical paraplegia.

All presentations are marked by a dramatic quality and sadness of mood.

Management

- Hysterical fit must be distinguished from genuine fits. (See page 231 for differences between hysterical and epileptic seizures)
- As hysterical symptoms can cause panic among relatives, explain to the relatives the psychological nature of symptoms. Reassure that no harm would come to the patient
- Help the patient realize the meaning of symptoms, and help him find alternative ways of coping with stress
- Suggestion therapy with IV pentothal may be helpful in some cases.

TRANSIENT SITUATIONAL DISTURBANCES

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

Management

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

DELIRIUM TREMENS

Delirium tremens is an acute condition resulting from withdrawal of alcohol (See Page 243 for details).

Management

- Keep the patient in a quiet and safe environment
- Sedation is usually given with diazepam 10 mg or lorazepam 4 mg IV, followed by oral administration

- Maintain fluid and electrolyte balance
- Reassure patient and family.

(Refer Chapter 9, Page 246 for further details on management).

EPILEPTIC FUROR

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

Management

- Sedation: Inj. Diazepam 10 mg IV [or] Inj. Luminal 10 mg IV followed by oral anticonvulsants
- Haloperidol 10 mg IV helps to reduce psychotic behavior.

ACUTE DRUG-INDUCED EXTRAPYRAMIDAL SYNDROME

Antipsychotics can cause a variety of movement-related side-effects, collectively known as extrapyramidal syndrome (EPS). Neuroleptic malignant syndrome is rare but most serious of these symptoms and occurs in a small minority of patients taking neuroleptics, especially high-potency compounds, (Refer Chapter 5, Page 126 for a detailed description).

Management

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

DRUG TOXICITY

Drug over-dosage may be accidental or suicidal. In either case, all attempts must

be made to find out the drug consumed. A detailed history should be collected and symptomatic treatment instituted.

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

Management

- Administer O₂
 - Start IV line
 - Assess for cardiac arrhythmias
 - Refer for hemodialysis
 - Administer anticonvulsants.
- (Refer Chapter 5, Page 131 for further details on lithium toxicity).

VICTIMS OF DISASTER

Victims of disaster are people, who have survived a sudden, unexpected, overwhelming stress. This is beyond normally what is expected in life, like in an earthquake, flood, riots and terrorism. Anger, frustration, guilt, numbness and confusion are common features in these people.

Management

- Treatment for life threatening physical problems
- Critical incident debriefing (CID) is a special technique, which is used to lessen the discomfort of the disaster victims.
- CID includes five phases: Fact, thought, reaction, reaching and re-entry:
 - In the *fact phase*, each participant is involved to share his or her perception of the incident. The group members describe the incident, new information and pieces of information are integrated into a more understandable whole

- The *thought phase*, builds on this information by asking participants to reflect the incident and to share what they were feeling personally during different times of the crisis
 - In the *reaction phase*, participants are asked to evaluate the impact of the emotional aspects of the incident (for example, what was the worst part of the incident for you). Previously not discussed and less acceptable feelings are allowed to emerge in a safe environment. Knowing that other people are experiencing the same feelings makes them realize that these feelings are normal behavioral responses to abnormal circumstances, and this brings a lot of relief to people who are under intense stress. Participants discuss stress related symptoms they had during the incident or are experiencing currently
 - The *teaching phase*, focuses on specific cognitive, emotional and spiritual strategies to reduce stress and ways to enhance group support
 - In the final *re-entry phase*, the facilitator encourages questions and summarizes the process. Finally, individuals are referred to further counseling if needed
- Group therapy
 - In selected cases benzodiazepines are prescribed to reduce anxiety and induce sleep
 - Referral to mental health service, if required
 - Educate the victims that these emotional reactions are normal reactions to an extraordinary and abnormal situation, and are to be expected under the circumstances. Educate about the available services
 - Teach coping strategies to avoid the development of the crises. For example, strategies to be taught can include how to request information, access resources and obtain support.

RAPE VICTIM

Rape is a perpetuation of an act of sexual intercourse with a female against her will and consent.

Signs and Symptoms

Acute disorganization characterized by self blame, fear of being killed, feeling of degradation and loss of self-esteem, feelings of depersonalization and derealization, recurrent intrusive thoughts, anxiety and depression are commonly seen. Long-term psychological effects like post traumatic stress disorders (PTSD) can occur in some cases.

Management

- Be supportive, reassuring and non-judgmental
- Physical examination for any injuries
- Give morning after pill to prevent possible pregnancy
- Send samples for STD and HIV infection
- Explain to the patient the possibility of PTSD, sexual problems like vaginismus and anorgasmia which may appear later

STRESS ADAPTATION MODEL

Stress is the “non-specific response of the body to any kind of demand made upon it.” (Selye-1956).

Stress is the arousal of mind and body in response to demands made upon them. (Schafer-2000).

A **stressor** is any person or situation that produces anxiety responses. Stress and stressors are different for each person; therefore, it is important for the nurse to seek information about stress producers for that patient. What is extremely stressful for one person might be relaxing to someone else.

1. *The environmental stressors:* Noise, pollution, traffic, crowding and weather.

2. *Physiological stressors*: Illness, injuries, hormonal fluctuations, inadequate sleep or nutrition.
3. *Social stressors*: Financial problems, work demands, social events, losing a loved one, etc.
4. *Thoughts*: Negative self talk, catastrophizing and perfectionism.

MODELS OF STRESS

Models of stress assist nurses' to identify the stressor in a particular situation and to predict the individual's responses. Nurses can use the knowledge of these models to assist patients in strengthening healthy coping responses and in adjusting unhealthy, unproductive responses.

Three main models of stress are:

- Stimulus-based model
- Response-based model
- Transaction-based model.

Stimulus-Based Model (Holmes and Rahe Model-1960)

According to this model, stress is defined as a stimulus, a life event, or a set of circumstances that arouses physiologic and psychological reactions that may increase the individual's vulnerability to illness.

Holmes and Rahe developed the social readjustments rating scale [SRRS] consisting of 43 life changes or events which are both positive and negative in nature and considered stressful. The SRRS provides a general impression of the stressors in a person's life. The more stressors a person experiences in a short period (1-2 years) the more likely that physical illnesses, mental disorders or other stress responses will follow.

This theory also explains that many people with high scores on the SRRS do not subsequently experience serious problems. In addition, low scores do not guarantee a life

free of dangers of stress. One reason is that mediating factors, such as how the individual perceives and copes with each stressor, plays an important role in determining the impact of stressors on each individual.

Response-Based Model

Selye's stress response is characterized by a chain or pattern of physiologic events called the general adaptation syndrome.

General Adaptation Syndrome (Hans Selye, 1945)

Homeostatic mechanisms are aimed at counteracting the everyday stress of living. If they are successful, the internal environment maintains normal physiological limits of temperature, chemistry and pressure. If stress is extreme or long lasting, the normal mechanisms may not be sufficient. In this case, the stress triggers a wide-ranging set of bodily changes called the general adaptation syndrome (GAS).

Hans Selye, a pioneering stress theorist, developed general adaptation syndrome model that suggests that a person's response to stress consists of three stages (Fig. 13.1):

1. Alarm
2. Resistance
3. Exhaustion

When stress appears, it stimulates the hypothalamus to initiate the GAS through two pathways:

- The first pathway is stimulation of the sympathetic division of the autonomic nervous system and adrenal medulla. This produces an immediate set of responses called the alarm reaction
- The second pathway, called the resistance reaction involves the anterior pituitary gland and adrenal cortex; the resistance reaction is slower to start, but its effects last longer.

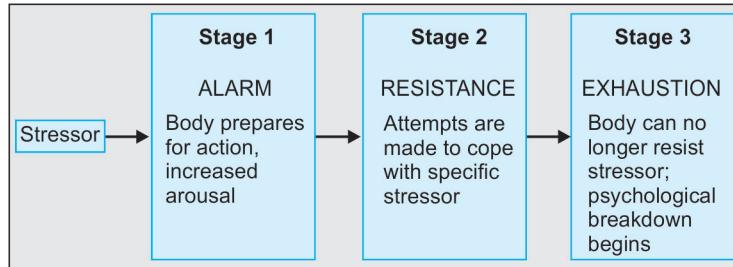


Fig. 13.1: Three stage model of general adaptation syndrome

Alarm Reaction or Fight-or-Flight Response

It is the body's initial reaction to a stressor. It is a set of reactions initiated when the hypothalamus stimulates the sympathetic division of the autonomic nervous system, and the adrenal medulla. The alarm reaction is meant to counteract a danger by mobilizing the body's resources for immediate physical activity.

The stress responses which characterize the alarm reaction include the following:

- Heart rate and strength of cardiac muscle contraction increases; this circulates blood quickly to areas where it is needed to fight the stress.
- Blood vessels supplying to the skin and viscera, except heart and lungs, constrict; at the same time blood vessels supplying to the skeletal muscles and brain dilate; these responses route more blood to organs active in the stress responses, thus decreasing blood supply to organs which do not assume an immediate active role.
- RBC production is increased leading to an increase in the ability of the blood to clot. This helps control bleeding.
- Liver converts glycogen into glucose and releases it into the bloodstream; this provides the energy needed to fight the stressor.
- The rate of breathing increases and respiratory passages widen to accommodate more air; this enables the body to acquire more oxygen.

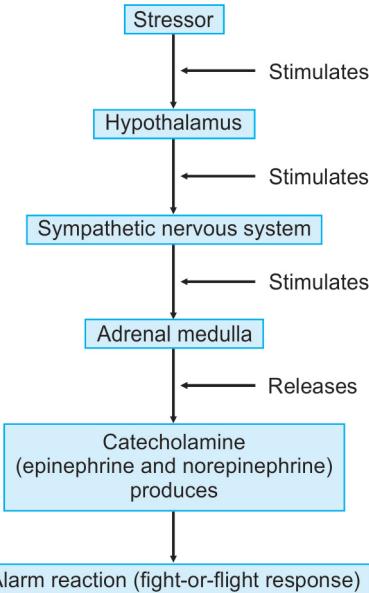


Fig. 13.2: Diagrammatic representation of alarm reaction

- Production of saliva and digestive enzymes reduces. This reaction takes place as digestive activity is not essential for counteracting stress (Fig. 13.2).

Resistance Reaction

- The resistance reaction is the second stage in the stress response. It is initiated by regulating hormones secreted by the hypothalamus, and is a long-term reaction. These regulating hormones are

corticotropin releasing hormone (CRH), Growth hormone releasing hormone (GHRH) and Thyrotropin releasing hormone (TRH).

- CRH stimulates the anterior pituitary to increase its secretion of adrenocorticotrophic hormone (ACTH). ACTH stimulates the adrenal cortex to secrete more of its hormones. The action of these hormones helps to control bleeding, maintain blood pressure, etc.
- GHRH stimulates the anterior pituitary to secrete human growth hormone (HGH). TRH causes the anterior pituitary to secrete thyroid-stimulating hormone (TSH). The combined actions of HGH and TSH help to supply additional energy to the body.

- The resistance reaction allows the body to continue fighting a stressor for a long time. Thus, it helps us to meet emotional crisis, perform strenuous tasks, fight infection, or resist the threat of bleeding to death.
- Generally, the resistance reaction is successful in helping us cope with a stressful situation, and our bodies then return to normal. Occasionally, it fails to fight the stressor, especially if it is too severe or long-lasting. In this case, the GAS moves into the stage of exhaustion (Fig. 13.3).

Exhaustion Stage

At this stage, the cells start to die, and the organs weaken. A long-term resistance

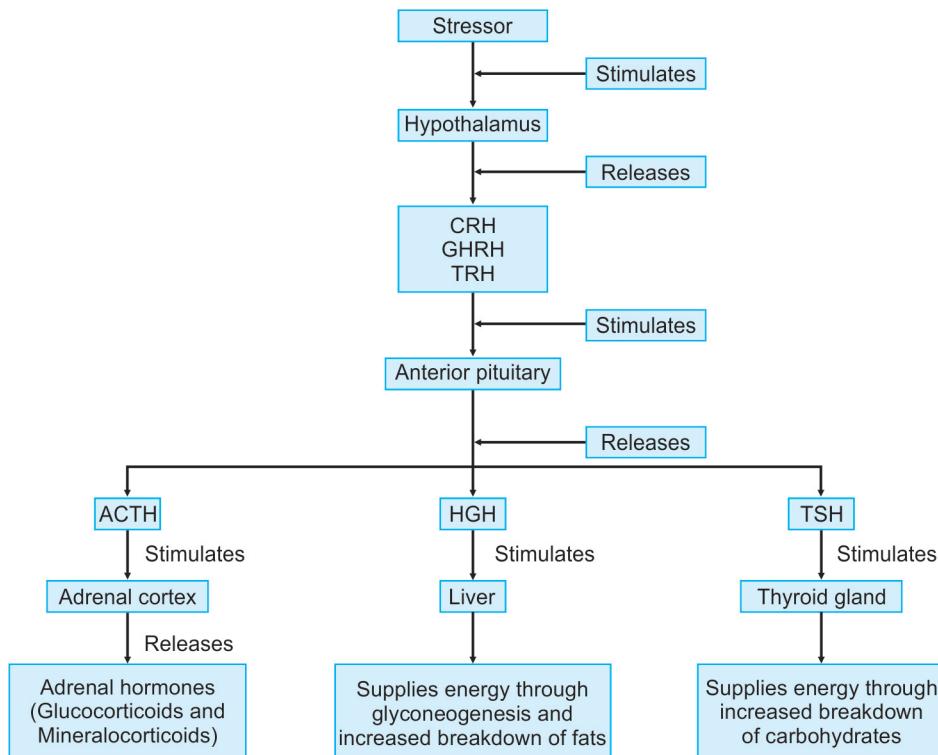


Fig. 13.3: Diagrammatic representation of resistance reaction

Abbreviations: CRH, corticotropin releasing hormone; GHRH, Growth hormone-releasing hormone; TRH, thyrotropin releasing hormone; ACTH, adrenocorticotrophic hormone; HGH, human growth hormone; TSH, Thyroid stimulating hormone

reaction puts heavy demand on the body, particularly on the heart, blood vessels and adrenal cortex, which may suddenly fail under the strain. In this respect, ability to handle stressors is determined to a large extent by the general health.

Transaction-Based Model

Transactional theories of stress are based on the work of Lazarus (1966). The Lazarus transactional stress theory encompasses a set of cognitive, affective and adaptive (coping) responses that arise out of person-environment transactions. The person and the environment are inseparable; each affects and is affected by the other. The individual responds to perceived environmental changes by adaptive or coping response.

Lazarus recognizes that certain environmental demands and pressures produce stress in substantial number of people. He emphasizes that people and groups differ in their sensitivity and vulnerability to certain types of events, as well as in their interpretations and reactions. For example, in terms of illness, one person may respond with denial, another with anxiety and still another with depression. To explain variations among individuals under comparable conditions, the Lazarus model takes into account cognitive processes that intervene between the encounter and the reaction and the factors that affect the nature of this process.

COPING RESOURCES

Social and emotional support available to the person helps him/her to effectively cope with stress. Persons maintaining close interpersonal relationship (IPR) with friends and families are able to use more adaptive strategies. Social support includes both material support (providing resources) and emotional support (listening to the person and encouraging him/her).

COPING MECHANISMS

The term coping is used to refer to the process by which a person attempts to manage stressful demands. It takes two major forms. A person can focus on the specific problem or situation that has arisen, trying to find some way of changing it or avoiding it in the future, this is called problem focused coping. Problem focused coping strategy helps to resolve or change a person's behavior or situation or manage life stressors. These are:

1. Learning problem solving methods
2. Applying the process to identified problems
3. Role playing interactions with others

A person can also focus on alleviating the emotions associated with the stressful situation, even if the situation itself cannot be changed. This is called emotion-focused coping. Emotion-focused coping strategies help persons relax and reduce feelings of stress. These include progressive relaxation, deep breathing, guided imagery and distractions such as music or other activities.

Coping strategies generally fall into four categories. When the problem is solved in a rational and productive way and the anxiety is reduced it is said to be adaptive. If the solution temporarily relieves the anxiety, but the problem still exists and must be dealt with again at a later time, such coping is termed as palliative. These two types of coping usually result in a positive outcome.

If unsuccessful attempts are made to decrease the anxiety without attempting to solve the problem, coping strategies are maladaptive and anxiety remains. The individual who does not attempt to reduce the anxiety or solve the problem is considered to have dysfunctional management of the stressor and the emotional response.

Coping strategies are learned by observation of those who model them in family and social environment. Nurses have a major role in helping patients with stress to cope more effectively. The major role of a psychiatric nurse is to help patients learn or regain highly

Box 13.1: Common adaptive coping techniques

- » Problem solving
- » Assertiveness
- » Positive self-talk and self acceptance
- » Stress and anger management
- » Learning skills needed for communication and relationships
- » Conflict resolution
- » Time management
- » Community living skills

effective coping strategies and avoid ineffective or destructive strategies (Box 13.1).

Strategies that temporarily decrease the effects of anxiety are:

- Visualization, guided imagery, prayer and meditation
- Concentrating on breathing and striving for slow, long, deep breathing
- Relaxation training for decreasing tension and increasing muscle relaxation
- Engaging in yoga, adopting a healthy lifestyle, such as balanced diet, quality sleep and exercise routine
- Avoiding smoking, alcohol and other substances
- Decreasing unhealthy and self destructive behaviors or coping, such as avoidance of issues
- Spending time with caring, supportive and optimistic people for social support
- Reducing competing activities
- Engaging in personal growth activities and increasing self awareness
- Listening to music
- Using cognitive restructuring to decrease a negative view of self others, problems and life; replacing these with affirming positive and empowering thoughts.

GRIEF

Grief is a reaction of an individual to a significant loss. Shock, disbelief, anger, resentment

and depression are common features in affected individuals.

Grief is defined as the emotional process of coping with a loss. The reality of loss can be applied to the absence of anything that is significant or meaningful to our existence. This can include death of a loved one, a separation or divorce, loss of a body part, loss of a job and losses that result from a natural or imposed disaster.

All of these events or circumstances may leave the person with a sense of emptiness, hopelessness and detachment from the meaning that previously was found in life. The extent to which emotional energy was previously invested in these objects, persons, and relationships will determine the intensity with which an individual responds to the absence of that object.

Anticipatory grief may be seen in individuals and families who are expecting a major loss in the near future. *Conventional grief* is primarily associated with the grief that is experienced following a loss. This process of bereavement or adapting to loss may take days, weeks or years, depending on the sense of loss for the person involved. Each person responds to loss in a unique way. This response is based on the person's level of development, past experiences and current coping strategies.

Grief also manifests myriad physiologic and psychologic responses (Table 13.1).

THEORIES OF GRIEF

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

Stage I—Denial: This is a stage of shock and disbelief. The response may be “No, it can’t be true!” Denial is a protective mechanism that allows the individual to cope within

Table 13.1: Physiologic and psychologic responses to grief

Physiological responses to grief	Psychological responses to grief
Crying	Intense loneliness and sadness
Sighing respirations	Anxiety or panic episodes
Shortness of breath, palpitations	Difficulty concentrating and focusing
Fatigue, weakness, exhaustion	Disorientation
Insomnia	Anger
Loss of appetite	Ambivalence and low self-esteem (may be warning of possible suicidality and need for professional help)
Choking sensation	
Tightness in chest	
Gastrointestinal disturbances	

an immediate time-frame while organizing more effective defense strategies (Fig. 13.4A).

Stage II—Anger: “Why me?” and “It is not fair!” are comments often expressed during the anger stage. Anger may be directed at self or displaced on loved ones, caregivers, and even God. There may be a preoccupation with an idealized image of the lost entity (Fig. 13.4B).

Stage III—Bargaining: “If God will help me through this, I promise I will go to church every Sunday and volunteer my time to help others.” During this stage, which is generally not visible or evident to others, a bargain is made with God in an attempt to reverse or postpone the loss (Fig. 13.4C).

Stage IV—Depression: During this stage, the full impact of the loss is experienced. This is a time of quiet desperation and disengagement from all associations with the lost entity (Fig. 13.4D).

Stage V—Acceptance: The final stage brings a feeling of peace regarding the loss that has occurred. Focus is on the reality of the loss and its meaning for the individuals affected by it (Fig. 13.4E).

All individuals do not experience each of these stages in response to a loss, nor do they necessarily experience them in this order. Some individuals grieving behavior may

fluctuate, and even overlap between stages.

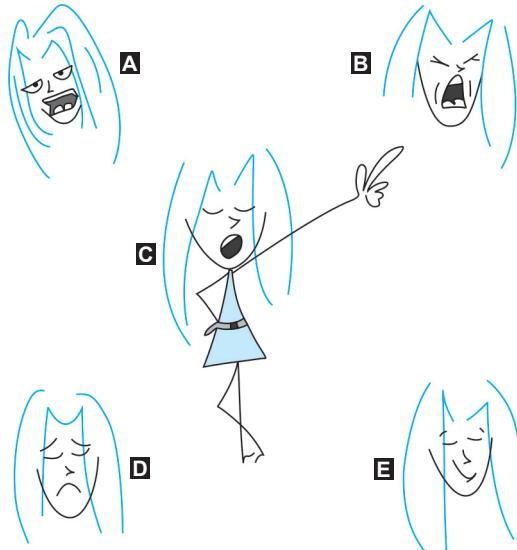
John Bowlby hypothesized four stages in the grief process. He implies that these behaviors can be observed in all individuals who have experienced the loss of something or someone of value—even in infants as young as 6 months of age.

- Stage 1: Numbness or protest
- Stage 2: Disequilibrium
- Stage 3: Disorganization
- Stage 4: Reorganization

Worden views the bereaved as active and self-determining rather than passive participants in the grief process. He proposes that bereavement includes a set of tasks that must be reconciled in order to complete the grief process. Worden’s four tasks of mourning includes accepting the reality of loss, working through the pain of grief, adjusting to an environment that has changed because of the loss, emotionally relocating that which has been lost and moving on with life.

GRIEF PROCESS

The grieving process describes a series of occurrences in the resolution of loss. This process provides support as an individual works through the feelings of anger, hopelessness and futility that accompany loss. It provides time to put things into perspective, to place into memory that which



Figs 13.4A to E: Five stages of grief. (A) Denial; (B) Anger; (C) Bargaining; (D) Depression; and (E) Acceptance

is gone, and to embrace life. Growth occurs as the bereaved person comes to the point of letting off the past. This does not reduce the importance of the loss but allows the person to continue living with a new perspective. This acceptance indicates that the grief process is coming to a close.

Resolution of Grief

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

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

- If the relationship with the lost entity had been marked by ambivalence, reaction to the loss may be burdened with guilt, which

lengthens the grief reaction

- In anticipatory grief where a loss is anticipated, individuals often begin the work of grieving before the actual loss occurs. Most people experience the grieving behavior once the actual loss occurs, but having this time to prepare for the loss can facilitate the process of mourning, actually decreasing the length and intensity of the response
- The number of recent losses experienced by an individual also affects the length of the grieving process and whether he is able to complete one grieving process before another loss occurs.

Maladaptive Grief Responses

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

These are prolonged, delayed/inhibited, and distorted responses.

Prolonged Response

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

Delayed or Inhibited Response

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

Distorted Response

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

Management and Treatment

Management

- Evaluation to find out any primary psychiatric disorder
- Patient is encouraged to talk about his feelings concerning the deceased in a private room
- Reassurance is given that this is a normal process and will subside on its own
- If necessary, refer to psychiatric services.

Treatment

Normal grief does not require any treatment while complicated grief requires medication

depending on the prevailing behavior responses.

Nursing Intervention

- Provide an open accepting environment
- Encourage ventilation of feelings and listen actively
- Provide various diversional activities
- Provide teaching about common symptoms of grief
- Reinforce goal-directed activities
- Bring together similar aggrieved persons, to encourage communication, share experiences of the loss and to offer companionship, social and emotional support
- Assist patient to identify ambivalent feelings of guilt or anger towards loss of object
- Assist in developing positive methods of coping with the loss
- Provide positive feedback for use of effective coping strategies
- Encourage patient to utilize family, religious or cultural supports that provide a meaning for the patient
- Encourage participation in group activities.

PRINCIPLES OF COUNSELING

Counseling is a form of supportive psychotherapy in which the nurse and other qualified professionals such as licensed mental health counselors, offer guidance or assist the patient in viewing options to problems that are discussed by the patient in the context of the nurse-patient relationship (ANA, 2000).

The commonly used principles are:

Respect: Counselor's ability lies in communicating to the patient the belief that every person possesses an inherent strength and capacity, the right to choose his own alternatives and make his own decisions.

Authenticity: Counselor should have genuineness, honesty and simplicity and avoid superiority feeling.

Non-possessive warmth: Demonstration of concern, interest and value for others and a deep concern for the well-being of the other person.

Non-judgmental attitude: Avoid bias, making assumptions or judgments about the patient.

Accurate understanding of the patient: It includes precise evaluation of the perceptual and cognitive behavior of the individual.

Recognizing the patient's potential: Recognizing the strengths and abilities of the patient.

Confidentiality: Maintain confidentiality and develop trust. Avoid revealing patient's identity, personal details and other information without consent. Assure confidentiality to the patient.

TECHNIQUES OF COUNSELING

Many counseling techniques are used to help a person who is in distress. Brief problem focused therapy works on solving the immediate problem (Box 13.2).

Active listening: It is an active process of receiving information. Responses on the part of the nurse such as maintaining eye-to-eye contact, nodding, gesturing and other forms of receptive non-verbal communication convey to the patient that he is being listened to and understood. This type of interaction allows the person to express feelings and thoughts without fear of being judged or criticized.

Box 13.2: Techniques of counseling

- » Active listening
- » Exploring
- » Encouraging
- » Reinforcing new ways of coping
- » Linking the patient to a larger supportive social network
- » Empathy
- » Clarification

For example, face the patient; maintain eye contact; be open, alert and patient; respond appropriately.

Exploring: Delving further into a subject or idea. For example, "tell me more about that, would you describe it more fully?"

Encouraging description of perceptions: Asking for a patient's view on his situation. For example, "What do you think is happening to you right now?"

Reinforcement: Giving feedback on positive behaviors. For example, "This new approach worked for you. Keep it up."

Linking the patient to a larger supportive social network: Getting support from significant others. Persons who suffer from emotional problems most of the time feel lonely, unheard by others and helpless. During counseling, get the family members and friends support to the person. They can interact with him, empathize with him and get involved in solving his problems.

Empathy: Recognizing and acknowledging patient's feelings. For example, "I can hear how painful it is for you to talk about this."

Clarification: Asking person to restate, elaborate or give examples of ideas or feelings. For example, "what do you mean by feeling sick inside? Give me an example of feeling 'lost'.

CRISIS AND CRISIS PRONENESS

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

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

Definition

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

Crisis Proneness

Hendricks (1985) suggests that certain individuals are more prone to crisis than others. For list of characteristics often found in individuals who are regarded as being more susceptible to crisis (Box 13.3).

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

Box 13.3: Crisis proneness characteristics

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

Types of Crisis

Matuatorial Crisis

A matuatorial crisis is a stage in a person's life where adjustment and adaptation to new responsibilities and life patterns are necessary.

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

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

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

Situational Crisis

A situational crisis is one that is precipitated by an unanticipated stressful event that creates disequilibrium by threatening one's sense of biological, social or psychological integrity. Examples of events that can precipitate situational crises are premature birth, status and role changes, death of a loved one, physical or mental illness, divorce, change in geographic location and poor performance in school.

Social Crisis

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

Because of the severity of the effects of social crisis, coping strategies may not be

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

Phases of Crisis

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

Phase I

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

Phase II

The ineffectiveness of the Phase I coping mechanisms leads to further disorganization. The individual experiences a sense of vulnerability. The individual may attempt to cope with the situation in a random fashion. If the anxiety continues and there is no reduction, the individual enters phase III.

Phase III

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

Phase IV

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

Signs and Symptoms of Crisis

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

Process of Crisis (Resolution of Crisis)

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

1. Realistic appraisal of the precipitating event, i.e. recognition of the relationship between the event and feelings of anxiety is necessary for effective problem-solving to occur.
2. Availability of support systems.
3. Availability of coping measures over a lifetime: A person develops a repertoire of successful coping strategies that enable him to identify and resolve stressful situations.

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

Pseudo-resolution

In this, the individual uses repression and pushes out of consciousness the incident and the intense emotions associated with it, resulting in the individual functioning at the same earlier level. But in future, if and when a crisis occurs, the repressed feelings may surface and influence the feelings aroused by the new crisis. In such a situation, the particular crisis may be more difficult to resolve because the feelings associated with the earlier crisis are neither expressed nor handled at that time.

Unsuccessful Resolution

In this, the victim uses pathological adaptation at any phase of crisis, resulting in a lower

level of functioning. The victim, rather than accepting the loss and reorganizing his life, keeps ruminating over the loss. An example is prolonged grief reaction, which results in depression.

Successful Resolution

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

CRISIS INTERVENTION

Crisis intervention is a technique used to help an individual or family to understand and cope with the intense feelings that are typical of a crisis. Nurses function as part of the inter-disciplinary team in the use of crisis intervention as a therapeutic modality. Nurses may employ crisis techniques in their work with high-risk groups such as patients with chronic diseases, new parents and bereaved persons. Nurses may also use crisis intervention in dealing with intra-group staff issues and patient management issues.

Aims of Crisis Intervention

Technique

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

Intervention

Steps to Provide a Correct Cognitive Perception

Assessment of the situation

- This may be achieved by direct questioning with the purpose of identification of the problem and the people involved.

- It is necessary to identify the support systems available and to know the depth in which the individual's feelings are affected.
- Assessment should also be done to identify the strengths and limitations of the victim.

Defining the event

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

Develop a plan of action

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

Steps to Assist the Victim in managing the Intense Feelings

Helping the individual to be aware of the feelings

- The victim needs help in identifying his own feelings, which is the first step in handling them.
- The therapist should use appropriate communication technique so that the victim will be comfortable expressing his feelings without the fear of being judged or criticized.

- The therapist should also be efficient in observing verbal and non-verbal behavior of the victim, so that he will be able to make a careful assessment of his feelings.

Help the individual to attain mastery over the feelings

- The individual should be given adequate support and guidance through therapeutic process in order to handle feelings associated with crisis but special care should be taken not to give any false reassurance.
- He should not in any way be encouraged to blame others, as this will only let him escape from taking any responsibility.
- Care must be taken to ensure that the individual does not develop too much dependence on the therapist, which is unhealthy.
- After the victim and the support groups prepare the plan of action under the guidance of the therapist, it should be discussed with the victim and the concerned others, so that they will have a clear understanding of the methods of implementation of the plan.
- To improve coping with the situation necessary environmental manipulation must be done in physical or interpersonal areas.
- It is advisable to have another appointment for the victim to visit the therapist within a week, in order to assess how the plan is working out, and if needed, to revise and modify the plan.

Principles of Crisis Intervention

- Be specific, use concise statements, and avoid overwhelming the patient with irrelevant questions or excessive detail
- Encourage the expression of feelings
- A calm, controlled presence reassures the person that the nurse can help
- Listen for facts and feelings: seeking clarification, paraphrasing and reflection are effective strategies

- Allow sufficient time for the individuals involved to process information and ask questions
- Help patients legitimize feelings by letting them know that others in similar situations have experienced comparable emotions
- Clarify distortions by getting persons to look at the situation realistically, focus on what can be changed versus what cannot
- Empower person by allowing them to make informed choices
- Assist the person in confronting reality
- Encourage the person to focus on one implication at a time.

Techniques of Crisis Intervention

- Catharsis:** The release of feelings that takes place as the patient talks about emotionally charged areas.
- Clarification:** Encouraging the patient to express more clearly the relationship between certain events.
- Manipulation:** Using the patient's emotions, wishes or values to benefit the patient in the therapeutic process.
- Reinforcement of behavior:** Giving the patient positive reinforcement to adaptive behavior.
- Support of defenses:** Encouraging the use of healthy, adaptive defenses and discouraging those that are unhealthy or maladaptive.
- Increasing self-esteem:** Helping the patient to regain feelings of self worth.
- Exploration of solutions:** Examining alternative ways of solving the immediate problem.

GERIATRIC CONSIDERATIONS

Older persons who were most successful at adapting to losses earlier in life will cope more adaptively with the losses and grief inherent in

aging. The elderly persons who experienced more losses are unable to complete the grief process resulting in bereavement overload. Such people are less able to adapt and re-integrate physical and mental health and are prone to depressive disorders.

ROLE OF A NURSE IN CRISIS INTERVENTION

Nurses respond to crisis situations on a daily basis. Crisis can occur in any unit, e.g. in general hospitals, home settings, community health centers, schools, offices, and in private practice. Indeed, nurses may be called upon to function as crisis helpers in any situation.

Knowledge of crisis intervention techniques is thus an important clinical skill of all nurses, regardless of the setting or practice specialty.

Nursing Assessment

The first step of crisis intervention is assessment. During this phase, the nurse collects data regarding the following factors:

- Precipitating event or stressor
- Patient's perception of the event or stressor
- Nature and strength of the patient's support systems, coping resources
- Level of psychological stress patient is suffering from and the degree of impairment he is experiencing
- Patient's previous strengths and coping mechanisms.

During this phase, the nurse begins to establish a positive working relationship with the patient.

Nursing Diagnoses

The primary nursing diagnoses in crisis intervention are:

- Ineffective individual coping
- Ineffective family coping
- Dysfunctional family process

- Post-trauma response

- Ineffective individual coping refers to the inability to ask for help, problem solving or meet role expectations.
- Ineffective family coping occurs when the family's support systems are not successful and family's economic or social well being is threatened.
- Altered family processes result when family members are unable to adapt to the traumatic experience constructively.
- Post-traumatic response is a sustained painful response to an overwhelming traumatic event.

Planning

In planning, the previously collected data is analyzed and specific interventions are proposed. During this phase the nurse undertakes the following activities:

- Dynamics underlying the present crisis are formulated
- Alternative solutions to the problem are explored
- Steps for achieving the solutions are identified
- Environmental support needed to help the patient is decided upon, coping mechanisms that need to be developed and those which need to be strengthened are identified.

Implementation

The following interventions are carried out to resolve crisis:

Environmental Manipulation

Environmental manipulation includes interventions that directly change the patient's physical or interpersonal situation. These interventions may remove stress or provide situational support. For example, a patient having difficulty in his job may take a week of sick leave so that he can be temporarily removed from that stress situation.

General Support

The nurse uses warmth, acceptance, empathy and reassurance to provide general support to the patient.

Generic Approach

The generic approach is designed to reach high risk individuals and large groups as quickly as possible. It applies a specific method to all individuals faced with a similar type of crisis (for example, in social disasters). Debriefing is a method of generic approach. In debriefing method, disaster victims are helped to recall events and clarify traumatic experiences. It attempts to place the traumatic event in perspective, allows the individual to relive the event in a factual way, encourages group support, and provides information on normal reaction to critical events. The goal of debriefing is to prevent the maladaptive responses that may result if the trauma is suppressed.

Individual Approach

The individual approach is a type of crisis intervention similar to the diagnosis and treatment of a specific problem in a specific patient. It is particularly useful in combined situational and maturational crises and also beneficial when symptoms include homicidal and suicidal risk. The nurse must use the intervention that is most likely to help the patient develop an adaptive response to the crisis.

Evaluation

The nurse and patient review the changes that have occurred. The nurse should give credit for successful changes to patients so that they realize their effectiveness and understand that what they learnt from crisis may help in coping with future crisis. If the goals have not been met, the patient and nurse can return

to the first step-assessment and continue through the phases again.

MODALITIES OF CRISIS INTERVENTION

Community-based crisis intervention modalities have recently been developed. They are based on the philosophy that the health, care team must be active and go out to the patients rather than wait for the patients to come to them. Nurses working in these modalities intervene in a variety of community settings, ranging from patient's home to street corners.

Mobile Crisis Programs

Mobile crisis teams provide front-line interdisciplinary crisis intervention to individuals, families and communities. The nurse, who is a member of a mobile crisis team, should be able to provide on-site assessment, crisis management, treatment, referral and educational services to patients, families and the community at large. Nurses are, thus, able to ensure mental healthcare for even the most underserved populations efficiently and cost effectively.

Telephone Contacts

Crisis intervention is sometimes practiced over telephone rather than through face-to-face contacts. The nurse should have effective listening skills to provide crisis intervention to victims.

Group Work

People who have common traits on stressors will form a group. The group provides an opportunity for members to express common concerns and experiences, foster hope and build mutual support. The nurse's role in the group is active, focal and focused on the present. The nurse and the group help the

patient solve the problem and reinforce new problem solving behavior.

Disaster Response

As part of the community, nurses are called on when an adventitious or social crisis strikes the community. Floods, earthquakes, airplane crashes, fires, nuclear accidents, etc. precipitate large number of crises. The nurse has an important role in dealing with psychosocial problems of disaster victims. The nurse participates in crisis operations and acts as a case-finder for persons suffering from psychosocial stress. It is important that nurses in the immediate post disaster period go to places where victims are likely to gather, such as hospitals, shelters, morgues. During this period, nurses use the generic approach of crisis intervention so that as many people as possible can receive help in a short duration of time.

Victim Outreach Programs

Victim outreach programs use crisis intervention techniques to identify the needs of victims and then to connect them with appropriate referrals and other resources.

Nurses often work in victim outreach programs, where victims are often seen immediately after the crisis. These victims need thorough evaluation, empathic support, and information and help with the large system and social networking system.

Crisis Intervention Centers

Crisis intervention centers provide emergency psychiatric care and counseling to victims, experiencing extreme stress or conflict, often involving suicide attempts or drug or alcohol abuse. These centers, which are usually self-contained units within a hospital or community healthcare center, provide services 24 hours a day. The services may be delivered directly on the premises, or counseling may

be provided over the telephone. The primary objective of crisis intervention centers is to help the person cope with immediate problem and to offer guidance and support for long-term therapy.

Health Education

Nurses are involved in identifying people who are at high-risk for developing crisis and in teaching coping strategies to avoid the development of crisis. The public also needs education so that they can identify those needing crisis services, be aware of available services, change their attitude so that people will feel free to seek services, and obtain information about how others deal with potential crisis producing problems.

REVIEW QUESTIONS

Long Essays

1. List the common psychiatric emergencies. Describe nursing management for a suicidal patient.
2. Explain management of aggressive patient.
3. Role of a nurse in crisis intervention.

Short Essays

1. Suicidal risk
2. Suicide prevention
3. Grief process
4. What is normal grief reaction?
5. General adaptation syndrome
6. Describe coping strategies
7. Principles of counseling
8. Modalities of crisis intervention.

Short Answers

1. Stages of grief
2. Definition and types of crisis
3. Bereavement
4. Maturational crisis
5. Techniques of crisis intervention.

MULTIPLE CHOICE QUESTIONS

1. Following are the initial approaches during a psychiatric emergency, except:

- a. Quick evaluation to identify the condition
- b. Initial approach should be warm and direct
- c. Hospital security should be adequate to control violent patients
- d. Initial focus should be on control of emotions

2. All are psychiatric emergencies, except:

- a. Major depression with suicidal attempt
- b. Manic excitement
- c. Chronic schizophrenia with blunt affect
- d. Alcohol intoxication

3. While planning nursing process for a patient who is at risk for suicide, which of the following is a priority area for providing care?

- a. Sleep
- b. Nutrition
- c. Self-esteem
- d. Safety

4. Which one of the following is a commonest condition associated with high risk of suicide?

- a. Hypomania
- b. Major depression
- c. Chronic schizophrenia
- d. Drug abuse

5. In major depressive patients, which of the following is a risk factor for suicide tendency?

- a. Psychomotor retardation
- b. Pessimistic cognition
- c. Stress from the situation
- d. Drug-induced sedation

6. In schizophrenia patients which of the following is a risk factor for suicide tendency?

- a. Unable to control drug side effects

- b. Poor social support
- c. Lack of understanding about disease
- d. Associated depression

7. In mania patients, which of the following is a risk factor for suicide tendency?

- a. Hyperactive behavior
- b. Grandiose ideas
- c. Poor social support
- d. Stress from the situation

8. Following are all signs of suicide tendencies, except:

- a. Expressing suicidal ideas
- b. Writing farewell letters
- c. Appearing peaceful and happy
- d. Eating adequate food and having adequate sleep

9. Nursing intervention that is appropriate for a patient who is suicidal is:

- a. Report to the unit doctor
- b. Ignore patient's suicidal comments
- c. Reassure the patient that suicidal thoughts will be reduced
- d. Teach healthier problem solving skills

10. Patient tells you that "I am just a burden, everyone will be happy if I die", nurse is aware that:

- a. Suicide talk is an attention-getting tool
- b. Suicide is an impulse act, it is not thought out
- c. Suicidal talk or ideation can lead to suicide behavior
- d. Suicidal people seldom really attempt suicide

11. Which methods would a nurse use to determine a patient's potential risk for suicide?

- a. Do not focus much on suicidal ideations
- b. Question the patient directly on suicidal thoughts
- c. Divert the patient's mind by asking future plans
- d. Continuously observing the patient behavior for cues of suicide ideation

- 12. Nursing supervisor tells you that, Ms. Uma must be placed on suicide precaution. The first intervention you begin is:**
- Place Ms Uma in a locked room
 - Begin one-to-one observation at least every 15 minutes
 - Allow Ms Uma to do whatever she wants to
 - Isolate Ms Uma from others
- 13. The following disorders contribute to aggressive behavior in a patient, except:**
- Delirium
 - Acute Mania episode
 - Agitated depression
 - Generalized anxiety disorder
- 14. Following are all appropriate nursing interventions for aggressive patients, except:**
- Encourage the patient to talk out his aggressive feelings
 - Keep environmental stimuli to a minimum
 - Use punishment strategies
 - Remove hazardous objects and substances from the patient vicinity
- 15. A 20-year-old female is sexually assaulted on her way back home. Rape is an example of:**
- Situational crisis
 - Matuational crisis
 - Social crisis
 - Adventitious crisis
- 16. The primary goal of crisis intervention is to:**
- Help the patient express his/her feelings
 - Identify stressors
 - Help the patient return to pre-crisis level
 - Support the family members
- 17. Unanticipated stressful event leads to a _____ crisis:**
- Matuational
- 18. Retirement is a _____ crisis.**
- Matuational
 - Situational
 - Social
 - Multiple
- 19. Floods are an example of _____ crisis.**
- Matuational
 - Situational
 - Social
 - Multiple
- 20. Healthy resolution of crisis depends upon all of the following factors, except:**
- Realistic appraisal of the precipitating event
 - Availability of support system
 - Availability of adaptive coping measures
 - Availability of medical facilities
- 21. As per Caplan, which of the following phase is associated with successful crisis resolution?**
- Phase 1
 - Phase 2
 - Phase 3
 - Phase 4
- 22. Prolonged grief reaction is an example of:**
- Pseudo-resolution of crisis
 - Unsuccessful resolution of crisis
 - Successful resolution of crisis
 - Pathological resolution of crisis
- 23. Which of the following nursing intervention is more appropriate to provide a correct cognitive perception of the situation to a crisis patient?**
- Assessment of the situation
 - Defining the problem
 - Develop a plan of action
 - All of the above

- 24. Which of the following nursing intervention assists the crisis victim in managing the intense feelings?**
- Help the victim to identify his own feelings
 - Develop a plan of action
 - Provide health education
 - Encourage the victim to focus on one problem at a time
- 25. The most important assessment data for the nurse to gather from a patient in crisis would be:**
- Eating habits
 - Strength and limitations
 - Work habits
 - Economical background
- 26. Which factors are most essential for the nurse to assess when providing crisis intervention for a patient?**
- Anxiety level
 - Communication and coping skills
 - Patient's perception of triggering event and availability of resources
 - Level of depression
- 27. The General Adaptation Syndrome (GAS) was described by:**
- Hans Selye
 - Hull
- 28. GAS is a response to:**
- Poor intelligence
 - Wrong perception
 - Stress
 - Poor nutrition
- 29. The set of reactions occurring as a result of the first stage of GAS can be termed as:**
- Resistance reaction
 - Exhaustion reaction
 - Stress reaction
 - Fight or flight response
- 30. The stages of General Adaptation Syndrome progress in the following stages:**
- Resistance - exhaustion - alarm
 - Alarm - exhaustion - resistance
 - Alarm - resistance - exhaustion
 - Exhaustion - alarm - resistance
- 31. Which of the following is the first step in counseling?**
- Developing insight into the problem
 - Collecting data from client
 - Establishing rapport with the client
 - Encourage the client to ventilate his problems.

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. d | 2. c | 3. d | 4. b | 5. b | 6. d | 7. b | 8. d | 9. d | 10. c |
| 11. b | 12. b | 13. d | 14. c | 15. a | 16. c | 17. b | 18. a | 19. c | 20. d |
| 21. c | 22. b | 23. d | 24. a | 25. b | 26. c | 27. a | 28. c | 29. d | 30. c |
| 31. c | | | | | | | | | |

Chapter 14

Legal Issues in Mental Health Nursing

THE INDIAN MENTAL HEALTH ACT (1987) – SECTIONS AND THEIR IMPLICATIONS

History

The Indian Mental Health Act (MHA) was drafted by the parliament in 1987, but it came into effect in all the States and Union Territories of India in April 1993. This Act replaces the Indian Lunacy Act of 1912.

Reasons for Enactment

1. The attitude of the society towards the mentally ill has changed considerably and it is now realized that no stigma should be attached to such illness, as it is curable practically when diagnosed at an early stage. Thus, the mentally ill individuals should be treated like any other sick persons and the environment around them made as normal as possible.
2. The experience of working of the Indian Lunacy Act, 1912 has revealed that it has become outmoded with the rapid advancement of medical science and the understanding of nature of malady. It has, therefore become necessary to make fresh legislation in accordance with the new approach.

Objectives of the Indian Mental Health Act

- To regulate admission into psychiatric hospitals and psychiatric nursing homes
- To protect society from the presence of mentally ill persons
- To protect citizens from being detained in psychiatric hospitals/nursing homes without sufficient cause
- To regulate maintenance charges of psychiatric hospitals/nursing homes
- To provide facilities for establishing guardianship of mentally ill persons who are incapable of managing their own affairs
- To establish central and state authorities for mental health services
- To regulate the powers of the government for establishing, licensing and controlling psychiatric hospitals/nursing homes
- To provide legal aid to mentally ill persons at state expense in certain cases.

Salient Features of the Act

The Act is divided into 10 Chapters consisting of 98 sections.

CHAPTER I

It contains preliminary information. Some definitions included in this are:

- Psychiatric hospital/Nursing home:** A hospital/nursing home established or maintained by the Government or any other person for the care of mentally ill persons.
- Mentally ill person:** A person who is in need of treatment by reason of any mental disorder other than mental retardation.
- Psychiatrist:** A medical practitioner possessing a postgraduate degree or diploma in psychiatry recognized by the MCI (Medical Council of India).
- Reception order:** An order made under the provisions of this Act for the admission and detention of a mentally ill person in a psychiatric hospital/nursing home.

Outdated definitions are changed based on newer concepts and knowledge.

<i>Old term</i>	<i>New term</i>
• Lunatic	• Mentally ill person
• Lunatic asylum	• Psychiatric hospital
• Criminal lunatic	• Mentally ill prisoner

The term 'psychiatrist' is well-defined.

CHAPTER II

It deals with establishment of Central and State authorities for regulation and coordination of mental health services.

CHAPTER III

It provides guidelines for establishment and maintenance of psychiatric hospitals/nursing homes.

CHAPTER IV

It deals with the procedures for admission and detention in psychiatric hospitals/nursing homes (Fig. 14.1).

Admission on Voluntary Basis

Any person who considers himself to be mentally ill and wishes to be admitted to a psychiatric hospital may apply to the medical officer-in-charge; if he is a minor, the guardian can make this application on his behalf.

The medical officer should make inquiry within 24 hours and should admit the patient if he opines that treatment is required. The voluntary patient thus admitted is now bound to abide by the rules made by the institution (Box 14.1).

Admission under Special Circumstances (Involuntary Patient)

Any mentally ill patient who is unwilling for admission on a voluntary basis may

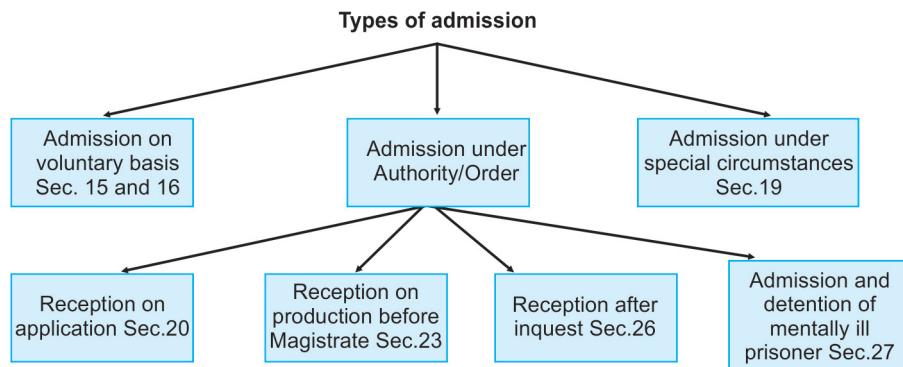
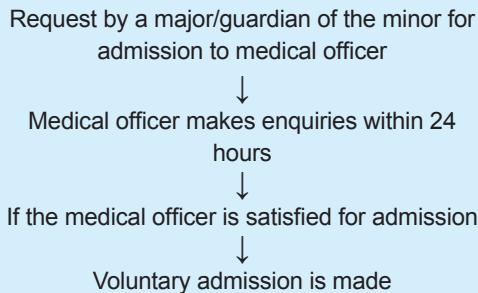


Fig. 14.1: Types of admission and related sections

Box 14.1: Admission on voluntary basis

be admitted and kept as an inpatient in a psychiatric hospital/nursing home. For such purpose an application should be made out on his/her behalf by a relative or a friend of the mentally ill person, provided the medical officer deems fit (Box 14.2).

Admission under Authority or Order

Any mentally ill person can be admitted and detained at a psychiatric hospital or psychiatric nursing home in accordance with

an order passed by the court of law or an approved authority (Fig. 14.2). The authority can pass an order for reception and detention mainly under four different categories, which include:

1. Reception order on application.
2. Reception order on production of a mentally ill person before a magistrate.
3. Reception order after inquest.
4. Admission and detention of a mentally ill prisoner.

Reception order on application: Only a relative not other than husband, wife, guardian or a friend can make out an application for the admission of a mentally ill patient. Such an application should be made out to the magistrate in writing supported by two medical certificates, one of them issued by a gazetted medical officer. However, no person being a minor or one who has not seen the mentally ill patient in the last 14 days can make such an application. The patient may now be admitted after the magistrate obtains consent from the medical officer-in-charge of the mental hospital. The medical officer-in-charge can

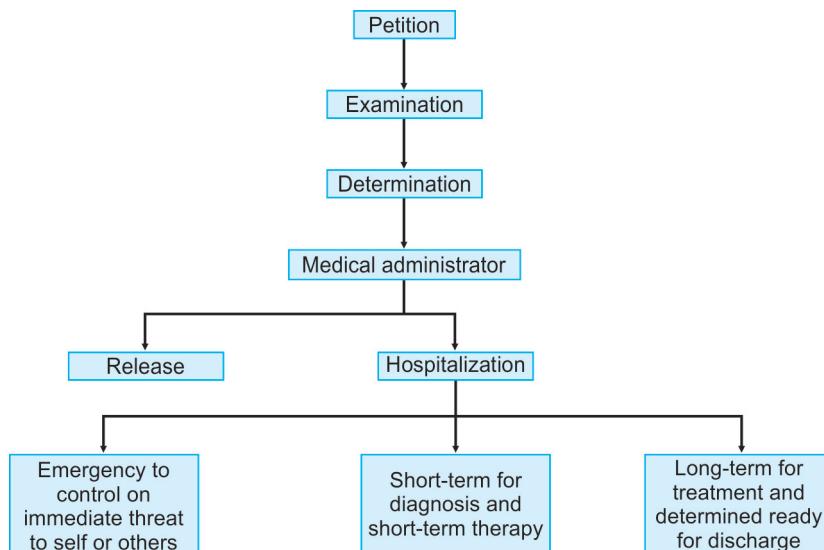
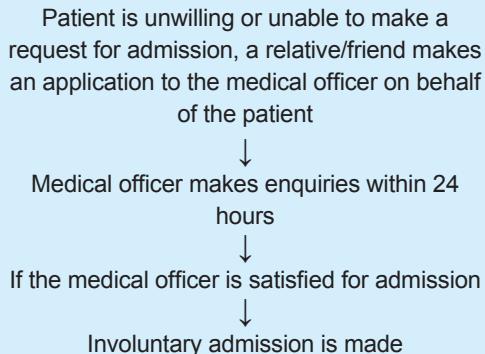
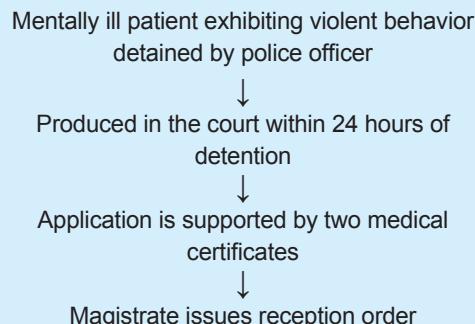


Fig. 14.2: Admission under reception order

Box 14.2: Admission under special circumstances



Box 14.4: Reception order on production before magistrate

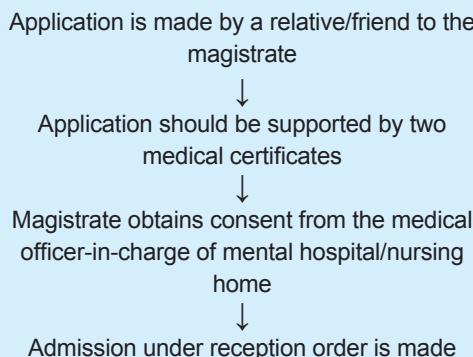


extend inpatient treatment to more than 6 months by making such an application to the magistrate (Box 14.3).

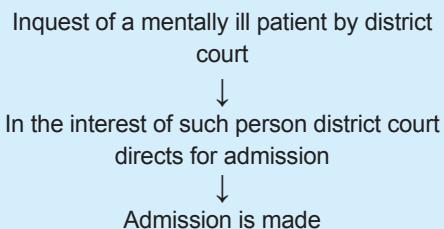
Reception order on production of a mentally ill person before a magistrate: Mentally ill patients exhibiting violent behavior, creating obscene scenes and dangerous to the society can be detained by the police officer and produced in court within 24 hours of such detention, supported by two medical certificates, subsequent to which the magistrate issues a reception order (Box 14.4).

Reception order after inquest: A district court holding an inquisition regarding any

Box 14.3: Reception order on application



Box 14.5: Reception order after inquest



person who is found to be mentally ill, in the interest of such person, may, by order, direct for admission and kept as an in-patient in a psychiatric hospital or psychiatric nursing home. Every such order may be varied from time to time or revoked by the district court (Box 14.5).

Admission and detention of a mentally ill prisoner: A mentally ill prisoner may be admitted into a mental hospital on the order of the presiding officer or a court.

CHAPTER V

It deals mainly with the procedure to be followed for the discharge of mentally ill persons from a mental hospital under different circumstances (Fig. 14.3).

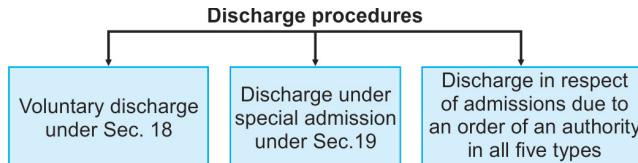


Fig. 14.3: Discharge procedure and related sections

Discharge of a Patient Admitted on Voluntary Basis

Medical officer in-charge of psychiatric hospital/nursing home on recommendation from two medical practitioners preferably a psychiatrist, can issue directions for discharge of the patient.

Discharge of a Patient Admitted under Special Circumstances

A relative or a friend may make an application to the medical officer for care and custody of the patient. The relatives are required to furnish a bond with or without sureties, along with an undertaking that the mentally ill person shall be prevented from causing injury to self or others.

Discharge of a Patient Admitted on Reception Order

An applicant who feels that the patient has recovered from illness may make an application for discharge to the magistrate. A certificate should accompany such as an application from medical officer-in-charge of the psychiatric hospital/nursing home. If the magistrate deems fit, he may issue an order for discharge (Fig. 14.4).

Discharge of a Patient Admitted by Police

In cases where the police detain the mentally ill individual in hospital, he may be discharged after the family members agree in writing to take proper care, and the medical officer-in-charge opines that he is fit to be discharged.

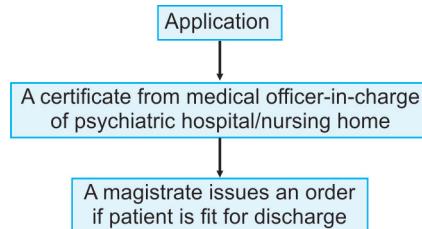


Fig. 14.4: Discharge under reception order

Discharge of a Mentally III Prisoner

The hospital authorities have to report every 6 months about the person's state of mind to the authority which had ordered detention. As soon as they find that the person is fit to stand the trial, they have to inform the same to the authority concerned. The person is then handed over to the prison officer for further legal action.

Leave of Absence (Section 45)

Leave of absence means, when mentally ill patients are detained in a hospital, they may be given time limited leave, to leave the hospital with permission to visit family members. On application by a relative or others to the medical officer-in-charge and a bond duly signed stating that the patient will be taken proper care of and prevented from injuring self or others, leave of absence may be granted (for a period of maximum 60 days). It is a step towards community treatment, enables the patient to retain or obtain skills which will be necessary once the patient is discharged. It is in consonance with the modern trend that the mental illness is

curable and does not need hospitalization for a long period.

CHAPTER VI

It deals with judicial enquiry regarding mentally ill persons possessing property, their custody and management of property. Under section 54(1) a guardian may be appointed by court of law on behalf of an alleged mentally ill person incapable of looking after self and property. Under *section 97* of the Act when a mentally ill person is not represented by a legal practitioner in any proceedings before a District Court or Magistrate and such a patient does not have sufficient means to engage a legal practitioner then the District Court or Magistrate shall assign a legal practitioner to represent him at the expense of the state.

CHAPTER VII

It deals with ways and means to meet the cost of maintenance of mentally ill persons detained in psychiatric hospital/nursing home. Under *section 78* when a mentally ill patient is detained as an inpatient and does not have property to bear the cost of treatment, in such cases his expense shall be borne by the Government of the State.

CHAPTER VIII

It is the latest addition to the Act that contains a very novel and explicit provision for protection of human rights of mentally ill persons. *Section 81* provides that:

1. No mentally ill person shall be subjected during treatment to any indignity (physical or mental) or cruelty.
2. No mentally ill person under treatment shall be used for the purpose of research unless:
 - Such research is of direct benefit to him
 - A consent has been obtained in writing from the person (in voluntary admission) or from the guardian/relative (if admission was involuntary).

3. No letter or communication sent by or to a mentally ill person shall be intercepted, detained or destroyed.

CHAPTER IX

It deals with procedures to be followed for the establishment and maintenance of psychiatric hospitals/nursing homes, and the penalties, which can be relatively severe and explicit, for contravening them. The *Article 6(1)* of the Mental Health Act prohibits the running of a home without license and *Article 11 (1b)* says the licensing authority can revoke the license if the maintenance of the home is being carried out in a manner detrimental to the moral, mental or physical well-being of the inpatients.

CHAPTER X

It deals with clarification pertaining to certain procedures to be followed by the medical officer-in-charge of the psychiatric hospital/nursing home.

Positive Qualities of the MHA 1987

- Incorporates the latest scientific knowledge and social concepts
- An attempt is made to make mental illness look on par with physical illness to reduce stigma
- The definitions are in a progressive way
- The 'treatability' is the essential criterion
- Indian Mental Health Act is not applicable to untreatable conditions, like mental retardation and dementia
- Psychiatric patients admitted in general hospitals or nursing homes are spared
- Formation of mental health authorities provide opportunities for better monitoring of services
- Outpatient services are mandatory in psychiatry hospitals or nursing homes
- Admission procedures are simplified

- Discharge procedures are made easier
- Provision for separate hospitals for children, addicts and psychopaths
- Efforts made to safeguard human rights of mentally ill person.

Nursing Implications

A psychiatric nurse is in the ward 24 hours of the day, and the final responsibility of the ward management is on the nurse. She should, therefore, be well-versed in legal aspects of care and treatment of the mentally ill. This knowledge helps her to guide the patients and relatives in matters related to rights of the patient and other aspects of mental health care. The legal and ethical context of care is important for all psychiatric nurses because it focuses concern on the rights of patients and the quality care they receive. The knowledge of legal aspects enhances the freedom of both the nurse and the patient, informs their ethical decision making, and ultimately results in better care.

Chapter III	It describes the procedure to be followed for administering care, treatment and discharge. The term 'parole' refers to the 'permission given to patients to perform certain rituals or attend certain family functions.' During parole, the patient can leave the hospital any time and can be brought back forcefully if he does not return within a maximum period of 90 days
Chapter IV	It deals with proceedings of lunacy in presidency town
Chapter V	It deals with proceedings in lunacy outside presidency towns
Chapter VI	It deals with establishment of asylums
Chapter VII	It deals with expenses of lunatics
Chapter VIII	It deals with rules to be imposed by the State Government regarding care of lunatics

THE INDIAN LUNACY ACT (1912)

It is derived from English Lunacy Act, 1890 and it contains eight Chapters. Act 4 of Indian Lunacy Act (ILA), 1912, replaced Act 36 of The Indian Lunatic Asylums Act, 1858. It was enacted to govern reception, detention and care of lunatics and their property and to consolidate and amend the laws relating to lunacy. The act was divided into 4 parts and 8 chapters consisting of 100 sections. The enactment of ILA of 1912 was followed by opening of many new asylums, an improvement in the general conditions of asylums, and an increase in awareness regarding the prevailing situation of lunatics in such asylums.

Chapter I	It contains some preliminary information and definitions
Chapter II	It contains mainly the procedure to be followed to admit a psychiatric patient into a mental hospital

THE MENTAL HEALTH CARE BILL, 2013

The Mental Health Care Bill, 2013 was introduced in the Rajya Sabha on August 19, 2013. The Bill abolishes the Mental Health Act, 1987.

Reasons to the Bill

The Government approved the United Nations Convention on the Rights of Persons with Disabilities in 2007. The Convention requires the laws of the country to align with the Convention. The new Bill was introduced as the existing Act does not adequately protect the rights of persons with mental illness nor promotes their access to mental healthcare.

The Key Features of the Bill

- Every person shall have the right to access mental healthcare and treatment from services run or funded by the Government

- A mentally-ill person shall have the right to make an advance directive that states how he wants to be treated for the illness during a mental health situation and who his nominated representative shall be
- Every mental health establishment has to be registered with the relevant Central or State Mental Health Authority. These authorities are in addition responsible for supervising and maintaining a register of all mental health establishments
- The Mental Health Review Commission will be a quasi-judicial body that will periodically review the use of and the procedure for making advance directives and advise the Government on protection of the rights of mentally ill persons
- A person who attempts suicide shall be presumed to be suffering from mental illness at that time and will not be punished under the Indian Penal Code
- Electroconvulsive therapy is allowed only with the use of muscle relaxants and anesthesia. The therapy is prohibited for minors.

Chapters

- Chapter 1 : Preliminary information on definitions, short titles, extent and commencement
- Chapter 2 : Mental illness and capacity to make mental healthcare and treatment decisions
- Chapter 3 : Advance directive
- Chapter 4 : Nominated representative
- Chapter 5 : Rights of persons with mental illness
- Chapter 6 : Duties of appropriate Government
- Chapter 7 : Central mental health authority
- Chapter 8 : State mental health authority
- Chapter 9 : Finance, accounts and audit
- Chapter 10 : Mental health establishments
- Chapter 11 : Mental health review commission
- Chapter 12 : Admission, treatment and discharge

- Chapter 13 : Responsibilities of other agencies
- Chapter 14 : Restriction to discharge functions by professionals not covered by profession
- Chapter 15 : Offences and penalties
- Chapter 16 : Miscellaneous

BASIC RIGHTS OF MENTALLY ILL PATIENTS AND NURSE'S RESPONSIBILITIES

Chapter VIII of Mental Health Act 1987 contains a very novel and explicit provision of protection of human rights. *Universal Declaration of Human Rights (UDHR) in Article 24(1)* explicitly mentions, "Every one has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services." *Article 5 of UDHR* states no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. *Article 66(1) of Persons with Disability Act* states, "The appropriate government and the local authorities shall within the limits of their economic capacity and development undertake or cause to be undertaken rehabilitation of all persons with disabilities." Mental illness is also recognized as disability according to *section 2 of the Person with Disability (PWD) Act, 1995*.

Some of the Rights of Psychiatric Patients

- The right to wear their own clothes
- The right to have individual storage space for their private use
- The right to keep and use their own personal possessions
- The right to spend a sum of their money for their own expenses

- The right to have reasonable access to all communication media like telephone, letter writing and mailing
- The right to see visitors everyday
- The right to treatment in the least restricted setting
- The right to hold civil service status
- The right to refuse electroconvulsive therapy
- The right to manage and dispose of property and execute wills.

Nurse's Implications for Protecting Patient's Rights

Psychiatric patients are often the least capable of protecting their own rights. It is, therefore, one of the responsibilities of the nurse to guide the patients and relatives in matters related to their rights and protect the patient from any mistreatment.

- To protect patient's rights, the nurse should be aware of these rights in the first place.
- She should ensure that ward procedures and policies should not violate patient's rights.
- Discussing these rights with the mental health team and including these rights in the nursing care plan is all part of her responsibility in protecting the patient's rights.

FORENSIC PSYCHIATRY

Forensic psychiatry is the branch of medicine that deals with disorders of the mind and their relation to legal principles. The basic forensic psychiatry includes:

1. Crime and psychiatric disorders
2. Criminal responsibility
3. Civil responsibility
4. Laws relating to psychiatric disorders
5. Admission procedures of patients in a psychiatric hospital
6. Civil rights of the mentally ill
7. Psychiatrists and the court

Crime and Psychiatric Disorders

There are close associations between crime and psychiatric disorders like personality disorder particularly antisocial personality, drug dependence disorders, schizophrenia, affective disorders and epilepsy.

Mentally ill people may commit offence because:

- They do not understand the implication of their behavior
- Due to delusions and hallucinations
- Abnormal mental states like confusion, excitement, etc.
- Drug related violence

Criminal Responsibility

According to section 84 of the Indian Penal Code of 1860, "Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is 'incapable of knowing the nature of the act,' or that he is doing what is either wrong or contrary to law."

Criteria used to determine criminal responsibility:

- M'Naghten's rule
- The irresistible impulse test
- The Durham test/Product rule
- American law institute

M'Naghten's rule

The rule states that the individual at the time of the crime did not know the nature and quality of the act and if he did know what he was doing, he did not comprehend it to be wrong. These rules are referred to as the nature and quality rule and right from wrong test.

Origin of the Rule

Daniel M'Naghten was a 29-year-old man of gloomy and reserved social habits, which included membership of religious groups. He decided to murder Sir Robert Peel, the

Prime Minister. He made elaborate plans and traveled to London, but in fact mistakenly shot and killed Edward Drummond, Peel's private secretary. During the trial, M'Naghten himself admitted, "they have accused me of crimes of which I am not guilty, they do everything to harass and prosecute me, in fact they wish to murder me. I was driven to desperation by persecution". M'Naghten knew that he was doing and was aware that he was committing a criminal act but felt compelled to do so, an act he performed with cool deliberation. Psychiatrists were called and it was accepted that his delusions were real, that the act was committed under a delusion. M'Naghten was found "not guilty on the grounds of insanity".

Irresistible Impulse Act

According to this rule, a person may have known an act was illegal but as a result of mental impairment lost control of their actions.

Durham's Rule/Product Rule

An accused is not criminally responsible if his unlawful act was the product of mental disease/defect. In this, the causal connection between the mental abnormality and the alleged crime should be established.

American Law Institute (ALI) Test

A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.

The ALI test is similar to the combination of the M'Naghten rule and the irresistible impulse test. This rule excludes psychopaths.

Civil Responsibilities of a Mentally Ill Person

Management of Property

The court may on an application from any relative direct an inquiry to ascertain whether a person is of unsound mind and incapable of managing his property. In such a case, a manager is appointed by the court of law to take care of his property, which may include sale or disposal of the property to settle his debts/expenses.

Marriage

As per the Hindu Marriage Act (1955), marriage between any two individuals one of whom was of unsound mind at the time of marriage is considered null and void in the eyes of the law. Unsoundness of mind for a continuous period can be sighted as a ground for obtaining divorce. The other party can file for divorce when lunacy continues for a period of more than 2 years after marriage. However, if divorce is filed after a 3-year period, divorce is granted with a pre-condition that the other party has to pay maintenance charges for the mentally ill person.

Testamentary Capacity

As per the Indian Succession Act, testamentary capacity of the mental ability of a person is a pre-condition for making a valid will. The testator must be a major, free from coercion, understanding and displaying soundness of mind. At times, doctors and nurses are called upon to witness the will of an ailing person. Under such circumstances, the doctor tests the testator for orientation, concentration and memory. A person affected by delusional disorder can also make a valid will, if those delusions are not related to the disposal of the property.

Right to Vote

A person of unsound mind cannot contest for elections or exercise the privilege of voting.

In conclusion, nursing practice must confirm to preset legal standards and continuously reorient itself to the ever evolving legal standards. It is only the motivated and capable nurse who can incorporate legal knowledge while dispensing patient care, and it is to her that many patients will turn for information and care.

Laws Relating to Psychiatric Disorders

- *Laws relating to psychiatry in India*
 - The Care and Treatment Legislation (Mental Health Legislations)
 - Criminal Responsibilities Formulation (Criminal Laws)
 - Civil Status Provisions (Civil Laws)
- *Mental health related legislations*
 - Mental Health Act 1987
 - Persons with Disabilities Act 1996
 - Rehabilitation Council of India Act 1992
 - Juvenile Justice Act 1986
 - Consumer Protection Act 1986
- *Civil laws relating to mental ill persons*
 - Indian Evidence Act 1925—Sec 118
 - Law of Contract—Sec 6, 11, 12
 - Right to Vote and Stand for Election—Act 326, 102 of the Constitution of India
 - Law of Torts
 - Testamentary Capacity—Sec 59 of Indian Succession Act 1925
 - Marriage and Mental Health Legislation
 - » Indian Divorce Act 1869
 - » Parsi Marriage + Divorce Act 1936
 - » Dissolution of Muslim Marriage Act 1939
 - » The Special Marriage Act 1954
 - » The Hindu Marriage Act 1955, 1976
 - » The Family Court Act 1984
- *Civil laws relating to psychiatry*
 - Provisions as to Accused Persons of Unsound Mind—Sec 328-339 Cr. P. C. 1973

- Criminal Responsibility—Sec 84 IPC-1860
- Attempt to Commit Suicide—Sec 309 IPC
- Right to Private Defense against an Insane Person—Sec 98 IPC
- Unnatural Offences—Sec 377 IPC (Sexual Perversions)
- Affrays (Sec 159 in Mania)
- Misconduct in Public under Intoxication (for example, Alcohol Defense—Sec 510 IPC)
- NDPS Act 1985 (Amended 1988)

- *Suicide and Indian law*

- Suicide is the only criminal act for which a person is punished if he fails in the attempt to do so
- "No person shall be deprived of his life" Act 21 of Constitution of India
- Sec 309/IPC—attempt to commit suicide- punishable
- 1994-S.C. Judgment—Sec 309 was declared void
- Sec 306—abetment of suicide an offence
- No specific laws for assisted suicide and euthanasia
- *The Narcotic Drug and Psychotropic Substances Act (Act 61 of 1985)*
(See Page 353 for details)

Admission Procedures of Patients in a Psychiatric Hospital

See page 343 for details.

Civil Rights of the Mentally Ill

Due to global human right concerns, efforts have been made to safeguard the human rights of the mentally ill. A person who is supposed to look after the mentally ill person and who does not take proper care and shows cruelty, may be summoned by the court, on receipt of such an information either from the public or police. Stringent punishment has also been provided for those who subject the mentally ill to physical and mental indignity

while in hospital. It has also been stated that the mentally ill person will not be used in research, except after obtaining proper consent from him and any communication or correspondence in any form shall not usually be censored or intercepted.

Psychiatrists and the Court

Psychiatry has become established as a medical specialty and psychiatrists now have achieved the status of an expert for the purpose of assisting the law in performing its role. Based on a plea of insanity a psychiatrist can give evidence convincing a judge that the crimes were committed as a result of his mental illness.

ACTS RELATED TO NARCOTIC AND PSYCHOTROPIC SUBSTANCES AND ILLEGAL DRUG TRAFFICKING

The Narcotic Drug and Psychotropic Substances Act of 1985 - Act 61

On 16th September 1985, Act 61 of NDPSA 1985 was enforced.

Contents

- The act includes narcotic drugs (opium, poppy, straw, cannabis, cocaine, coca and all related synthesized drugs) and psychotropic substances (76 drugs and their derivatives, for example major tranquilizers, minor tranquilizers, pentazocine, barbiturates, etc.).
- In this act, if a person produces, possesses, transports, imports, sells, purchases or uses any narcotic drugs or psychotropic substances (except 'Ganja') he shall be punishable with:
 - Rigorous imprisonment for not less than 10 years, which may be extended up to

20 years and a fine of not less than 1 lakh rupees, which may extend to two lakh rupees

- For repeat offence a rigorous imprisonment of not less than 15 years which may be extended up to 30 years and a fine of not less than 1.5 lakh rupees, which may be extended up to 3 lakh rupees
- For handling 'Ganja', a rigorous imprisonment which may extend to 10 years and a fine up to 1 lakh rupees
- On carrying 'small quantities', for example, Heroin—250 mg, Opium—5 g, Cocaine—125 mg, Charas—5 g, as were later specified in this act, the punishment may extend to 1 year or a fine or both. For Ganja (below 500 g), imprisonment is up to 6 months
- Under a specified court order, there is a provision for detoxification of the patient
- Under a later enactment, the prevention of illicit traffic in Narcotic Drugs and Psychotropic Substances Act (NDPSA), 1988 (Act 46) was passed. Now there is a provision for preventive detention, seizure of property, death penalty if a person is bound to be trafficking more than or equal to 1 kg of pure heroin despite conviction and warning on the first attempt.

ADMISSION AND DISCHARGE PROCEDURES – ROLES AND RESPONSIBILITIES OF A NURSE

Role of a Nurse in Admission Procedure

- Settling the patient in the ward
- Welcoming to the ward
- Introducing to the other staff members and patients
- Before assigning a bed, consider biological and emotional needs

- If any patients have suicidal ideation or floridly psychotic, he should be located in a place where the patient can be closely observed
- The patient should be shown various facilities like availability of bathroom, recreation, refreshments, etc.
- Acquaint the patient with some of the ward rules, for example, meal time, ward activities, visiting hours, how to make appointments to see staff member, timings of any group meetings, etc.
- Provide appropriate information
- Head to foot observation for any injury
- Orientation toward structure, policies
- Find out whether patient had food before admission
- Enquire about any legal issue that the patient has prior to admission
- Perform history collection and MSE
- Write nurse notes; enter in admission register.

Role of the Nurse in Leave of Absence (Parole)

Parole is the permission given to patients to perform certain rituals or attend certain family functions.

- Relatives are clearly instructed about the purpose for which the patient is being sent home and when he should be brought back
- Instruct the relatives as to how they should converse or behave with the mentally ill person according to the instructions given by the doctor
- If the patient is receiving any medications, insist on regularity and give necessary instructions to the family members about dosage, side effects, etc.
- The relatives should be asked to observe communication pattern, sleeping pattern, drug allergy, socialization, ability to perform role.

Role of the Nurse in Discharge Procedure

- Nurse must ensure that the patient leaves the unit with all belongings and personal effects, has the appropriate medications with him, and appointment for follow-up has been made and understood.
- All necessary instructions, especially regarding his medication regimen, side-effects, etc. must be clearly given to the patient and his family members.
- Any paper work, signing of documents should be completed. The hospital file along with all charts and notes should be sent to the medical records section.
- The nurse should ascertain his travel plan and offer assistance if necessary.
- The nurse must bear in mind that the patient may have mixed feelings about leaving the hospital and going back to his home environment. She should help him cope with any distress about separating from his new-found friends and staff members.

LEGAL RESPONSIBILITIES OF A NURSE

Probably no other nursing specialty area demands as great a need for knowledge of the law and ethics as does psychiatric mental health nursing. Psychiatric nurses are confronted on a daily basis with the interface of legal issues as they attempt to balance the rights of the patient with the rights of society. Nurses and other healthcare providers must never violate the rights of mentally ill patients.

Nurses must be aware of:

- Both the laws in the state in which they practice
- Patient's rights
- Criminal and civil responsibilities of mentally ill patients
- Legal documentation

Thus, knowledge of the law regarding psychiatry in the area where the nurse is practicing helps her to protect herself from liability and the patient from unnecessary detention and mistreatment. The nurse should:

- Protect the patient's rights
- Keep legal records safely
- Maintain confidentiality of patient information
- Take informed/substitute consent from patient/relatives for any procedure
- Explain based on level of anxiety, span of attention and level of ability to decide.

- Practice within the scope of state laws and nurse practice act
- Collaborate with colleagues to determine the best course of action
- Use established practice standard to guide decisions and action
- Always put patient rights and welfare first
- Develop effective interpersonal relationship with patients and family
- Document all assessment data, treatment, interventions and evaluation of the patient's response to care accurately and thoroughly

Nursing Malpractice

Malpractice involves the failure of professionals to provide proper and competent care that is given by the members of their profession, resulting in harm to the patient.

For malpractice the following elements of nursing negligence must be proved

A legal duty of care existed

- The nurse performed the duty negligently
- The damages were suffered by the plaintiff as a result
- Damages were substantial.

Common areas of liability in psychiatric services

- Patient suicide
- Failure to diagnose
- Problems related to electroconvulsive therapy
- Misuse of psychoactive prescription drugs
- Breach of confidentiality
- Failure to obtain informed consent
- Inadequate supervision by trainers and employees
- Failure to report abuse.

Steps to avoid liability in psychiatric services

- The nurse is responsible in reporting information to coworkers involved in patient care
- Maintain the records accurately and clearly
- Maintain confidentiality of patients information

Confidentiality

During the nurse-patient relationship, a lot of information is gathered through direct and indirect sources, which is both verbal and written. Keeping in view the ethics of the nursing practice, such information gathered is kept confidential and best used for providing enhanced care rather than for other purposes, such as gossip or personal gain.

Confidentiality refers to the non-disclosure of private information related to one individual to another, such as from patient to nurse. Any breach of confidentiality could jeopardize the best interests of the patient, be it social or economical, keeping in view the social stigma attached to mental illness.

Informed Consent

Informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and a nurse that results in a patient's authorization or agreement to a specific medical intervention. The informed consent should include:

- The patient's diagnosis if known
- Nature and purpose of a proposed treatment or procedure
- Mode of administering the treatment
- The risk and benefit of a proposed treatment or procedure.

- Alternate treatment procedures—risks and benefits
- The risks and benefits of not receiving treatment

However, in the case of psychiatric patients the ability to give informed consent as regards a procedure is highly debatable due to the nature of the problem. Though most of the patients perceive and act in their own best interests, some may not be capable of giving a valid consent. Due to such variations, the patients have to be screened for the following:

- Legal age and sound mind
- Intelligence and understanding ability
- Ability to express choices
- Capacity to comprehend the information given about the treatment.

Substituted Consent

It refers to the situation where a patient is not capable of giving their own consent to the proposed treatment. In such cases authorization is given by another individual, being a guardian appointed by the court or the kith and kin on behalf of the patient.

Before getting the consent of the patient or his legal guardian, a full explanation is necessary in regard to the risks involved in the investigation, treatment and/or procedures administered to the patient.

Informed consent to be obtained for the following conditions:

1. Admission of a person to a psychiatric hospital on a voluntary basis.
2. Procedures like ECT, psychosurgery and other invasive investigatory procedures like lumbar puncture, spheoidal EEG, etc.
3. Pentothal analysis (narco-analysis).
4. Drug treatments like disulfiram therapy and clozapine therapy.
5. Administration of any research drugs (drug trials).

Record Keeping

Nursing notes and progress records constitute legal documents and hence should be

maintained carefully. They should be non-judgmental and the statements made should be objective in nature.

Specific Problems in Mental Hospitals

Specific problems that might arise in mental hospitals in everyday practice which may have legal implications are:

- Escape from mental hospital
- Death
- Pregnancy
- Unknown patient
- Mentally ill offender.

Escape from mental hospital: In mental hospitals, escaping of mentally ill patient is a very common problem. As voluntary admissions increased incidences of escape of mentally ill patients decreased. Escape is more serious in case of involuntary admissions, admission on reception order, mentally ill offenders, mentally ill prisoners and women.

The reason for escape may include unsatisfactory living conditions in the mental hospital (inadequate food and absence of recreational facilities), severity of illness, attitude of the staff and, inadequate attention being given to the patient by doctors or the nursing staff.

In case of involuntary admission or admission under reception order, the escape of mentally ill offenders should immediately be intimated to the senior supervisor/medical superintendent by the ward staff. The medical superintendent should in turn inform either the local police station or the family (if necessary details are available) or the concerned court (if admission through court orders) as the case may be.

Escape can be prevented by respecting the rights of the mentally ill person, rehabilitating the mentally ill patient in the community on recovery, providing safe and comfortable environment, arranging for the stay of family member with the patient in case of voluntary admission and collecting proper address and necessary details during admission.

Death: Patients admitted in a mental hospital may die due to a physical cause. Every attempt should be made to provide best medical care to patient. If needed critically ill patient should be shifted to specialty hospitals. Once the death has already occurred, if the family members are staying along with the patient the body can be handed over to them. If the family members are not staying with the patient, the information of the death needs to be intimated immediately to them telephonically and the dead body be kept in the hospital mortuary till the family arrives. If no family member turns up for 3 days (72 hours) or family details are not known, arrangements of last rites or the dead person should be confirmed according to his religion and handed over to municipal authorities. Post mortem is not mandatory in all the cases. It is advisable only in suspected cases where death has occurred as a result of accident or in an unnatural way. All the deaths occurring in a mental hospital should be discussed by conducting mortality review meetings involving the concerned people not only to ascertain the cause but also to rule out negligence in medical care.

Pregnancy: Pregnancy in a female patient may occur under two different circumstances. One, wherein the patient is already pregnant at the time of admission, and the other wherein the patient becomes pregnant during her stay in the hospital. The second situation is more serious. Before admitting any female patient in the reproductive age group the doctor should always ensure the presence or absence of pregnancy. In reception order cases, detailed gynecological examination should always be performed to rule out pregnancy.

When a pregnant unknown patient gets admitted in mental hospital all the efforts should be made to trace the family. If the pregnancy appears to be a result of rape and

the patient is not in a position to take care of the child it is advisable to terminate the pregnancy on humanitarian grounds. If the pregnancy is already in an advanced stage and the patient is not in a position to take care of the child in near future, also attempts at contacting the family fails then arrangement may be made to hand over the child to social welfare associations.

Unknown patient: Mentally ill patients wandering aimlessly may become unknown patients to mental hospitals. The nurse has to spend enough time with the patient to know the name and other details of the patient. Most of the time once his or her psychiatric or physical status improves the patient is usually able to recall and inform the details.

Mentally ill offender: In mental hospitals there should be a separate criminal or forensic ward with adequate security provided by the police. Mentally ill criminals may belong to any of the three groups: those incapable of standing trial, those acquitted by reason of being mentally ill, and prisoners who develop mental illness. Mentally ill criminal admitted in mental hospital based on court order, should be treated just like any other patient. Security considerations and legal aspects need to be taken care of.

For all reception order patients nurses recording should be done from time to time. Nurse's notes shall be legal document in such situations.

REVIEW QUESTIONS

Long Essays

1. Explain in detail about Indian Mental Health Act 1987, and describe role of a nurse in admission procedures.
2. Describe types of admission in psychiatric hospitals – role of a nurse.
3. Legal aspects of psychiatric nursing.

Short Essays

1. Rights of psychiatric patients
2. Forensic psychiatry
3. Criminal responsibility related to psychiatric disorders
4. Discharge procedure for a mentally ill patient
5. Role of a nurse in protection of rights of mentally ill patient

Short Answers

1. Nursing malpractice
2. Confidentiality
3. Informed consent
4. Leave of absence

MULTIPLE CHOICE QUESTIONS

- 1. The Indian Mental Health Act was passed during the year:**
 - a. 1987
 - b. 1947
 - c. 1992
 - d. 1942
- 2. The Indian Lunacy Act was passed during the year:**
 - a. 1910
 - b. 1912
 - c. 1920
 - d. 1987
- 3. The following all are objectives of Indian Mental Health Act, except:**
 - a. Regulate admission into a psychiatric hospital
 - b. Protect the society from mentally ill patients
 - c. Establish Central and State authorities for mental health services
 - d. Removal of misconceptions regarding mental illnesses among the public
- 4. According to Mental Health Act 1987, admission under special circumstances means:**
 - a. Application for admission is made by the patient himself
 - b. Application for admission is made by relatives or friends of the patient
 - c. Application for admission is made by a Gazetted medical officer
 - d. Application for admission is made by a Magistrate
- 5. Temporary treatment order for a mentally ill patient is valid for:**
 - a. 3 months
 - b. 6 months
 - c. 9 months
 - d. 12 months
- 6. According to Mental Health Act 1987, leave of absence means:**
 - a. Mentally ill patient is detained in the hospital
 - b. Mentally ill patient is permitted for discharge
 - c. Mentally ill patient is given time limited leave
 - d. Mentally ill patient is given permission for any therapeutic procedure
- 7. The Narcotic Drugs and Psychotropic Substances Act (NDPSA) was passed in the year:**
 - a. 1985
 - b. 1982
 - c. 1995
 - d. 2000
- 8. Which law in India has deemed the attempt to commit suicide a punishable offence?**
 - a. Section 309 of the IPC
 - b. Section 114 (b) of the IPC
 - c. Mental Health Act
 - d. Sections 328-339 of the IPC
- 9. Relative of Mr. B brought him to psychiatry OPD with an application made out to the magistrate and got him admitted in the hospital. Mr. B got admitted under which type of admission?**
 - a. Admission of mentally ill prisoner
 - b. Admission on voluntary basis
 - c. Admission under reception order
 - d. Admission under special circumstances

- 10. Which of the following represents appropriate criteria for admission of a patient under special circumstances into a psychiatric hospital?**
- Patient unwilling/unable to make a request for admission
 - Patient who has threatened suicide
 - Patient who has a long history of mental illness
 - Patient whose family has requested admission
- 11. The nurse on the evening shift of a psychiatric ward refuses to allow patients to wear their own clothes unless they participate regularly in group meetings. This practice violates which of the following?**
- The Rights of mentally ill patients
 - Ethical standards of nursing practice
 - Nurse-patient relationship
 - State nurse practice acts
- 12. All of the following represent appropriate maintenance of patient confidentiality by the psychiatric nurse, except:**
- Discussing patient's current problems and past history in treatment team meeting
 - Explaining the patient's condition to family members
 - Sending copy of patient's records to a referring agency without patient's written consent
- 13. Which of the following psychiatric treatments require that a psychiatric nurse obtain written informed consent from a patient?**
- Supportive psychotherapy
 - Electroconvulsive therapy
 - Behavioral therapy
 - Group therapy
- 14. Substitute consent is given in which of the following situations?**
- When the patient is not capable of giving his own consent
 - When the family members are willing to arrange for treatment
 - When the patient's behavior is not controllable
 - When the patient is having legal problems
- 15. Mr. Y was admitted by police personnel in a mental hospital. He is discharged by the concerned medical officer after their family members assure proper care by way of a written undertaking. Mr. Y got discharged under which type of discharge procedure?**
- Discharge of a mentally ill prisoner
 - Discharge on a voluntary basis
 - Discharge of a patient admitted by police
 - Discharge under reception order

KEY

- | | | | | | | | | | |
|-------|-------|-------|-------|-------|------|------|------|------|-------|
| 1. a | 2. b | 3. d | 4. b | 5. b | 6. c | 7. a | 8. a | 9. c | 10. a |
| 11. a | 12. d | 13. b | 14. a | 15. c | | | | | |

Chapter 15

Community Mental Health Nursing

The methods of treating mental illness have changed dramatically in the past century. Community mental health as a treatment philosophy was mandated by the Community Mental Health Centers Act of 1963, thus bringing about the shift of mental healthcare from the institution to the community, and heralding the era of deinstitutionalization.

DEVELOPMENT OF COMMUNITY MENTAL HEALTH IN INDIA

The institutional treatment for mental disorders in India and the use of allopathic medicine were introduced by the European rulers. As a matter of fact, Charaka and other stalwarts of indigenous medical systems considered mental disorders to be *asadhyā* (unmanageable). Thus, their treatment was left to folk healers, who practiced their art in the community setting.

The various events which influenced the development of psychiatric services in India have occurred over five discernible phases.

The **first** is the colonial period prior to India's attaining independence. From the later half of the 18th century onwards, several lunatic asylums were built in different parts of the country. Thus, the first mental asylum was established in Bombay (1745), the second in Calcutta (1781), the third in Madras (1794) and the fourth in Bihar. These asylums had

acquired all the bad qualities and treated mentally ill at par with criminals.

Philippe Pinel, the director of asylum of Bicêtre in France, William Tuke in England, and Benjamin Rush in United States led a movement against the ill treatment of mentally ill in the asylums and started human care and removed physical restraints. In 1841, Dorothea Dix was appointed as inspector of institution for the mentally ill and began crusading for more humane treatment. The result was the establishment of 32 mental hospitals in the US. Most hospitals were built in rural areas. Thus, the concept of community mental health came in practice. The book 'A Mind that found itself' written by an ex-psychiatric patient Clifford W Beers (1908), exposed the awful conditions in the mental hospitals. This led to the formation of National Mental Health Association in USA to fight for better care to the mentally ill, which in turn paved the way for 'Mental Hygiene Movement'.

Adolf Meyer in 1909 advocated management of mentally ill patients outside the institution and proposed a comprehensive community mental health approach. The period between 1955 and 1980 was an era of de-institutionalization in USA and other western countries. This provided an impetus to the development of community psychiatry.

The inspiration for the community mental health movement in India comes from three sources.

1. First source is the realization in western countries that the treatment of mentally ill patients should be given in mental hospitals. In the 1960s, American Psychiatrists discussed the 'social breakdown syndrome', which resulted from long-term hospitalization. This prompted the Kennedy administration to launch the community mental health program.
2. The second source is the realization that institution based psychiatry care through trained professionals can in fact be very expensive and that countries like India will not have the sufficient manpower and facilities to deliver services through conventional methods, for many years.
3. The third source was, discovery that para-professionals and non-professionals could, deliver reasonable mental health care by undergoing simple and short innovative training.

Till 1946, the approach of the Indian Government was to establish custodial centers. Col. M Taylor (1946), superintendent of the European Mental Hospital at 'Ranchi', surveyed 17 mental hospitals and observed outdated care. The situation at the time of independence is clearly illustrated in the recommendations of Bhore Committee 1946.

1950s saw the **second** phase of development of psychiatric services, when there was a breakthrough in the area of delivery of care to the mentally ill (first approach). All India Institute of Mental health (later called as NIMHANS) was established in 1954 at Bengaluru for the training of mental health professionals. NIMHANS which has been a World Health Organization collaborating center for research and training in mental health since 1987 is the largest center for the training of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses in India. Many new mental hospitals were built in different places, such as Amritsar (1947), Hyderabad (1953), Srinagar (1958), Jamnagar (1960) and New Delhi (1966). This phase can rightly be

referred to as the era of mental hospitals in free India as most of the mental healthcare services in the country were centered around the mental hospitals. In 1957, Dr Vidyasagar, superintendent of Amritsar Mental Hospital, involved the family members of the mentally ill in the management, by allowing them to stay with their patients in open tents pitched in the hospital campus. He showed that the patients recovered fast and were taken back to their homes. Based on this principle, family wards were established in Bengaluru Mental hospital and CMC Vellore.

The **third** phase began in the mid 1960s with the establishment of General Hospital Psychiatric Units (GHPOs). Though the first general hospital psychiatric department was started at Mumbai and Kolkata way back in 1933, more units and departments started working in 1970s. Mudaliar Committee, in 1962, envisaged that within the next 10 years, psychiatric units would be set up in all the districts of the country. Even in 1998, except in states like Kerala, Karnataka and Tamil Nadu, majority of the States in the country did not have such units. The general hospital psychiatric units had a number of advantages over the mental hospitals (Box 15.1).

The **fourth** phase of development of psychiatric services in the country saw the extension of care from mental hospitals and general hospitals to the primary healthcare

Box 15.1: Advantages of general hospital psychiatric units over mental hospitals

- » Shorter periods of hospitalization
- » Involvement of family members
- » Greater acceptance of services
- » Easily approachable without stigma
- » Attracted more patients with minor mental health problems
- » Encourage more outpatient care
- » Integration of mental health into the general health system

centers and the community. By the mid 1970s, it was realized that the existing mental health services were highly centralized and situated predominantly in urban areas, catering to the needs of only a small proportion of the population. Indian psychiatrists showed their concern for organizing mental health services. Indian psychiatric society conducted seminars and workshops in Madurai (1971), Trivandrum (1985) and Nagpur (1976). WHO/SEARO meetings (1971, 1974) and the presidential addresses in annual conferences of Indian Psychiatric Society emphasized the need to integrate mental health into the general healthcare and provide the same through primary care approach. An expert committee of the WHO had recommended that developing countries should organize mental health services by integrating these services with their existing system of primary health care. It brought out a technical report in 1974 and paved the way for community mental health program. Efforts were made to operationalize the primary care approach in the country. The noted ones are community care approach in two centers—Sakalwara village near Bengaluru and Raipur Rani Block of Ambala District, Haryana state. These programs demonstrated that basic mental healthcare can be provided by health workers and doctors in primary healthcare centers, if they are adequately trained. India adopted a National Mental Health Program in 1982, which has an integration of mental health into general health services as the primary approach for delivering mental healthcare throughout the country.

During the past few years, a wide variety of factors have contributed to the **fifth** phase of development, which is currently bringing about major changes in mental health services. A series of media exposes about the poor and scandalous situation in many mental hospitals and the plight of their inmates brought into the fore the issue of mental hospital reforms. The media also focused its attention on the rights of the mentally ill and the situation of

mentally ill persons housed in jails. Coupled with these were several writ petitions on some of these issues, filed by social activists in courts in different parts of the country, including the Supreme Court. These have resulted in commissions of inquiry and certain momentous pronouncements by the Supreme Court of India, contributing to substantial increases in funding and improvements in the conditions of many mental hospitals. The Supreme Court also decreed against housing mentally ill persons in jails. The archaic Indian Lunacy Act of 1912 has now been replaced by a new Mental Health Act (1987). Mental hospitals are steadily acquiring newer roles and functions. Many of them have opened out-patient services for ambulatory care of new patients and follow-up and after-care of discharged patients. Rehabilitation services of various types which never existed before are being added. The average period of hospitalization is being reduced by several conscious efforts. Some hospitals have opened 'short-stay' wards, 'open wards' and 'family wards.' Mental hospitals with these newer functions will continue to be an important component of mental health services in India, especially for the care of patients with more severely disabling disorders.

In recent years, there has been a perceptible growth of voluntary and non-governmental organizations taking an active interest in various aspects of mental health. These organizations in different parts of the country are involved in a variety of programs which include the rehabilitation of patients with chronic mental illness, running day care facilities, half-way homes, quarter-way homes and crisis intervention centers, suicide prevention work, the treatment and rehabilitation of substance abusers and mental health education. They have the advantage of highly committed volunteers and the potential for initiating innovative programs. In a large country like India with a population of over 900 million, voluntary organizations can substantially contribute to governmental

efforts for the prevention and treatment of mental disorders and associated disabilities and the promotion of mental health. There is a need for a larger number of such organizations.

Another visible development during the past few years has been the growth of private sector in psychiatric services, especially in the urban areas. Number of private nursing homes and hospitals for the mentally ill, as well as psychiatry wards in private and general hospitals has been on the rise. Private consultant psychiatrists with office based practices have also been growing in number in most large cities. While these facilities have added to the overall availability and quality of psychiatric services, they cater to the needs of only certain sections of society such as the urban middle and upper classes.

The public health consequences of mental and psychosocial disorders are now being realized in India more than ever before. An increasing number of persons with various minor mental disorders are beginning to

seek mental health care services. The special needs of certain categories of the population such as children, the aged, women and the rural underprivileged have been recognized. Although the availability of a variety of mental health services has steadily increased in India, there is still a wide gap between the existing morbidity and the available services. With the current rapid urbanization and economic liberalization in the country and the resultant social change the demand for mental health services is only likely to increase (Table 15.1).

Organization of Mental Health Services in India

The organization of mental health services demands a wide variety of interventions ranging from public awareness, early identification, treatment for acute illness, family education, long term care, rehabilitation, re-integration and ensuring of human rights of the ill persons. Mental health services are delivered through

Table 15.1: Summary of phases of community mental health development in India

Phases	Development
I Phase – Colonial period prior to India's attaining independence	Establishment of lunatic asylums in different parts of the country
II Phase – During 1950s	Establishment of mental hospitals at Bengaluru (1954), Amritsar (1947), Hyderabad (1953), Srinagar (1958) and Jamnagar (1960), Delhi (1966)
III Phase – During mid 1960s	Growth of general hospital psychiatry units
IV Phase – During 1970s	<ul style="list-style-type: none"> » Extension of care from mental hospitals and general hospitals to the primary healthcare centers and the community » Bengaluru and Chandigarh initiated pilot programs to develop and evaluate an extension of mental health services for the rural underprivileged population
V Phase – During 1990s	<ul style="list-style-type: none"> » Substantial increases in funding and improvements in the conditions of many mental hospitals » Voluntary and non-governmental organizations taking an active interest in various aspects of mental health » Growth of private sector in psychiatric services » Growth of private consultant psychiatrists

Table 15.2: Mental health services at various levels in India

Central level	National level hospitals. For example, NIMHANS, Bengaluru
State level	State level hospitals, For example, DIMHANS, Dharwad
	National Mental Health Program
District level	General hospital psychiatric units
	District Mental Health Program
Local level	Primary health centers
	Community mental health centers
	Sub-centers

mental hospitals at Central, State and District levels (Table 15.2).

Some of the Innovative Programs in Mental Health

Crash programs offered at NIMHANS, Bengaluru

Dr RM Varma, Director and Dr Karan Singh, Minister of Health in the Central Government, jointly introduced community based mental health program at NIMHANS. A community psychiatry unit was started in October 1975. This unit launched the following programs:

1. Primary health center (PHC) based rural mental health program: Under this program manuals were prepared to train multipurpose workers to recognize severe mental illness cases and to follow them up, to train the PHC doctors to diagnose and treat cases of severe mental disorder patients.
2. General practitioner (GP) based urban mental health program: Under this program manual was prepared to teach the GPs methods of treating common mental disorders.
3. School mental health program: In this program school teachers were trained to diagnose children with emotional problems and counsel them.
4. Home-based follow-up of psychiatric patients: Here nurses were trained to follow-up patients in their own homes through monthly visits.
5. Extension programs by "Satellite Clinics": Mental health team conducts a weekly or monthly clinic at taluk or district headquarters. The local medical and non-government voluntary organizations are motivated to be the local hosts and help in patient care. Such satellite clinics are functioning successfully in 6 centers of Karnataka and a few centers in other parts of the country.
6. Extensive use of outdoor services: Family members are encouraged to treat their patients at home and get drugs and suggestions from the hospital by regular visits. All types of treatment, including ECT are given in the outpatient setups. Short stay ward (few hours to 48 hours) facility is organized in the outpatient building so that acute problems are managed and the patient is discharged. The hospital organizes free or subsidized drug supply so that drug compliance improves.
7. Involvement of ICDS personnel in child mental healthcare.
8. Anganwadi workers are trained in basic mental healthcare so that they identify and refer children with mental retardation and behavioral problems to medical institutions.
9. Training by volunteers: Interested and committed 'natural helpers' in the community are given 40 sessions

- of training in counseling so as to help individuals in distress.
10. Student enrichment program and student volunteers program to educate about mental health.

The Chandigarh Experiment

Soon after the community psychiatry unit in NIMHANS began, a rural mental health program was started in the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, with the help of WHO. Besides Chandigarh and Bengaluru, similar rural mental health programs were taken up at other psychiatric centers in Baroda, Kolkata, Delhi, Hyderabad, Jaipur, Lucknow, Patiala and Vellore. Some of the States like Haryana, Himachal Pradesh, Punjab, Pondicherry, Uttar Pradesh, Maharashtra, Gujarat, Kerala, Rajasthan, Andhra Pradesh, Assam and West Bengal initiated pilot programs from October 1985.

NATIONAL MENTAL HEALTH PROGRAM

India is the first among the developing countries to formulate the National Mental Health Program (NMHP) based on the principle of decentralized and deprofessionalized mental healthcare. The Government of India felt the necessity for evolving a plan of action aimed at the mental health component of the National Health Program. The first draft of National Mental Health Program, was designed by 68 experts from the field of mental health, general health and health administration and was accepted for implementation in the country in 1982.

Objectives

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population.

2. To encourage the application of mental health knowledge in general healthcare and in social development.
3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

During the 10th Five year plan (2003), NMHP was re-strategized and from a single pronged program it became a multipronged program for effective reach and impact on mental illnesses. The main strategies were as follows:

1. Extension of DMHP to 100 districts
2. Upgradation of Psychiatry wings of Government Medical Colleges/General Hospitals
3. Modernization of State Mental hospitals
4. Information Education and Communication (IEC)
5. Monitoring and Evaluation

In the 11th Five Year Plan, the NMHP has the following components/schemes:

1. District Mental Health Program (DMHP)
2. Manpower Development Schemes—Centers of Excellence and Setting Up/ Strengthening PG Training Departments of Mental Health Specialties
3. Modernization of State Run Mental Hospitals
4. Up gradation of Psychiatric Wings of Medical Colleges/General Hospitals
5. Information Education and Communication (IEC)
6. Training and Research
7. Monitoring and Evaluation

During the 11th Five Year Plan an allocation of ₹ 1000 crore has been made for the National Mental Health Program. A sum of 70 crore has been provided in 2008–09 for implementation of NMHP. During the 11th Five Year Plan, it has been proposed to decentralize the Program and synchronize with National Rural Health Mission for optimizing the results. The main components of NMHP that have been proposed are as under:

- To establish Centres of Excellence in Mental Health by upgrading and strengthening of identified existing mental hospitals for addressing acute manpower shortage.
- To provide impetus for development of Manpower in Mental Health, other training centres (Govt. Medical Colleges/General Hospitals, etc.) would also be supported for starting PG courses in Mental Health or increasing intake capacity.
- Spill over of 10th Plan schemes for modernization of state run mental hospitals and up-gradation of psychiatric wings of medical colleges/general hospitals.
- District Mental Health Program with added components of life skills training and counseling services in schools and colleges, work place stress management and suicide prevention services.
- Research—there is huge gap in research in mental health which needs to be addressed.
- IEC—a lot of stigma is attached to mental illnesses. It needs to be stressed that the mental illness is treatable. An intensive media campaign is planned for 11th Plan duration.
- NGOs and Public Private Partnership for implementation of the Program. This would increase the outreach of community mental health initiatives under DMHP.
- Monitoring Implementation and Evaluation—Effective monitoring at Central/ State/District level will facilitate implementation of various components of NMHP.

The Government has accorded high priority particularly to child and adolescent mental healthcare during the 12th Five Year Plan (2012–2017). The Government is integrating different components of National Mental Health Program with the components of National Rural Health Mission namely School Health, Reproductive Child Health and Adolescent Friendly Clinics during the Twelfth Five Year Plan to reach out to the community in a more effective manner.

Targets of National Mental Health Program

Within One Year

- Each State of India will have adopted the present plan of action in the field of mental health.
- The Government of India will have appointed a focal point within the Ministry of Health specifically for mental health action.
- A national coordinating group will be formed comprising representatives of all State senior health administrators and professionals from psychiatry, education, social welfare and related professions.
- A taskforce will have worked out the outlines of a curriculum of mental health for the health workers identified in the different states as most suitable to apply basic mental health skills and for medical officers working at PHC level.

Within 5 Years

- At least 5000 of the target non-medical professionals will have undergone a 2-week training in mental healthcare.
- At least 20% of all physicians working in PHC centers will have undergone 2 weeks training in mental health.
- Creation of the post of a psychiatrist in at least 50% of the districts.
- A psychiatrist at the district level will visit all PHC settings regularly and at least once in every month for supervision of the mental health program for continuing education. This program will be fully operational in at least one district in every state and union territory and at least 50% of all districts in some states.
- Each state will appoint a program officer responsible for organization and supervision of the mental health program.
- Each state will provide additional support for creating or augmenting community

- mental health components in the teaching institutions.
- On the recommendation of a task force, appropriate psychotropic drugs to be used at PHC level will be included in the list of essential drugs in India.
 - In psychiatric units with in-patients, beds will be provided at medical college hospitals in the country.

Various Activities Planned for Implementation of National Mental Health Program

- Community mental health programs at primary healthcare level in States and Union Territories, with a plan to cover a population of about 3–5 lakhs in the 7th five-year plan.
- Training of existing PHC personnel for mental healthcare delivery with no additional staff.
- Development of a State level Mental Health Advisory Committee and identification of a State level program officer (preferably a psychiatrist).
- Establishment of Regional Centers of community mental health (at least 1 during the plan period).
- Formation of National Advisory Group on Mental Health.
- Development of a task force for mental hospitals.
- Prevention and promotion of mental health.
- Task force for mental health education for undergraduate medical students.
- Voluntary agencies to be involved in mental healthcare.
- Priority areas identified as child mental health, public mental health education and drug dependence.
- Mental health training of at least 1 doctor at every district hospital during the next 5 years.
- Establishment of a department of psychiatry in all medical colleges and strengthening of existing ones.

- Provision for at least 3 to 4 essential psychotropic drugs in adequate quantity, at the PHC level.

An important example of the District Mental Health Program is at Bellary district, Karnataka (about 320 km from Bengaluru). Started in 1985, it caters to a population of 1.5 million. District hospital psychiatry units have been opened in every district of Kerala and Tamil Nadu.

Following the implementation of National Mental Health Program in India 1982, other neighboring countries soon followed the example by drawing national programs for mental health (Sri Lanka 1982; Bangladesh 1982; Pakistan 1986; Nepal 1987).

Progress between 1982 and 2002

Since, the adoption of NMHP the progress is very significant in the following areas:

1. Development of models for the integration of mental health with primary health care (Raipur Rani model in North and Sakalawara in South India).
2. In 1984, the district model for mental healthcare was initiated by NIMHANS, Bengaluru. It identified the practicability of the district mental health team initiating mental health care. This was extended to 25 districts in 20 states between 1995 and 2000.
3. Increase in community care alternatives and NGO initiatives.
4. Public awareness increased enormously due to community based mental healthcare.
5. Legislations supporting mental health care were developed namely, the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985, the MHA 1987 and persons with Disability Act 1995. All of these legislations have changed the mental healthcare approach.
6. Recognition of human rights of the mentally ill by the National Human Rights Commission.
7. The National Health Policy 2002 clearly recognized mental health as a part of

general health and specified how mental health has to be included as a part of general health services and the importance of human rights of the mentally ill.

8. Growth of mass media—Both professionals and non-professionals participated in discussing mental health issues through the media.
9. ICMR, New Delhi, gave a big push to mental health research. This research helped to understand the role of cultural context in mental disorders, and also shown the feasibility of developing models involving schools, primary healthcare, general practitioners and working with families.

After an in-depth situation analysis and extensive consultations with State authorities, the NMHP underwent radical restructuring to have a balance between various components of mental healthcare delivery system, and clearly specified budget allocations. *The re-strategized NMHP was formally launched on 22nd Oct 2003* by the Hon'ble Health secretary at a National workshop held at Vigyan Bhawan, New Delhi. The salient features include:

- Redesigning DMHP around a nodal institution, which in most instances will be the zonal medical college
- Strengthening medical colleges to improve psychiatric treatment facilities with adequate manpower
- Streamlining and modernization of mental hospitals
- Research and development programs in the field of community mental health
- The re-strategized NMHP expected to provide a balanced framework for the provision of comprehensive community based mental health services with a closely networked referral system
- Promoting intersectoral collaboration and linkages with other national programs
- Provision of essential psychotropic drugs; family support
- Developing self-help groups and provision of funds for their activities

- Human resource development conducting short-term training courses for professional and paraprofessionals
- Organizing public mental health education
- Involving private sectors and voluntary organizations in provision of mental healthcare services at community
- At district level, mental health team has to be posted to render clinical care and integration of mental health at peripheral institutions
- Services are focused to special sections of high risk populations.

DISTRICT MENTAL HEALTH PROGRAM

The District Mental Health Program (DMHP) was launched under National Mental Health Program in the year 1996 (in 9th Five Year Plan). The DMHP was based on 'Bellary Model', initially launched in 4 districts at the end of 9th Five year plan expanded to 27 districts of the country. Presently, the DMHP is being implemented in 123 districts of the country. It is planned to increase the number of DMHPs to cover all of the districts in the country as part of the 11th Five year plan in a phased manner. The Government of India scheme envisages developing mental health services through organization of DMHP. This involves assisting the State governments to implement the DMHP in each district. A specified sum of money about rupees one crore per district is given to each state for a period of 5 years for implementation of DMHP.

The main objective is:

- To provide Community Mental Health Services and integration of mental health with General health services through decentralization of treatment from Specialized Mental Hospital based care to primary healthcare services.

Components of District Mental Health Program

- Training programs of all workers in the mental health team at the identified Nodal

Institute in the State, imparting short-term training to general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist. The Health workers are being trained in identifying mentally ill persons.

- Public education in the mental health to increase awareness and reduce stigma.
- Outpatient and indoor services for early detection and treatment.
- Providing valuable data and experience at the level of community to the State and Centre for future planning, improvement in service and research.

The team of workers at the district under the program consists of:

- A Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatry/Community Nurse, a Program Manager, a Program/Case Registry Assistant and a Record Keeper.

Activities of DMHP

- Integration of mental healthcare into the existing general health services by training of PHC personnel (doctors, nurses, health workers and pharmacists) to offer basic mental care. To implement this activity mental health professional from nearby medical college will conduct/organize training programs for primary healthcare personnel to provide essential mental healthcare in the district.
- Early identification and treatment for mental illnesses in the community by active case identification by health workers, conducting periodic mental health camps in each Taluk of the district.
- Referring all persons with mental health problems to their respective primary health unit or to the Taluk hospital after initial evaluation and initiation of treatment in the camps.
- Intensive education to the community about availability of treatment for mental

disorders, universal nature of mental illness, and regarding the need for regular follow-up in the primary health center. These efforts will bring in large number of persons with mental disorders into care and consequent reduction in stigma and discrimination.

- Facilitate adequate psychosocial care of the recovered mentally ill person in the community by making appropriate linkages with NGOs in the local area.
- Promotive and preventive activities for positive mental health for example, school mental health services, life skill education, college counseling services, work place stress management and suicide prevention services.
- Linking psychosocial care and public education with social welfare departments (public private partnership).
- The DMHP in urban location will address the mental health needs through the existing public healthcare infrastructure such as municipality hospitals/corporation hospitals/other specialty hospitals, mental hospitals and medical college hospitals.
- Under DMHP, a small amount of ₹ 50,000/ will be available for research purpose. Non-governmental agencies in the district, medical college department of psychiatry can be encouraged to take-up research work.

At the end of 2002, 28 districts in 25 states were having DMHP and during the next 5 year plan about 100 districts were expected to have the program. At the end of 5 years, State Governments were required to continue the program with their own resources.

In October 2003, Government of India launched a program with ₹ 190 crores which includes implementation of DMHP in 100 districts. ₹ 50 lakhs each to improve the Department of Psychiatry in all Government medical colleges and ₹ 3 crores each to improve every mental hospital.

Nurse's Role

The National Mental Health Program for India (1982) recommended the formation of a District Mental Health Team (DMHT) in order to decentralize mental health care at the district level with two qualified psychiatric nurses and a psychiatrist. The role of the psychiatric nurse in the district mental health program is to provide care to the in-patients. The care includes meeting their basic needs, conducting occupational therapy, recreational therapy and individual and group therapy, along with mental health education to families and the public in general. In addition to the above, qualified psychiatric nurses will actively participate in decentralized training to professionals and non-professionals working at taluk and Primary Health Centers (PHCs). They will also supervise the task of multipurpose workers in mental healthcare delivery. They will assist psychiatrists in research activities in monitoring mental healthcare at district and PHC levels. Their active participation in mental health education to the public will go a long way in creating public awareness in the care of individuals with various mental disorders.

INSTITUTIONALIZATION VS DEINSTITUTIONALIZATION

Before World War II, effective medications were largely unavailable, and the mentally ill were separated from the community and housed in institutions for the protection of patients as well as society. Nursing care for these patients was primarily custodial. The institutions provide structure, social contest, food, clothing and medical services to mentally ill patients.

By 1900, the State hospitals were overcrowded and understaffed. The construction of new hospitals had not kept pace with the growing population. Conditions in State hospitals deteriorated. Institutionalization caused

passive dependent behavior among psychiatric inpatients and resistance to discharge.

More recently, scientific advances have led to the use of effective medications and somatic therapies to treat symptoms of psychiatric illness. It became costly to run these large buildings and continue to employ staff.

The combination of these effects, as well as new laws pertaining to the care of the mentally ill resulted in a movement called deinstitutionalization. Deinstitutionalization was both a historical fact and a set of legal mandates governing the treatment of mentally ill persons. In deinstitutionalization policy, people who formerly required long hospital stays become able to leave the institutions and return to their communities and homes.

The philosophy of deinstitutionalization, changing healthcare economics and advances in the treatment of mental illness, especially psychopharmacology developments, significantly influenced the transformation of state mental hospitals (Boxes 15.2 and 15.3).

Three Essential Components of a Sound Deinstitutionalization Process

1. Prevention of inappropriate mental hospital admissions through the provision of community facilities.

Box 15.2: Positive effects of deinstitutionalization

- » Allow for the integration of family and social system in care of patients
- » Better care would be provided to mentally ill patients in their home communities surrounded by those who were not mentally ill
- » It was a huge step in returning a sense of worth, ability and independence to those who had been dependent on others for their care for so long

Box 15.3: Negative effects of deinstitutionalization

- » Unfortunately, adequate support services were not in place in many communities and a decreased quality of life for the mentally ill resulted
- » Revolving door syndrome: Patients were often returned to hospitals, stabilized and discharged again in a cycling pattern
- » Emergency department use by acutely disturbed individuals has increased dramatically
- » General hospital psychiatric units are overwhelmed at times with a continuous flow of patients being admitted and discharged
- » Patients with severe and persistent mental illness not receiving adequate care commit homicides
- » Homelessness among patients increased
- » State prisons are occupied by severely mentally ill patients.

2. Discharge to the community of long-term institutional patients who have received adequate preparation.
3. Establishment and maintenance of community support systems of non-institutionalized patients.

Institutionalization

In recent years, the focus of psychiatric care has moved away from extended care predominantly in patient settings toward shorter lengths of inpatient stays and a wider choice among the continuum of care options. Most inpatient psychiatric settings now have an average length of stay of 5 to 10 days when compared to 24 to 30 days during 1980s.

Indications for Institutionalization Inpatient Hospital Admission

- Prevention of harm to self or others
- Management of severe symptoms
- Need for a rapid, multidisciplinary diagnostic evaluation that requires frequent observation by specially trained personnel.

Treatment Objectives

- Rapid evaluation and diagnosis
- Decreasing behavior that is dangerous to self or others
- Preparing the patient and significant caregivers to manage the patient's care in a less restrictive setting
- Arranging for effective aftercare to facilitate continued improvement in the patients condition and functional level.

Community support services programs were developed to meet the needs of persons with mental illness outside the institution. These programs focus on rehabilitation, vocational needs, education and socialization as well as management of symptoms and medications.

In India, alternative community based services are not adequately developed and existing mental hospitals are not fully equipped with therapeutic activities. What is now required is the need for a balanced approach, i.e. inpatient treatment needs to be improved and community based health programs strengthened.

There is an urgent need to sensitize governments on the importance of mental health and clearly define the goals and objectives of community based health programs. Mental health services should be integrated into the overall primary health care system. Innovative community based health programs which are culturally and gender appropriate and reach out to all segments of the population need to be developed. Well-organized community based care is urgently required besides increasing the number of psychiatric beds in general hospitals.

MODELS OF PREVENTIVE PSYCHIATRY: LEVELS OF PREVENTION—ROLE OF A NURSE

In the 1960s, psychiatrist Gerald Caplan described levels of prevention specific to psychiatry. He described *primary prevention*

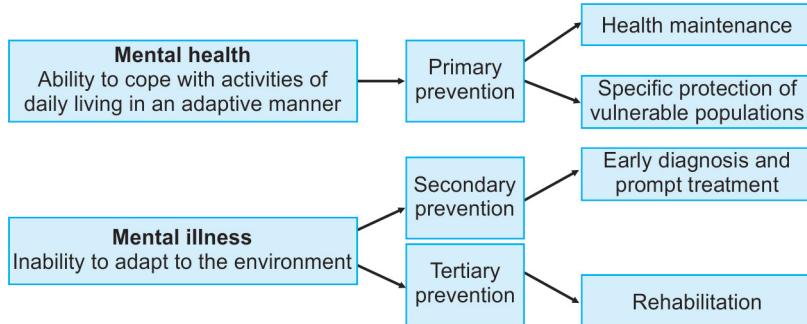


Fig. 15.1: Levels of prevention (This paradigm was developed by Bloom, 1979)

as an effort directed towards reducing the incidence of mental disorders in a community. *Secondary prevention* refers to decreasing the duration of disorder while *tertiary prevention* refers to reducing the level of impairment (Fig. 15.1).

Primary Prevention

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

Role of a Nurse in Primary Prevention

Community mental health nurses are in a key position to identify individual, family and group needs, conflicts and stressors. Thus, they play a major role in identifying high-risk groups and preventing the occurrence of mental illness in them. Some interventions include:

1. *Individual centered intervention*
 - Antenatal care to the mother and educating her regarding the adverse effects of irradiation, certain drugs and prematurity
 - Ensuring timely and efficient obstetrical assistance to guard against the ill effects of anoxia and injury to the newborn at birth
 - Dietary corrections to those infants suffering from metabolic disorders
 - Correction of endocrine disorders
 - Liberalization of laws regarding termination of pregnancy, when it is unwanted

- Training programs for physically, and mentally handicapped children like blind, deaf, mute and mentally subnormal, etc.
- Counseling the parents of physically and mentally handicapped children, with particular reference to the nature of defects. The parents need to accept and emotionally support the child and be satisfied with limited goals in the field of achievement
- Fostering bonding behaviors. Explaining importance of warm, accepting, intimate relationship and avoiding the prolonged separation of mother and child are essential

2. *Interventions oriented to the child in the school*

- Teaching growth and development to parents and teachers
- Identifying the problems of scholastic performance and emotional disturbances among school children and giving timely intervention. School teachers can be taught to recognize the beginning symptoms of problems and referring to appropriate agencies

3. *Family centered interventions to ensure harmonious relationship*

- Consulting with parents about appropriate disciplinary measures
- Promoting open health communication in families

- Rendering crisis counseling to the parents of physically and mentally handicapped children
 - Ensuring harmonious relationship among members of the family and teaching healthy adaptive techniques at the time of stress producing events.
- 4. Interventions oriented to keep families intact**
- Extending mental health education services at Child Guidance Clinics about child rearing practices; at parent-teacher associations regarding the triad relationship between teacher, child and parent; and at various extramural health agencies regarding integration of mental health into general health practice
 - Strengthening social support for the frustrated aged and helping them to retain their usefulness
 - Promoting educational services in the field of mental health and mental hygiene
 - Developing parent-teacher associations
 - Rendering home-maker services—when there is absence of the mother from home due to illness or other reasons for prolonged periods, the public health nurse can arrange for the service
 - Providing marital counseling for those having marital problems.
- 5. Interventions for families in crisis**
- In developmental crisis situations, such as the child passing through adolescence, birth of a new baby, retirement or menopause, death of a wage earner in the family, desertion by the spouse, etc. crisis intervention can be given at:
 - » Mental hygiene clinics
 - » Psychiatric first-aid centers
 - » Walk-in clinics
- 6. Mental health education**
- Conduct mass health education programs through film shows, flash cards and appropriate audio-visual aids regarding prevention of mental illnesses and promotion of mental health in the community
 - Educate health workers regarding prevention of mental illness so that they can function effectively in all the areas of prevention
- 7. Society-centered preventive measures**
- Community development-Culturally deprived families need biological and psychosocial supplies. They need better hygienic living conditions, proper food, education, health facilities, and recreational facilities. Otherwise psychopathy, alcoholism, drug addiction, crime and mental illness, will result in such situations
 - Collection and evaluation of epidemiological, biostatistical data.

Secondary Prevention

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

Role of a Nurse in Secondary Prevention

- **Early diagnosis and case finding:** This can be achieved by educating the public, community leaders, industrialists, Mahilamandals, Balwadis, etc. in how to recognize early symptoms of mental illness. Case finding through screening and periodic examination of population at risk, monitoring of patients, etc. Thus, in clinics, schools, home healthcare and the work place, community mental health nurses detect early signs of increased levels of anxiety, decreased ability to cope with stress and failure to perceive self, the environment and/or reality accurately, and provide direct services as appropriate.
- **Early reference:** The public should be educated to refer these cases to proper hospitals as soon as they recognize early symptoms of mental illness.

- *Screening programs:* Simple questionnaires should be developed to identify the symptoms of mental illness, and administration of the same in the community for early identification of cases. These questionnaires can be simplified in local languages, and used widely in the colleges, schools, industries, etc.
- *Early and effective treatment for patient, and if necessary, to family members as relevant;* providing counseling services to caregivers of mentally ill patients.
- *Training of health personnel:* Orientation courses should be provided to health workers to detect cases in the course of their routine work.
- *Consultation services:* Nurses working in general hospitals may come across various conditions such as puerperal psychosis, anxiety states, peptic ulcer, ulcerative colitis, bronchial asthma, etc. These basic care providers need guidance and consultation to deal with these conditions in an effective manner.
- *Crisis intervention:* If crisis is not tackled in time it may lead to mental disorders or even suicide. Sometimes anticipating the crisis situation and guiding the individual in time can help them to cope with the crisis situation in a better way.
- Occupational and recreational activities should be organized in the hospital so that idling is prevented.
- Community based programs can be launched through meeting with the family members when the need for discharge from the hospital should be emphasized. These programs can be implemented through day hospitals, night hospitals, after care clinics, half-way homes, ex-patient hostels, foster care homes, etc. Follow up care can be handed over to community health nurses.
- There should be constant communication between the community health nurses and the mental health institution regarding the follow-up of the discharged patient. The ultimate aim of the hospital and community based programs is to resocialize and remotivate the patient for a functional role in the community consistent with his resources.
- There are a wide range of services that need to be provided to patients as part of the tertiary prevention program. Nurses need to be familiar with the agencies in the community that provide these services. Collaborative relationships between mental health care providers and community agencies are absolutely essential if rehabilitation is to succeed.
- An important intervention in the maintenance of patients in their own homes in the community is the Training in Community Living (TCL) program, designed by 'Stein and Test'. In this model, when a person is referred for hospital admission the staff goes to the community with him rather than his going to the hospital to be with the staff. This real world experience with the patient enables the nurse to assess accurately the skills that the person needs to learn and to mutually agree on realistic goals.
- Another aspect of community life that is more difficult to assess accurately and deal with effectively is the stigma attached to mental illness. Many patients and their

Tertiary Prevention

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

Role of a Nurse in Tertiary Prevention

- Family members should be involved actively in the treatment program so that effective follow-up can be ensured.

families try to avoid stigma by keeping the nature of the person's illness a secret. The need for secrecy places additional stress on the family system because there is always the fear that the truth will be revealed. Nurses in the community are in a key position to monitor community attitudes and help in fostering a realistic attitude towards the mentally ill.

- For some patients, the emotional climate of the family to which they return can have a significant effect on their adjustment, and eventually recovery from the debilitating effects of chronic mental illness. Families sometimes view mental illness as a weakness of character that can be overcome by exertion of moral effort. This type of familial attitude may result in guilt on the part of the patient who believes that he has disappointed his significant others. Guilt leads to increased anxiety and decreased self-esteem. These are the conditions that interfere with a high level of functioning. Therefore, nurses working with families need to foster healthy attitudes towards the mentally ill member.

- Mental retardation
- Alcohol and drug dependence.

Need for Rehabilitation of Mentally Ill Patients

- In disorders like schizophrenia, bipolar disorder and substance abuse there is a proportion of persons who do not fully recover and have limitations in their functioning resulting in disability.
- Due to scarcity of services in India, large numbers of severely ill persons are not under any treatment resulting in greater disability. Where there is associated disability along with the symptoms of illness the disability improvement requires rehabilitation.

Principles of Rehabilitation

- Increasing independence would be the first step in rehabilitation process
- Primary focus is on improvement of capabilities and competence of patients with psychiatric problems
- Maximum use must be made of residual capacities
- Patient's active participation is very essential
- Skill development, therapeutic environment are fundamental interventions for a successful rehabilitation process.

Psychiatric Rehabilitation Approaches

- Psychoeducation:* Includes diagnosing the problem, telling the person what to expect regarding illness and discussing treatment alternatives.
- Working with families:* Encouraging family members to get involved in treatment and rehabilitation programs.
- Group therapy:* Positive aspects of group therapy include an opportunity for ongoing contact with others, validation of their perceptions, sharing their views about problems and problem solving abilities.

PSYCHIATRIC REHABILITATION

Rehabilitation is the process of enabling the individual to return to his highest possible level of functioning. It is an important component of the community mental health program, and is undertaken at the level of tertiary prevention.

Definition

Rehabilitation is, "an attempt to provide the best possible community role which will enable the patient to achieve the maximum range of activity, interest and of which he is capable."

—Maxwell Jones (1952)

The following disorders are indicated commonly for rehabilitation:

- Chronic schizophrenia
- Chronic organic mental disorders

- **Social skills training:** It involves teaching specific living skills that the patient is expected to have in order to survive in the community.

Rehabilitation Team

Professionals contributing to psychiatric rehabilitation include psychiatrist, clinical psychologist, psychiatric social worker, psychiatric nurse, occupational therapist, recreational therapist, counselor and other mental health paraprofessionals.

Steps in Psychiatric Rehabilitation

Psychiatric rehabilitation begins with a comprehensive medical psychiatric diagnosis and functional assessment. These are key elements in identifying impairments and disabilities. The steps of rehabilitation include:

- **Reduction of impairments:** Rehabilitation interventions with psychiatric patients require reduction or elimination of the symptoms and cognitive impairments that interfere with social and vocational performance. These impairments are reduced and eliminated for the greater part by various psychotropic agents.
- **Remediation of disabilities through skill training:** Skill training is used to remediate disabilities in social, family and vocational functioning. Patients generally require training in self-care skills, interpersonal skills, vocational and employment pursuits, recreational and leisure skills.
- **Remediating disabilities through supportive interventions:** When restoration of social and vocational functioning through skills training is limited by continuing deficits, rehabilitation strategies aim at helping the individuals compensate for handicap by learning skills in living and working environments, adjusting the individual and family expectations to a

level of functioning that is realistically attainable.

- **Remediation of handicaps:** In addition to clinical rehabilitation interventions, the disabled persons can be helped to overcome their handicaps through social rehabilitation interventions, e.g. community support programs.

Role of a Nurse in Psychiatric Rehabilitation

Rehabilitative psychiatric nursing must be studied in the context of both the patient and the social system. This requires the nurse to focus on three elements, the individual, family and community.

Assessment

Assessment of the Individual

The nurse should assess the individual in the areas of symptoms present, motivation, strengths, interpersonal skills, self-esteem, activities of daily living and drug compliance.

Assessment of Family

Components of family assessment:

- Family structure including developmental stages, roles, responsibilities, norms and values
- Family attitude towards the mentally ill member
- Emotional climate of the family
- Social support available to the family
- Past family experiences with mental health services
- The family's understanding of the patients problems and the plan of care.

Assessment of Community

It includes assessment of community agencies that provide services to people who have mental illnesses, assessment of attitudes of the people towards the mentally ill, etc.

Planning and Implementation

Planning and implementation in rehabilitative psychiatric nursing focuses on fostering independence by maximizing personal strengths. The nurse and the patient must work together to find ways for the patient to overcome any remaining impaired areas of functioning.

Individual Interventions

Hospital rehabilitation (Inpatient rehabilitation): This involves therapeutic community, recreational therapy, social skills training and training in basic living skills.

Community rehabilitation: Providing care in community settings (Homes, residential care settings, foster homes, etc.).

Family Interventions

- Health education to family members regarding the disease process, available resources, communication skills and problem solving techniques.
- Motivating the family members to provide proper care to the patient.
- Group therapy and support to family members through self-help groups; nurses are in a favorable position to help families cope with stress and adapt to changes in the family structure.

Community Interventions

There are several ways that nurses can intervene in the community tertiary prevention programs. Among these are health education to the public, training to school teachers, village leaders and paraprofessionals in the rehabilitation of mentally ill people.

Evaluation

Evaluation of psychiatric rehabilitation services usually takes place at the level of impact on the patient, family and the effectiveness of the community service system.

Box 15.4: Main vocational rehabilitation centers in India

- » Mithra Special School and Vocational Training Center for the Mentally Retarded, Chennai
- » Banyan, Chennai
- » Vocational Rehabilitation Center, Chennai
- » Shristi Center for Psychiatric Rehabilitation, Madurai
- » Vocational Training Center (VTC) for the physically handicapped run by the Ministry of Labor, Government of India, has opened up its facility for the mentally ill for the first time in Chennai
- » Indian Red Cross Society (IRCS) which runs VTC for the handicapped has offered vocational training for the chronic mentally ill
- » Indian Council for Child Welfare, an NGO caring for underprivileged children

Vocational Rehabilitation

Vocational rehabilitation is a part of continuous and co-ordinated process of rehabilitation which involves the provision of those vocational services (for example, vocational guidance, vocational training and selective placement) designed to enable a disabled person secure and retain suitable employment (Box 15.4).

Phases in Vocational Rehabilitation

- Vocational assessment
- Vocational counseling
- Vocational training
- Job exploration
- Job placement
- Follow-up.

Vocational assessment

It is done in four areas viz., clinical, social, psychological and vocational.

- Clinical assessment includes assessing for residual psychiatric symptoms which may affect his ability to function

- Social assessment includes assessing family support, attitude of family members and economic status of the family
- Psychological assessment includes assessing self-esteem, confidence, patient's level of motivation
- Vocational assessment includes assessing physical strength, hand co-ordination, attention, concentration, etc.

Vocational counseling

This includes informing patients and family members regarding the type of training available. Family consent should be taken for providing rehabilitation training.

Vocational training

It includes:

- Course content
- Duration of training
- Incentives
- Assessment of the progress
- Imparting skills
- Supervision

Job exploration

Finding out various jobs available in the community.

Job placement

This includes selecting suitable job, placement of the patient in the job, checking the facilities available and evaluating work performance.

Follow-up

It includes evaluation of the four dimensions viz., clinical, social, psychological and vocational.

Vocational Programs

Open competitive job placement: Though it is difficult to place the mentally restored in open competitive job placements, it is also possible to provide this opportunity for selected groups of patients with the clinical diagnoses of reactive psychosis, bipolar affective disorders, and acute psychotic episodes. They can be equipped to function successfully by regular follow-up programs.

Sheltered employment: This is provided for those disabled persons who because of the nature and severity of the disability cannot cope with ordinary employment. This is suitable for those with the problems of mental retardation, chronic mental illness (for example, schizophrenia, repeated attacks of affective disorder in spite of regular medication).

Self-employment: Persons who cannot cope with the demands of vocational adjustment in open competitive job situations, but who have the capacity to do some work with the help of any family members may be considered for self-employment schemes which are usually sponsored by different welfare schemes of nationalized banks and social welfare departments.

Home-bound work programs: For those disabled needing total care, work can be given at home, which shall be collected by the center and paid according to the performance.

Rehabilitation Services in India

One of the important recommendations of World Health Organization (WHO, 2001) has been to develop community based Mental Healthcare Program. In India, the National Human Rights Commission pointed out the need for management of growing chronic population and stressed the demand for providing rehabilitation activity in all hospitals. The Supreme Court has also directed to involve NGOs in the process of rehabilitation in the hospitals. In India, for a population of approximately 1 billion people, the psychiatric disorder like schizophrenia is prevalent in an estimated 4 million people and 60% of them require rehabilitation on their road to recovery (WHO, 2001). Taking Thumb rule of Ten, it has been estimated that about 20 to 25% of those ill with severe mental disorders need long-term rehabilitation. Thus, today a large proportion of persons with mental illness and mood disorders experience a poor quality of life with long-term disability,

persisting symptoms, or a relapsing course of illness which has given birth to the field of psychiatric and psychosocial rehabilitations in India.

At present in India, the rehabilitation facilities are very limited and largely the result of efforts of individuals and voluntary organizations. Rehabilitation services in mental health are delivered through hospital settings and community involvement.

Rehabilitation Facilities at Hospitals

The major findings for psychiatric rehabilitation activities revealed that only 36% of Government mental hospitals have a separate facility for vocational training. The rehabilitation activities were confined to the occupational unit (OT).

Rehabilitation Facilities at Community

The birth of psychosocial rehabilitation gave momentum for the Community Based Rehabilitation (CBR) Program. Some of the NGOs run rehabilitation centers are, Half way home-Medico Pastoral Association, CAD-BAM, Bengaluru, Family day care center, Long stay, Jyothi Niwas, Biopsychosocial model, Pune, Day care services, Sarthaj, Sheltered work shop, Ashadeep, Guwahati, Self-help Groups like Margdarshika, ASHA at Chennai, Richmond Fellowship in Bengaluru, SCARF, Chennai, SHRISTI, Madurai, PRERNA, Mumbai; SAMARPAN, Indore, BPA, Ahmedabad, ASHAADEEP, Janagadha, VARDAAN day care Center and many more.

MENTAL HEALTH SERVICES AVAILABLE AT THE PRIMARY, SECONDARY AND TERTIARY LEVEL

At Primary Level

- Subcenters
- Primary health centers
- Community mental health centers
- Psychiatric hospitals/nursing homes

Role of Medical Officer in Primary Health Center Related to Mental Health Care

- Provide skills to the team members
- Ensure supplies
- Support and supervision of other health care personnel
- Initiate community involvement
- Provide treatment for mentally ill persons
- Monitoring work of health personnel.

The effective measures to care for mentally ill persons at this level are:

- Correct diagnosis with explanation
- Avoiding unnecessary investigations
- Listening to the patient
- Teaching relaxation techniques
- Guidance about daily routines and activities
- Mobilizing the family resources
- Use of medicines for short periods and formulation of groups of patients for self-help.

Staff Nurse's Role

- First aid
- Nursing care of outpatients and inpatients
- Mental health education.

Multipurpose Health Workers Role

- Identification of cases
- First aid
- Referral
- Follow up
- Mental health education.

Community Health Guides or any Volunteer Role

- Identification of cases
- Referral
- Follow up
- Mental health education.

Secondary Level

- General hospital psychiatric units
- Government and private psychiatric hospitals
- Voluntary organizations.

Activities of Psychiatric Hospitals

Psychiatric hospitals have become part of a continuum of mental health services available to patients and their families, and offer a variety of treatments for psychiatric disorders. Their activities include:

- Outpatient treatment
- Inpatient treatment
- Education and training
- Research
- Rehabilitation
- Referral
- Follow-up
- Mental health education
- Community outreach programs.

Box 15.5: Main day care centers in India

- » Sanjivini, New Delhi
- » SCARF (Schizophrenia Research Foundation), Chennai, has started a day care center called "BAVISHYA" in 1985
- » Anugraha Day Care Center, Chennai
- » Association of the Friends of Mentally Ill, Mumbai
- » Institute of Mental Health, Ahmedabad
- » Psychiatric Center, Kolkata
- » NIMHANS, Bengaluru
- » The Richmond Fellowship Society, Bengaluru
- » Krupamayie Institute of Mental Health, Miraj

Tertiary Level

- Rehabilitation centers at Government and private psychiatric hospitals
- Voluntary organization
- Non-governmental mental health organizations.

Activities

- Rehabilitation
- Family and patient mental health education
- Community outreach programs
- Follow-up
- Training and education
- Research.

Mental Health Services Available for Psychiatric Patients

Partial Hospitalization

Partial hospitalization is an innovative alternative to hospitalization. Individuals in partial hospitalization program attend structured programming throughout the day and return home in the evenings. The main goal is development of skills that help patients better manage their symptoms. Patients are generally referred to partial hospitalization when they are experiencing acute psychiatric symptoms that are difficult to manage but

do not require 24-hour care. It is ideally suited to most of the psychiatric syndromes, particularly chronic psychotic disorders, neurotic conditions, personality disorders, drug and alcohol dependence and mental retardation. Day care centers, day hospitals and day treatment programs come under partial hospitalization.

Partial hospitalization has the advantages of lesser separation from families, more involvement in the treatment program and a lessening of patient's preoccupation with the illness, which may be intensified by full hospitalization (Box 15.5).

Quarterway Homes

This is a place usually located within the hospital campus itself, but not having the regular services of a hospital. There may not be routine nursing staff or routine rounds, and most of the activities of the place are taken care of by the patients themselves.

Halfway Home

A halfway home is a transitory residential center for mentally ill patients who no longer need the full services of a hospital, but are not yet ready for a completely independent living. It attempts to maintain a climate of health

rather than of illness, and to develop and strengthen individual capacities. At the same time, it enables the recognition of problems that require medical attention, and permits the discovery of conditions in the community which are acting adversely on the individual. Thus, halfway homes have a major role in the rehabilitation of the mentally ill individual.

Objectives

- To ensure a smooth transition from hospital to the family
- To integrate the individual into the mainstream of life.

Activities

Community mental health nurses play a vital role in monitoring the progress of discharged patients in halfway homes, especially with regard to their medication regimen and co-ordination of care. Some of the interventions carried out in halfway homes include:

- Assessment: *Clinical* assessment including assessing for residual psychiatric symptoms which may affect his ability to function; *social* assessment including assessing family support, attitude of family members and economic status of the family; *psychological* assessment including assessing self-esteem, confidence, patient's level of motivation; *vocational* assessment including assessing physical strength, hand coordination, attention, concentration, etc.
- Remediating disabilities through supportive interventions.

Outcomes

Expected outcomes could be: Successful return of the patients to their homes, prevention of relapses, economic self-sufficiency made possible through vocational counseling and self-employment programs.

Nurses need to be familiar with the various halfway homes available in the community; collaboration with such facilities is absolutely essential for successful rehabilitation (Box 15.6).

Box 15.6: List of halfway homes available in India

- » Medico-Pastoral Association, Bengaluru
- » Atmashakti Vidyalaya, Bengaluru
- » Richmond Fellowship, Bengaluru
- » Puraskara Aftercare Home, Bengaluru
- » Cadabam's Home for the Mentally Disabled, Bengaluru
- » Family Fellowship Society for Psychosocial Rehabilitation, Bengaluru
- » Raju Rehabilitation Foundation, Bengaluru
- » YWCA Halfway Home for Mentally Ill, Chennai
- » Dr. Boaz's Rehabilitation Center, Chennai
- » Dr. Dhairyam's Psychotherapy and Rehabilitation Center, Chennai
- » Sowkya Halfway Home at Madurai
- » Delhi Psychosocial Rehabilitation Society
- » Paripurnata Halfway Home, West Bengal
- » Society for Mental Health, Kerala

Self-help Groups

- Self-help groups are composed of people who are trying to cope with a specific problem or life crisis, and have improved the emotional health and well being of many people. Usually organized with a particular task in mind, such groups do not attempt to explore individual psychodynamics in great depth or change personality functioning significantly.
- A distinguishing characteristic of self-help groups is their homogeneity. The members have same disorders and share their experiences good or bad, successful or unsuccessful, with one another. The members work together using their strengths to gain control over their lives. By doing so, they educate each other, provide mutual support, and alleviate the sense of alienation usually felt by people drawn to this kind of group. In other words, self-help groups are based on the premise that *people who have experienced a particular problem are able to help others who have the same problem*.

- One of their most important functions is to demonstrate to individuals that they are not alone in having a particular problem. Sharing each others' experiences not only helps the members by providing mutual support, but also by generating alternate ways to view and resolve problems. Thus, they help in overcoming maladaptive patterns of behavior or states of feeling that traditional mental health professionals have not generally dealt with successfully.
- Self-help groups emphasize cohesion, which is exceptionally strong in these groups. Because the group members have similar problems and symptoms, they develop a strong emotional bond. But each group may have its unique characteristics, to which the members can attribute magical qualities of healing.
- Strategies: The strategies used by group leaders include promotion of dialogue, self-disclosure and encouragement among members. Concepts used in support groups include psychoeducation, self-disclosure, and mutual support.
- Processes: The processes involved in self-help groups are social affiliation; learning self-control; and modeling methods to cope with stress and acting to change the social environment.
- The end result is that these groups prevent physical, emotional and social problems and breakdowns; improve an individual's or a family's quality of life; and provide the education necessary to develop the member's potential further. Examples of self-help groups are Alcoholics Anonymous (AA), Association for Mentally Disabled (AMEND).
- The self-help group movement in India is in its ascendancy. One of the recent developments is the start of AMEND in Bengaluru. People with mental illness suffer from social stigma and discrimination. More so their family members are struck with disbelief, loneliness and sorrow. Families of such people have got together to form an organization in

Bengaluru called AMEND—Association for Mentally Disabled, under the leadership of Dr. Nirmala Srinivasan. AMEND has been advocating and practicing family based care. At AMEND, families share experiences, talk about side effects of medication and discuss how they can communicate problems to psychiatrists. AMEND also conducts workshops to train consumers in living skills so that they can look after themselves, tell them what is wrong with one self, why they need to take their medication, and what can happen if they stop and so on. Many of AMEND's consumers have been rehabilitated and are holding jobs as part of their occupational therapy.

Suicide Prevention Centers

In India, there are many suicide prevention centers from the voluntary sector doing good work and helping those in need. Some of them are:

- Helping Hands and MPA in Bengaluru
- Sneha in Chennai
- Sahara in Mumbai
- Sanjivini and Sumaitri in New Delhi

Others

- Community group homes
- Large homes for long-term care
- Hostels
- Home care programs
- District rehabilitation centers.

MENTAL HEALTH AGENCIES: GOVERNMENT AND VOLUNTARY, NATIONAL AND INTERNATIONAL

Mental Health Agencies— Government at National Level

There are 42 mental hospitals in the country with the bed availability of 20, 893 in the Government sector. In the private sector there are 5,096 beds. These facilities have to

manage an estimated 1.02 crore people with severe mental illness and 5.12 crore people with common mental disorders. Pursuant to the orders of the Hon'ble Supreme court in CWP No. 334 of 2001, the Government of India constituted a number of teams to inspect and report on the state of mental health services, with special focus on mental hospitals. These teams visited all State Capitals and Government run mental hospitals across the country during Nov 2001—Jan 2002 and submitted their report (Table 15.3).

Mental Health Agencies—International

- 1. World Health Organization (WHO):** WHO defines mental health as not simply absence of disease but a positive state of physical, mental and social well-being. WHO's present program now integrates mental health concerns to prevent and control mental disorders. One of the important recommendations of WHO (2001) has been to develop community based mental health care program.
- 2. The United Nations Educational Scientific and Cultural Organization (UNESCO):** Arranged the use of satellites for educational and mental health purposes. It helps in the training of scientists as well as in the development of scientific research in developing countries.
- 3. The World Federation for Mental Health (WFMH):** It was established in 1948 as an international congress of non-governmental organizations and individuals concerned with mental health. Its purpose is to promote co-operation between governmental and non-governmental mental health agencies at the international level. The federation with a membership of over 50 countries has been granted consultative status by both WHO and UNESCO and it assists the UN agencies by collecting information on mental health conditions all over the world. The goals of WFMH are as follows:

- To promote mental health and optimal functioning
- To prevent mental, neurological and psychosocial disorders
- To heighten public awareness about the importance of mental health
- To improve the care and treatment of those with mental, neurological and psychosocial disorders.

Activities of this organization include response during mental health crises, grassroots advocacy and public education in mental health field. The individual membership includes mental health workers of all disciplines, consumers of mental health services, family members, and citizens.

- 4. The Internal Society for Mental Health Online (ISMO):** It is a non-profit organization formed in 1997 to promote the understanding, use and development of online communication information and technology for the international mental health community. The archive serves as a valuable resource for researchers, clinicians and ordinary people interested in the topic of online mental health.
- 5. National Alliances for the Mentally Ill (NAMI):** It is a non-profit self-help, support and advocacy organization of consumers, families and friends of people with severe mental illnesses. It was founded in 1979.

Mental Health Agencies—Voluntary/Non-Governmental Organizations

Voluntary organizations are a valuable community resource for mental health. They are often more sensitive to the local realities than centrally driven programs, and are usually strongly committed to innovation and change. They often play an extremely important role in the absence of a formal or well-functioning mental health system, filling the gap between community needs and available community services and strategies.

Table 15.3: State-wise list of mental hospitals

<i>Name of the state</i>	<i>Name of the hospital and place</i>
Andhra Pradesh	1. Govt. Hospital for Mental Care, Vishakapatnam
Assam	2. Lokopriya Gopinath Bordoloi Institute of Mental Health, Tezpur
Bihar	3. Institute of Mental Health, Bhojpur
Jharkhand	4. Central Institute of Psychiatry, Ranchi 5. Ranchi Institute of Neuropsychiatry and Allied Science (RINPAS), Ranchi
Delhi	6. Institute of Human Behavior and Allied Sciences (IHBAS), Delhi
Goa	7. Institute of Psychiatry and Human Behavior, Panaji
Gujarat	8. Hospital for Mental Health, Bhuj 9. Hospital for Mental Health, Jamnagar 10. Hospital for Mental health, Ahamedabad 11. Hospital for Mental Health, Baroda
Himachal Pradesh	12. Himachal Hospital of Mental Health & Rehabilitation, Shimla
Jammu & Kashmir	13. Govt. Hospital for Psychiatric Diseases, Srinagar 14. Psychiatric Diseases Hospital GMC, Jammu
Karnataka	15. National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore 16. Dharwad Institute of Mental Health and Neuro Sciences (DIMHANS), Dharwad
Kerala	17. Mental Health Centre, Thiruvananthapuram 18. Govt. Mental Health Centre, Thrissur 19. Govt. Mental Health Centre, Kozhikode
Madhya Pradesh	20. Gwalior Manasik Arogyasala, Gwalior 21. Mental Hospital, Indore
Maharashtra	22. Regional Mental Hospital, Nagpur 23. Regional Mental Hospital, Pune 24. Regional Mental Hospital, Thane 25. Regional Mental Hospital, Ratnagiri
Meghalaya	26. Meghalaya Institute of Mental Health and Neuro Sciences, Shillong 27. Modern Psychiatric Hospital, Tripura
Nagaland	28. Mental Hospital, Nagaland
Odisha	29. Mental Health Institute, Cuttack
Punjab	30. Dr. Vidyasagar Punjab Mental Hospital, Amritsar
Rajasthan	31. Psychiatric Centre, Jaipur 32. Mental Hospital, Jodhpur
Tamil Nadu	33. Institute of Mental Health, Chennai
Telangana	34. Institute of Mental Health, Hyderabad
Uttar Pradesh	35. Institute of Mental Health and Hospital, Agra 36. Mental Hospital Bareilly, Bareilly 37. Mental Hospital, Varanasi
West Bengal	38. Lumbini Park Mental Hospital, Kolkata 39. Institute of Mental Care, Purulia 40. Mental Hospital Berhampore, Berhampore 41. Institute of Psychiatry, Kolkata 42. Calcutta Pavlov Hospital, Kolkata

Voluntary organizations can especially play an important role in developing suicide prevention and crisis support, formation of self-help of families, organizing community-based housing facilities for short-term and long-term care of persons with chronic illnesses, setting up of day care centers, sheltered employment facilities, life skill programs for school drop-out children and public mental health education.

Non-Governmental Organizations (NGOs)

Non-Governmental Organizations (NGOs) are recognized by Governments as non-profit or welfare oriented organizations, which play a key role as advocates, service providers, activists and researchers on a range of issues pertaining to human and social development. Mental Health Non-Governmental Organizations (MHNGOs) are located throughout India. While many are formed in urban areas, they have begun to extend services into rural areas too.

Scope and activities of MHNGOs

More recently scope and activities of MHNGOs, has broadened. Most MHNGOs provide services which are restricted to a defined community; however, the work of some such as the Alzheimer and Related Disorders Society of India (ARDSI), which was begun in Kochi, has now spread to more than a dozen centers in India.

Sangath Society (Goa), The Research Society (Mumbai) and Samadhan (New Delhi) extended their activities from mental retardation to commoner mental health problems seen in children, such as autism, hyperactivity and conduct disorders. They also provide outpatient and school based services for such problems.

Schizophrenia Research Foundation (SCARF) and the Medico-Pastoral Association (MPA) were started to fulfill the needs of severe mental disorders—the activities ranging from family counseling to vocational rehabilitation.

The TT Krishnamachari Foundation in Chennai, the TRADA (Total Response to Alcohol

and Drug Abuse) in Kerala and Karnataka, Alcoholics Anonymous and the Samaritans in many parts of the country and the National Addiction Research Centre in Mumbai are examples of MHNGOs that focus on substance abuse problems.

MHNGOs providing community based counseling and suicide prevention activities have mushroomed, for example, Sneha (Chennai), MPA (Bengaluru), Saarthak (Delhi) and Prerna (Mumbai) work on suicide prevention activities. Some MHNGOs (for example, Bapu Trust, Pune) focus on women's mental health.

Some MNGOs, such as AMEND (Bengaluru), are entirely run by and focus on families of those affected by severe mental disorders. ARDSI works with families who have a member affected by dementia. Some NGOs integrating mental health in their agenda include the Voluntary Health Associations of India (VHAI) and the Community Health Cell, Bengaluru.

MHNGOs activities and programs

NGOs get minimal Government funding and are mostly dependent on the general public or donor agencies for financial resources. A few have been able to mobilize research funds by the virtue of having established research credentials.

1. Clinical care and rehabilitation:

- Some MHNGOs provide facilities for inpatient care, in particular for the management of severe mental disorders. Virtually all of them provide some type of out patient clinic.
- The Research Society of Mumbai provides laboratory facilities for carrying out genetic tests for the diagnosis of genetic syndromes associated with childhood mental disabilities.
- MHNGOs working with schizophrenic patients have comprehensive services focusing both on the control of symptoms of the acute phase of the illness as well as rehabilitation to ensure optimal functioning in the long term. Providing

vocational training in skilled professions, such as carpentry and printing, social skills training and family therapy, are some examples of the kind of activities undertaken.

2. **Community outreach programs:** MHNGOs have a strong commitment to extend care into the community. Examples of primary preventive programs run by MHNGOs include: the telephone helplines for immediate access to counseling and advise for anyone in distress, early intervention for babies born at risk for developmental delay and education programs in schools and workplaces for prevention of substance abuse. Secondary prevention focuses on minimizing the handicaps associated with existing mental disorders. Examples of such programs include community based rehabilitation for childhood and adult mental disabilities and school programs to help children with hyperactivity and dyslexia stay in school.
3. **Support groups:** Alcoholics Anonymous is an example of support group philosophy which becomes the core to the process of treatment of alcohol dependence. Some MHNGOs run support groups for family members, e.g., families of elders with Alzheimer's disease, adults with schizophrenia and children with autism meet regularly to discuss common problems, support each other and provide practical solutions to everyday difficulties.
4. **Training:** Most of the MHNGOs provide opportunities for training other professionals and health workers in specific areas of mental health, such as counseling skills. Many colleges, for example, send their students to MHNGOs for field placements. Workshops with health workers, teachers and other key groups are a standard feature of the activities of many MHNGOs. The Richmond Fellowship has successfully established a full two-year MSc Program

in psychosocial rehabilitation. Many of these organizations regularly organize local, national or international conferences, seminars, workshops or symposia to discuss current issues in the field.

5. **Advocacy and building awareness:** MHNGOs have raised the awareness in different sectors of the community, such as health workers, teachers and lay persons, a priority area. The documentation and dissemination of relevant facts and research, and lobbying policy makers for changes in the law are vital instruments for improving mental healthcare. Prominent examples of the success of the efforts of MHNGOs are the inclusion of mental disabilities in the disability legislation of India. Many of the MHNGOs publish their work in annual reports and souvenirs. Others publish regular newsletters and host websites, marking the close affinity of MHNGOs with contemporary technological advances.
6. **Research:** Today, MHNGOs are at the forefront of ground-breaking research in India.
7. **Networking:** All the MHNGOs are strongly committed to collaboration and intersectoral partnerships. Networks are established between MHNGOs, with government organizations and with academic institutions. '*Paripurnata*' is, for example, a member of the Forum for Mental Health, an umbrella organization of more than a dozen MHNGOs that are located in West Bengal. '*Sneha*' has actively supported the development of similar organizations in other parts of India. Partnerships with Government are also a notable feature in some MHNGOs. '*Sangath*' currently runs a woman's health clinic in a government primary health center, as a part of a large research project on women's mental health. Partnerships with academic institutions are encouraged by many MHNGOs, particularly those with a key interest in research.

Box 15.7: Community mental health-psychiatric nurse attributes

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

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

COMMUNITY MENTAL HEALTH—PSYCHIATRIC NURSING

Community mental health—psychiatric nursing, is the application of specialized knowledge to populations and communities to promote and maintain mental health, and to rehabilitate populations at risk that continue to have residual effects of mental illness.

Psychiatric nursing in the community setting differs markedly from its hospital counterpart. The community setting requires that the psychiatric nurse possesses knowledge about a broad array of community resources and be flexible in approaching problems related to individual psychiatric symptoms, family and support systems and basic living needs such as housing and financial support (Box 15.7).

Goals of Community Mental Health Nursing

- To provide prevention activities to populations for the purpose of promoting mental health
- To provide interventions as early as possible

Community Mental Health Nursing Process

Assessment

The key aspects of assessment include:

- Impairments directly due to the psychiatric disorder such as persistent hallucinations, negative symptoms, social withdrawal, under-activity and slowness
- Secondary social disadvantages such as unemployment, poverty and homelessness, as well as the stigma attached to psychiatric illness
- Personal reactions to illness such as low self-esteem and hopelessness, poor motivation and capacity for self-management and performance of social roles
- Unpredictable behavior, risk of harm to self and others, and liability to relapse
- Financial position of the patient
- Availability of community resources
- Social circumstances to which the patient is likely to return to.

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

Intervention

Community psychiatric nurses must approach interventions with flexibility and resourcefulness to meet the broad range of needs of the patients with continued mental deficits. Interventions cannot be directed only towards discrete psychiatric symptoms, but must also facilitate patient's access to various community resources providing for basic needs such as housing, nutrition, etc.

Since people suffering from mental illness often remain in or return to the community following treatment, nurses must be able to assess the presence of continued mental health problems and plan and implement interventions within the confines of the resources available in the community.

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

Consultative role: Giving advice to other professionals in the community about the type and level of nursing care required for a given patient group.

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

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

Assessor/researcher role: Assessing the care given to the patient/patient group and also assess the outcome of ongoing care programs.

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

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

Manager/Administrator: Managing resources, planning and coordination.

Domiciliary care: Providing services to the patient by visiting their homes. Services like administration of medications, assessment of

the level of functioning and improvement of patients, monitoring of side-effects of drugs, counseling of patients and family members are offered at the patient's home setting.

Liaison role: Helping the patients and the family members by bridging the gap between the patient and the hospital, patient and the employers and also by networking in the community for resource development.

Preventive roles: These preventive roles are under primary, secondary and tertiary levels.

Other areas of community health psychiatric nursing are:

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

Tips for Working in the Community

• Identification of Patients in the Community: Talk to important people like village panchayat members, local leaders, teachers, educated youth, members of service agencies like angawadi, mahila-mandals, etc. and request them to tell you about individuals:

- Who talk nonsense and act in a manner considered strange or abnormal
- Who have become very quiet and do not talk or mix with other people
- Who claim to hear voices or see things that others cannot hear or see
- Who are suspicious and claim that others are trying to harm them
- Who have become unusually cheerful, crack jokes and say that they are very wealthy and superior to others when it is not really so
- Who have become very sad lately and cry without reason

- Who talk about suicide or have made an attempt at suicide
- Who get possessed by God or spirit or who are said to be the victims of black magic or evil power
- Who are dull, mentally not grown up like others of their age and slow since birth.

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

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

- Refer the patient immediately in the following conditions
 - The patient is severely ill, violent or unmanageable at home
 - History of recent head injury
 - Repeated convulsions (continuous or more than three times a day)
 - Disturbed behavior after delivery
 - The patient has attempted suicide or is threatening to commit suicide
 - Disturbed behavior in people with known diabetes or hypertension
 - People who show abnormal behavior after taking alcohol or any other intoxicating substances.
- Follow-up care with special emphasis on medication regimen, improvement made, and side-effects, patient's occupational function
- Be prepared to answer certain common questions asked regarding mental illness
 - *Is mental illness hereditary?*

The role of genetic factors is well-established only in some psychiatric illnesses (for example, schizophrenia, mania and depression). It is also not true that if a family member is suffering from schizophrenia, the other members will always develop the same illness. The chances are more but factors such as

personality and environmental factors play an equally important role.

- *Is mental illness contagious?*

Mental illnesses do not spread through contact of any form. Individual genetic vulnerability or predisposition and precipitating factors play an important role in disease occurrence.

- *Do ghosts, black magic, curse cause mental illness?*

Many people do not consider mental illness as an illness, but possession by a ghost or supernatural power. The causation of most of the mental illnesses is well known and specific methods are available to treat mental illnesses.

- *Is mental illness treatable?*

80% of the mental illnesses are fully curable and preventable. Excluding schizophrenia, all other mental illnesses can be easily controlled and prevented through proper medications and psychological therapies.

- *Can patients take up responsibilities after recovery?*

Like other physical illnesses mental illnesses are curable with drugs and other physical and psychological methods.

Depression and mania are self-limiting illnesses, lasting from 6 to 9 months. Anxiety neurosis, hysteria etc. are fully curable and preventable disorders. If schizophrenia is managed early and correctly, the patient may become socially and occupationally normal within few weeks.

Can marriage cure mental illness?

A mentally ill person can get worse if he gets married when he is ill, as marriage can become an additional stress. A patient who has recovered can get married and live a normal life like any other person.

A nurse can play an important role in community by making the public aware of some important principles related to mental illness:

- Mental illnesses, like physical illness, can be easily treated with medications and psychological methods.

- The treatment of mental illness is not just confined to drugs; it also includes many other psychological therapies like behavior modification therapy, counseling, activity therapy, family therapy, group therapy, etc.
- Continuity of treatment is more important for curing mental illnesses. Treatment should never be tampered without the advice of a psychiatrist.
- In majority of mental illnesses, for example, mania, depression and other neurotic disorders like dissociative disorder, patients completely recover without a residual effect if the treatment is taken on a regular basis.
- Early detection and prompt treatment for mental illnesses gives better improvement in psychiatric patients enabling them to lead socially productive lives.

Remember

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

MISCONCEPTIONS ABOUT MENTAL ILLNESS

Beliefs about mental illness have been characterized by superstition, ignorance and fear. Although time and advances in scientific understanding of mental illness have dispelled many false ideas, there remain a number of popular misconceptions. Some of them are:

- **Mental illness is caused by supernatural power and is the result of a curse or possession by evil spirit:** Many people do not consider mental illness as an illness, but possession by spirits or curse that has befallen on the patient or family because of past sins or misdeeds in previous life.

- **Mentally ill people show bizarre behavior:** Patients in mental hospitals and clinics are often pictured as a weird lot, who spend their time exhibiting useless bizarre behavior like twisting of hands, etc.
- **Mentally ill people are dangerous:** People who have or had a mental illness are viewed with suspicion and as dangerous persons.
- **Mental illness is something to be ashamed of:** This idea arouses an unsympathetic, cruel attitude towards a mentally ill person. This is the reason why many people hide mental illness in the family.
- **Mental illness is not curable:** People object to have normal relationship with mentally ill people, or to give them employment even after being cured, or even to accept them as neighbors.
- **Mental illness is contagious:** The fear that it is contagious is the main false notion which leads people to view suspiciously, or object to marital relations with a person belonging to the household of the mentally ill.
- **Mental illness is hereditary:** It is not a rule that children of mentally ill patients should become mentally ill.
- **Marriage can cure mental illness:** A mentally ill person can get worse if he gets married when he is ill, as marriage can become an additional stress. A patient who has recovered can get married and live a normal life like any other person.
- **Mental hospitals are places where only dangerous mentally ill individuals are treated and restraint is a major form of treatment:** People hesitate to take their relatives to mental hospitals for treatment because of fear. Further, as an ex-patient of a mental hospital he as well as his family members are often isolated. Therefore, people seek help from mental hospitals only as a last resort.

General Attitude Towards the Mentally Ill

- In general, the community responds to the mentally ill through denial, isolation

and rejection. There is also a lack of understanding of mental illness as any other illness, and a lack of tendency to reject both the patients and those who treat them.

- Mentally ill are viewed as people with no capacity for understanding.
- People feel mental illness cannot be cured, and even if the patient gets better, complete physical rest is considered essential.
- The mentally ill are by and large perceived as aggressive, violent and dangerous.

An individual's values and personal beliefs affect his attitude about mental illness, the mentally ill and treatment of mental illness. There still exists a stigma surrounding individuals who need or use psychiatric mental health services. The need continues for public education to modify or alter misconceptions about mental illness and people with mental disorders.

MENTAL HEALTH NURSING ISSUES FOR SPECIAL POPULATION

Children

Childhood is not a good time for all young people. Many children and adolescents live in less-than nurturing homes, face traumatic events, suffer maltreatment, become dependent on substances, fear that no one loves or will care for them, think of ways to hurt themselves, and develop illness such as mood and anxiety disorders.

Childhood mental illness has staggering effects. Untreated mental illness in childhood often results in long-term mental illness in adults. For example, children with untreated depression frequently have dysthymia as adults, and almost 50% of them having conduct disorder become antisocial adults. The less obvious results—conflict, shame, guilt, lowered self-esteem, blame, unmet needs of siblings, thwarted development and diminished productivity are just as debilitating.

Some children are at an increased risk for development of a psychiatric disorder because of family history of psychiatric and addictive disorders, physical health problem, immature development of the brain, brain abnormality; family problems (chronic parental conflict or divorced parents), intellectual deficits, low birth weight, multigenerational poverty, and separation from or abuse or neglect by caregivers.

Many psychiatric illnesses affect children and adolescents. Some of these illnesses are usually first diagnosed during infancy, childhood or adolescence. The manifestations, treatment or both in children and adolescents may differ from those in the adult. The childhood psychiatric disorders can be divided into several broad categories such as developmental disorders, disruptive behavior disorders, internalizing disorders, tic disorders, psychotic disorders and elimination disorders.

Nursing Interventions

- Helping the child master developmental tasks to overcome regressive, slow or impaired developmental behavior.
- Establishing a method of communication with patients who have difficulty communicating such as withdrawn, disoriented, mute, hostile, preoccupied or autistic child.
- Identifying stimuli that might foster abusive, destructive or otherwise negative behavior.
- Allow time for the patient to respond to therapeutic interventions.
- Educating family.
- Multifactorial approach has been shown as most effective treatment for childhood disorders.

ADOLESCENTS

According to the World Health Organization (WHO), individuals between 10–19 years of age fall under the adolescent age group. Adolescence is a period of physical growth and intellectual attainment at its peak, coupled

with setting of personality traits, decisions regarding future profession, and extreme emotional instability. This is also a period of identity crisis—physical, sexual and spiritual.

Mental Health Problems among Adolescents

- Rates of depression, Bipolar Affective Disorders (BPAD), attempted suicide, completed suicide, conduct disorders and schizophrenia increase during adolescence.
- Antisocial activities increase in frequency.
- Agoraphobia and social phobia become more common during adolescence.
- The incidence of acting out behavior, and juvenile violent crime in adolescents continues to rise. Violent crimes include homicide, forcible rape, robbery or aggravated assault. Adolescents are especially at an increased risk of sexual abuse. In turn rape and sexual abuse are associated with a greatly increased risk of depression and suicide.
- Substance abuse usually starts during adolescent age.
- Comorbidity or co-occurrence of psychiatric disorders, for example, adolescents with substance abuse disorders, are more likely to have comorbid disruptive behavior disorders. Comorbidity in adolescents is associated with impaired role functioning, likelihood of suicidal behavior, academic problems and increased conflict with parents.

Common Reasons for Mental Health Problems among Adolescents

- Emotional difficulties in adolescents often arise from faulty or inconsistent child-rearing practices.
- Environmental factors such as poverty, lack of adequate support systems, major cumulative life stresses, and maternal employment influence coping abilities among children and adolescents.

- Constitutional factors or those characteristics within the adolescent that affect the level of individual vulnerability.

Nursing Interventions

- Nursing care of adolescents begins with a thorough assessment of their health status. Data collection by the nurse is based on current and previous functioning in all aspects of an adolescent's life. The data collection should include the following information:
 - General appearance
 - Growth and development
 - General health status
 - Mental health status
 - Cultural and socioeconomic background
 - Communication patterns (family, peers, society)
 - Sexual behaviors and use of drugs, alcohol and other addictive substances
 - Available human and material sources (friends, school and community involvement)
- Nurses need to understand normal adolescent development and also the difference between constructive and age-appropriate exploration and engagement in activities that are potentially dangerous to physical and emotional well-being.
- Nurses who work in schools and community settings can engage in screening and early nursing intervention with high-risk teenagers to promote adaptive responses and prevent the development of future problems. Encouraging the adolescent to identify and discuss his/her feelings is extremely important in this regard.
- Nursing interventions useful in working with adolescents include health education, family, group and individual therapy and medication management. Emphasis should be laid on lifestyle and compliance issues, such as benefits of exercise, stress management and safer sex practices. Special attention should be given to talking with adolescents and working with their parents.

- Building a therapeutic relationship with an adolescent demands confidence and a strong sense of one's own identity or sense of comfort with one's memories of the teenage years. The nurse needs to offer unconditional acceptance and positive attitude and gentle encouragement for what the adolescent can become.

WOMEN

Women represent a special group for mental health care as in most societies, psychiatric disorders are more common in women. The common reasons for this include: Genetic differences, societal pressures on women, differences in rearing pattern and cultural expectations.

The mental disorders more commonly reported in females include major depression, neurotic depression, anxiety states, phobic neurosis, hypochondriasis, dissociative disorders, adjustment problems, attempted suicide, anorexia nervosa and senile dementia.

There are many psychiatric disorders peculiar to females which include:

- Premenstrual syndrome
- Psychiatric disorders associated with child birth
- Menopausal syndrome.

Premenstrual Syndrome

Menstruation is a normal physiological process in females. The various psychological symptoms attributed to premenstrual syndrome are: sadness, anxiety, anger, irritability, labile mood, decreased concentration, indecision, suspiciousness, sensitivity, suicidal or homicidal ideations, insomnia, hypersomnia, anorexia, craving for certain foods, fatigue, lethargy, agitation, libido changes, decreased motivation, impulsivity and social withdrawal.

This premenstrual syndrome starts about 5 to 10 days before onset of menses and lasts till the end of menses. It not only affects social but also occupational functioning, leading to various degrees of maladjustments.

Management

- The syndrome has been widely treated with progesterone, oral contraceptives, bromocriptine, diuretics and antidepressant drugs
- Psychological support and encouragement
- Cognitive behavior therapy.

Psychiatric Disorders Associated with Childbirth

There is an increased risk of mental illness associated with childbirth, mostly in the postpartum period but problems may also be present before or during pregnancy.

- Mental illness in pregnancy
- Puerperal mental disorders.

Mental Illness in Pregnancy

The incidence of mental illness in the first trimester of pregnancy is thought to be high, when compared to second and third trimesters of pregnancy. The predisposing factors for mental illnesses during pregnancy are; neurotic traits in premorbid personality, marital tension, history of previous abortion.

The majority of episodes of mental illness during pregnancy are neuroses. The commonest condition is depressive neurosis with anxiety, phobic anxiety and obsessive compulsive disorders. In most cases, these conditions resolve by the second trimester of pregnancy.

The major mental illnesses in pregnancy include bipolar affective disorder, severe depression and schizophrenia. The risk of women developing a new episode of one of these conditions in pregnancy is lower than at other times in her life.

Management

- The nurse should provide support, counseling, reassurance and information which is communicated in a caring, intelligible way.
- If the psychiatrist feels that there is a substantial risk of relapse if the women's medications are withdrawn, then this risk

has to be weighed against that of the drugs having a teratogenic effect on the fetus.

Puerperal Mental Disorders

Common puerperal mental disorders are:

- Baby blues
- Postpartum depression
- Postpartum psychosis.

Risk factors for postpartum psychiatric disorders: Substance abuse, severe premenstrual syndrome or premenstrual dysphoric disorder, mood instability while taking oral contraceptives or fertility medications, thyroid dysfunction, previous obstetric complications are pre-pregnancy risk factors.

Pregnancy risk factors are unwanted pregnancy, increased number of somatic complaints during pregnancy, depression or anxiety during pregnancy.

Risk factors associated with birth are premature or late birth, labor complications, separation from infant after delivery, difficult infant temperament, infants with medical, feeding, or sleeping problems, abrupt weaning, bottle-feeding.

Family risk factors are family history of depression, negative perceptions of parenting, not living with one's spouse, marital dissatisfaction, lack of support from family and friends, adverse life events or life stress, recent bereavement.

Hormonal changes are theorized to be a causative factor in postpartum mood disorders.

Baby Blues (Postnatal Blues, Transitory Mood Disorders)

Baby blues are a brief period of low mood, anxiety and tearfulness after the birth of a baby. Up to 80% of women experience baby blues, usually experience within the first week postpartum that may persist for several hours to several weeks.

Causes

Rapid physical changes, hormonal fluctuations-decreased thyroid, estrogen and progesterone levels, emotional letdown after birth, anxiety about increased responsibilities of motherhood, fatigue or sleep deprivation.

Signs and symptoms

Mood swings, crying spells, sadness, anxiety or dependency, impatience, irritability, restlessness, or loneliness.

Treatment

Rest, proper nutrition, help with responsibilities, support from family and friends, avoidance of isolation, reassurance, encouragement to look after themselves. If symptoms are not resolved assess for depression.

Postpartum Depression

Postpartum depression is more severe than the baby blues and can occur anytime in the first year postpartum. It affects 10 to 20% of mothers.

Signs and Symptoms

Persistent sadness, lack of joy in motherhood, depressed mood or uncontrollable mood swings, hopelessness, persistent guilt, perceptions of flaws in herself and or the infant, weight fluctuations, sleep problems, vague chronic pain, hyperventilation or heart palpitations, ambivalence towards the baby, repetitive thoughts of harming herself or her baby, inability to function.

Treatment

- Counseling
- Cognitive therapy
- Selective serotonin reuptake inhibitors and tricyclic antidepressants
- Good supervision and support.

Postpartum Psychosis

The most severe condition occurs in 1 to 2 in 1,000 postpartum women. Onset can vary from 2 to 3 days to 3 months after childbirth.

Signs and Symptoms

Insomnia, disinterest in eating, extreme anxiety and agitation, visual or auditory hallucinations, delusions denying birth or about the infant's death, confusion, fear, suspicion, rapid mood swings, dis-inhibited behavior, suicidal or homicidal thoughts/gestures, delirium and mania. Postpartum psychosis has a 5% suicide and a 4% infanticide rate.

Management

- It is a medical emergency, immediate assessment by a medical professional and hospitalization is required
- Individual or group counseling
- Cognitive-behavioral therapy
- Supportive psychotherapy
- Electroconvulsive therapy
- Antipsychotics
- Close follow-up
- Carbamazepine, sodium valproate, and short-acting benzodiazepines also appear to be relatively safe during breastfeeding.

General Measures to Promote Good Mental Health during Postnatal Period

- Get enough rest and regular exercises
- Call on family and friends for help
- Eat a well-balanced diet
- Consider joining a mothers' or postpartum support group
- Delay going back to work.

General Nursing Interventions

- Develop a relationship and monitor suicide risk

- Ask if the woman and her partner (if relevant) have a history of mental health problems and how they are currently managing
- Provide education about the 'normal' feelings experienced in the usual antenatal and postnatal circumstances
- Provide realistic expectations for parenting and self-care
- Provide information about the attachment needs of the infant and the importance of the parental role meeting these needs
- Reassure the woman and her family
- Help the person and her partner to identify the parental role issues that may be impacted on by the mental illness
- Recognition of symptoms and intervention early in the pregnancy may improve post-partum outcomes.

Prevention

- Identify high-risk sample
- Educate school children regarding the practicalities of childrearing
- Provide training for health professionals about the nature and effects of childbirth-related mental health problems
- Educate women and their partners about the practical and emotional support necessary for parenting
- Pre-conceptual counseling for couples
- Antenatal visits
- Advise women and men about which symptoms to observe and act upon promptly.
- Structured teaching and supportive counseling programs.

Menopausal Syndrome

Menopause, the cessation of ovulation generally occurs between 45 and 53 years of age. The hypoestrogenism that follows can lead to hot flashes; sleep disturbances, vaginal atrophy and dryness, and cognitive and affective disturbances like worrying, depression, anxiety, irritability, difficulty in concentration and low self-confidence.

Management

- Hormonal replacement therapy
- Reassurance
- Psychological support
- Early identification of emotional problems and prompt treatment
- Counseling
- Psychotherapy.

ELDERS

The growth rate of the elderly population is more rapid in India. According to 2011 census report, percentage of aged (60+) population is 8.0 in India.

Good mental health and emotional wellbeing is as important in older age as it is at any other time of life. Many people fear growing older, and assume that old age is depressing and distressing, characterized by loss and disability, offering little to look forward to. But the reality is that older people are as capable as younger people in coping with difficulties, enjoying the life, and taking on challenges.

Elderly people are highly prone to mental morbidities due to aging of the brain, problems associated with physical health, cerebral pathology, socioeconomic factors such as breakdown of the family support systems, and decrease in economic independence.

Common mental health issues directly affecting elderly are:

- Death of a spouse
- Retirement
- Loss of physical ability
- Loss of psychological ability
- Moving to a long-term care facility
- Death of a friend or other loved one
- Break-up of joint family system
- Increased dependency status
- Low social class
- Elderly abuse.

The mental disorders that are frequently encountered among elderly are dementia and mood disorders. Other disorders include sleep

disorders, neurotic and personality disorders, drug and alcohol abuse, delirium, and mental psychosis.

Strategies for successful aging:

- Maintaining health by living a healthy lifestyle
- Continuing to be physically and mentally active
- Having a strong support system such as family, friends and neighbors
- Being able to adjust and adapt to change
- Developing new interests
- Participating in personally rewarding activities such as employment or volunteering
- Having an adequate income to meet basic needs
- Avoiding stress producing situations when possible
- Being independent
- Doing what a person wants to do and not what family members and/or friends think he or she should do
- Planning a structured day and having something to look forward to.

The strain of the caregiver role has become a major dilemma in our society. Elder abuse is sometimes inflicted by caregivers in overwhelming and intolerable situations. Home health care, support groups and financial assistance are needed to ease the burden of this role strain.

Nursing Management

- The nurse who works with mentally ill elders is challenged to integrate psychiatric nursing skills with knowledge of physiological disorders, the normal aging process and sociocultural influences on the elderly and their families.
- The goal of nursing intervention is to promote maximum independence of the older adults, based on capacity and functional abilities.

- The key concepts of geropsychiatric nursing assessment include:
 - Mental health status examination (it includes mini-mental status examination, mental status examination, assessment for depression, anxiety and psychosis)
 - Frequently observed problem behavior
 - Functional abilities
 - General health and
 - Social support system
- Geropsychiatric nurses should be knowledgeable about the effects of psychotropic medication on elderly people. Nurses often work closely with the physician to monitor complex medication regimens and assist the patients and caregivers with medication management.
- Nursing interventions with geropsychiatric patients include creation of a therapeutic milieu, involvement in somatic therapies, and interpersonal interventions. The basic characteristics of a therapeutic milieu are: Cognitive stimulation, promotion of a sense of calm and quietness, consistent physical layout, structured routine, focus on strengths and abilities, minimizing of disruptive behavior, providing safety.
- Care givers should be involved in planning, implementation and evaluation of nursing interventions.

VICTIMS OF VIOLENCE AND ABUSE

Nurses encounter victims of violence and abuse in many settings. Experiencing violence is generally devastating. Survivors of abuse and violence are often seen in psychiatric settings. There are various forms of violence such as child abuse, domestic violence, sexual harassment, abuse and rape, elderly abuse. Traditionally, the word victim is used to describe people who have experienced violence.

Child Abuse

Abuse is considered an act of commission in which intentional physical, mental or emotional hardship is inflicted on a child by a parent or other person, it may include repeated injuries or unexplained cuts, bruises, fractures, burns or scars; harsh punishment or sexual abuse or exploitation.

Sexual abuse results in venereal disease or infection, vaginal or rectal bleeding, recurrent urinary tract infections or pregnancy. Emotional problems like behavioral changes, difficulty sleeping, chronic fears, or school problems. Some children develop enuresis, sexual problems, depression and substance abuse.

Nursing Interventions

- Assess for physical abuse, emergency medical care may be given for multiple injuries
- Observe for anxiety reaction or depression
- Crisis intervention
- Behavioral strategies that are helpful for young children to cope with traumatic events such as deep breathing exercises, progressive muscle relaxation, exposure techniques, thought stopping. Positive imagery, psycho-education and cognitive reframing and addressing grief reactions.

Domestic Violence

Domestic or family violence is defined as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, deprivation and intimidation. The battered women suffer with bruises, lacerations and injuries from the use of weapon. Physically and psychologically abused victims develop somatic complaints, higher levels of anxiety, insomnia, greater social dysfunction and depression.

Nursing Intervention

- Assess for physical injuries, signs of neglect like poor hygiene, malnutrition, dehydration or breakdown of the skin

- Provide emergency medical care crisis counseling
- Referral to local shelters or law enforcement officials or self help groups
- Encourage expression of feelings.

Sexual Assault and Rape

Sexual assault is the forced perpetration of an act of sexual contact with another person without consent. Rape is considered a universal crime against women, a violent sexual act committed against a woman's will and involving the threat of force. Three essential elements are necessary to define rape legally (Box 15.8).

- The use of force, threat, intimidation or duress
- Vaginal, oral or anal penetration
- Non-consent by the victim.

A maladaptive stress reaction referred to as "silent rape syndrome" may occur. The victim fails to disclose information about the rape to anyone, is unable to resolve feelings about the sexual assault, experiences increased anxiety, and may develop a sudden phobic reaction. Behavioral changes may include depression, suicidal behavior, somatization and acting out (for example, alcohol or drug abuse or sexual promiscuity).

Nursing interventions for sexual assault and rape

- Care for physical injuries
- Prevention or alleviation of psychological trauma, and referral for gynecologic, medical or psychological follow-up
- Documentation of physical and emotional status

Box 15.8: Emotional reactions to rape and sexual assault

- » Acute reactions: Anger, guilt, embarrassment, humiliation, denial, shock, disbelief or fear of death, multiple somatic complaints
- » Long-term feeling: Recurring dreams, nightmares and phobias

- Measures of venereal disease and pregnancy
- Use crisis intervention skills to reduce anxiety and provide supportive care
- Listen carefully, be calm and supportive, encourage the victim to speak and reassure her that the information given will be confidential and handled discretely
- Emphasis should be placed on follow-up appointment to repeat serology, cultures and pregnancy tests.

Elderly Abuse

Older adults are primarily abused, neglected or exploited by their caregivers, most of whom are spouses, adult children or other family members.

Older persons who are socially isolated, cognitively impaired, or dependent on others for daily personal needs seem to be most vulnerable to abuse and neglect. Causative factors eliciting elder abuse include severe physical or mental disabilities, financial dependency, personality conflicts, societal attitudes toward aging and frustration while caring for an impaired elderly person.

Various forms of elder abuse are physical, psychological, violation of rights, financial exploitation and neglect.

HANDICAPPED

Some people who grow up with a disability (handicap) devote most of their time and energy in overcoming it and excelling in developing skills which are difficult to acquire. While a few others cope with their disability by ignoring it and concentrating on achieving excellence in other areas.

The greatest isolation occurs in those who lose sight, speech or hearing. Sometimes this isolation may lead to confusion, disorientation and a terrifying feeling of being lost leading to aggressive behavior. Blind people need constant interpretation of their environment

while they are learning to use their other senses. It is important for the nurse to learn communication skills with the deaf such as gestures, mime, writing and demonstration.

The nursing care and rehabilitation of the disabled must aim at helping the patient to acknowledge his disability so that he can create a new idea of himself which includes his handicap.

HIV/AIDS

HIV/AIDS is one of the most devastating global epidemics of the twentieth century. The human immunodeficiency virus (HIV) and the resulting acquired immune deficiency syndrome (AIDS) include a variety of serious and debilitating disorders such as opportunistic infections resulting from a compromised immune system and significant co-occurring psychiatric illnesses. According to National AIDS Control Organization Annual Report 2012-13, HIV prevalence in India was an estimated 0.3 percent. According to India's huge population (1.2 billion), this equates to 2.1 million people living with HIV. In the same year, an estimated 130,000 people died from AIDS related illnesses.

Psychosocial Aspects of HIV/AIDS

- **Shock**, characterized by numbness, disbelief, despair and withdrawal.
- **Anxiety** can manifest in physical (Elevated blood pressure, muscle tension, changes in appetite, tension headaches, etc.) and behavioral symptoms (decreased productivity, concentration and interest, use of alcohol or drugs, absenteeism from work).
- Signs of **denial** may be shopping around syndrome, ignoring early signs of illness.
- **Anger** behaviors could be—deliberate effort to spread the virus to others, abusive language, abuse of alcohol or drugs, cursing God, friends or family members.
- Past life style evoke feelings of **guilt**.

- **Depression** invokes feelings of powerlessness, weight loss, memory loss, insomnia, etc.
- May have an exaggerated concern over ones health (**hypochondria**).

Counseling process involves:

- Problem identification and patient self exploration
- Information giving
- Problem resolution and behavior change
- Patient gaining skills and self understanding that enhance decision-making

Stages of counseling:

- Beginning stage or relationship building stage
- Information gathering stage
- End stage.

Beginning stage:

- History taking
- Exploration of patient's problems
- Prepare plan of action
- Establishing long-term and short-term plans.

Information gathering stage:

- Supporting the continuing expression and discussion of feelings
- Refer to available formal and informal resources
- Monitor progress and modify plans as necessary
- Promote the continuation of changes in behavior
- Help the person to move towards acceptance and control.

End stage

The counselor should end the relationship only when it is clear that the patient:

- Can cope with and adequately plan for day-to-day functioning
- Has a support system such as family, friends and support groups to help them carry through their plan of action
- Prepare the end of the counseling relationship

- Ensure maintenance of coping skills
- Make sure that all needed and available resources have been identified and are being used.

Pretest counseling

Counseling offered before taking an HIV test involves setting a supportive, non-judgmental environment, patient feels free to talk about HIV testing.

The following areas should be covered in pretest counseling session:

- Previous history of HIV counseling and testing
- Why the test is being requested
- HIV transmission and prevention
- Risk assessment
- Possible implications of either positive or negative results
- Disclosure of results to significant others
- History of handling crisis situation
- Available support system/resources
- Emphasis on safer sexual practice.

Post-test counseling

It is the counseling given to patients coming to receive their test results. Areas to be covered during posttest counseling are:

- Assess for patient's readiness to receive the results
- Reassure the confidentiality of results
- Allow for emotional expression
- Discuss disclosure of results to significant others
- Information on community resources
- Practical information for people living with HIV
- Emphasize on:
 - Use of condoms
 - Blood or organ donation
 - Infection control at home
 - Diet and nutrition
 - Importance of seeking medical attention.
- Be prepared to deal with the patient's emotions which may include—disbelief, anger, anxiety, guilt, apathy, fear of death.

For sero negative result explain on:

- Meaning of negative results
- The window period and the need for retest
- Possibility of infection after negative results
- Risk reduction
- Provide literature on HIV
- Assure accessibility for further counseling.

For sero positive result:

- Stay with the patient, listen to the patient and respond to the situation
- Identify coping mechanisms, call for assistance if required
- Provide 24 hour crisis hotline numbers
- Discuss how the patient hopes to handle the information
- Ask who the patient can talk to about the test result
- Refer the patient for emotional support.

Points to be emphasized on positive test result

- A positive test does not mean that the patient has AIDS
- Laboratory test can tell about immunity status
- Treatments are available to slow down the progression
- Encourage the patient to refer partner and children for HIV testing
- If the patient is pregnant, doesn't mean the baby is infected
- Refrain from risk behaviors
- Encourage the patient to talk about his/her feelings.

Nursing Management

- Psychiatric nurses are in a unique position to help diagnosis, treat and support patients affected by HIV/AIDS
- A thorough psychiatric history and complete neuropsychiatry evaluation are indicated when HIV positive patients present with psychiatric symptoms

- Planning health care for person with HIV/ AIDS must involve the multidisciplinary team
- Interventions include case management, medications, risk reduction, support groups, crisis intervention, encouragement of productive activity, enhancement of self-esteem, grief counseling, support during terminal stages, and support of significant others
- The psychiatric interventions for patients with HIV/AIDS are:
 - Helping patients change risky behavior, thus promoting prevention of HIV infection
 - Helping patients during the difficult process of HIV testing (pre and post-test counseling)
 - Helping establish the diagnosis and treatment of other psychiatric illnesses commonly seen in patients with HIV
 - Implementing psychosocial interventions like psychotherapy, cognitive behavioral therapy, counseling, etc.
 - Helping patients, their families and others in their lives with interpersonal problems related to HIV/AIDS
- Assisting AIDS patients during the final phase of their illness (Boxes 15.9 and 15.10).

Some important instructions which must be communicated to a HIV positive patient include:

- Talk about the things he can do safely
- Provide information regarding precautions to avoid transmission
- Safe-sex information, correct use of condoms all the time
- Necessity to stop donating blood, donating organs, sharing needles, etc.
- Safety practices in HIV drug use, blood donation, tests, etc.
- Regular medical monitoring
- Safety tips to patients who work in jobs where they may infect others
- Need to discuss HIV infection with their sexual partner.

The level of support required to assist patients and others who deal with AIDS demands skilled interventions and an integrated team effort among mental health professionals including psychiatric nurses.

Box 15.9: Steps in pre-test counseling

- » Assess the individual's motivation for testing
- » Assess what information the person already has about HIV/AIDS
- » Provide basic information regarding HIV in very simple terms
- » Clarify/correct misconceptions, if necessary
- » Describe the process of antibody testing
- » Give information about the accuracy of tests
- » Explain window period
- » Explain what the test result means, i.e. in terms of being HIV positive, negative or indeterminate
- » Discuss the issue of confidentiality
- » Facilitate informed decision and consent for the test
- » Review patient's assessment of own risk
- » Provide risk reduction information
- » Assess the patient's social network and coping strategies

Box 15.10: Steps in post-test counseling

- » Build rapport
- » Reveal test result (never divulge the test result over the telephone)
- » After disclosing that the test is positive, keep quiet for a while – let the patient react and ventilate his feelings; give him time to absorb the test result
- » Explore the patients understanding of the medical meaning of test
- » Empathize to understand the way he feels
- » Assess his commitment to reducing risk. If change is resisted, emphasize harm reduction
- » Assess patients lifestyle—tell him how a few changes with regard to diet, substance abuse, etc. will have to be made
- » Develop a health plan
- » Find out how he usually copes with stress; assess social support network available
- » Explore and assist patient to face the consequences of having to declare HIV status to significant others, for example, spouse/sexual partners, family, health-care providers, etc.
- » Work with the families regarding their own anxieties about their own health or the future of the infected person. Provide counseling services to family members if so desired by the patient

REVIEW QUESTIONS**Long Essays**

1. List levels of prevention. Describe role of a nurse in prevention of psychiatric disorders.
2. Define rehabilitation. Explain role of a nurse in psychiatric rehabilitation.
3. Enumerate the therapeutic activities of a nurse in community mental healthcare.
4. Explain in detail about mental health services available for mentally ill patients.
5. Describe development of community mental health in India.

Short Essays

1. Mental health services available at various levels
2. National Mental Health Program
3. Institutionalization vs Deinstitutionalization
4. Levels of prevention in psychiatry
5. Vocational rehabilitation
6. Rehabilitation services in India
7. Self-help groups
8. International mental health agencies
9. Mental health problems among adolescents
10. Psychosocial issues of HIV/AIDS patients.

Short Answers

1. District Mental Health Program
2. Goals of community mental health nursing
3. Primary prevention
4. Tertiary prevention
5. Halfway homes

MULTIPLE CHOICE QUESTIONS

1. **The book: 'A mind that found itself' was written by ex-psychiatric patient:**
 - a. Dorothea Dix
 - b. Benjamin Rush
 - c. Clifford W Beers
 - d. Maxwell Jone
2. **All of the following are advantages of general hospital psychiatric units over mental hospitals, except:**
 - a. Greater acceptance of services
 - b. Encourage more outpatient care
 - c. Greater opportunity to attract patients with minor mental health problems
 - d. Regulation of mental health authority
3. **District Mental Health Program under National Mental Health Program was launched in:**
 - a. 1987
 - b. 1996
 - c. 2000
 - d. 2005

- 4. The follow-up and disability management is a part of:**
- Primary prevention
 - Secondary prevention
 - Tertiary prevention
 - Dextra prevention
- 5. The main aim of primary prevention is:**
- Strengthening individual, family and group coping abilities
 - Helping mentally ill patients to regain pre-morbid level of functioning through treatment
 - Helping to reduce the discomfort and disability associated with illness
 - Enable the patient to achieve maximum range of interest and activity
- 6. The main aim of secondary prevention is:**
- Strengthening individual, family and group coping abilities
 - Helping mentally ill patients to regain pre-morbid level of functioning through treatment
 - Helping to reduce the discomfort and disability associated with illness
 - Enable the patient to achieve maximum range of interest and activity
- 7. The main aim of tertiary prevention is:**
- Strengthening individual, family and group coping abilities
 - Helping mentally ill patients to regain pre-morbid level of functioning through treatment
 - Helping to reduce the discomfort and disability associated with illness
- 8. The main aim of psychiatric rehabilitation is:**
- Strengthening individual, family and group coping abilities
 - Helping mentally ill patients to regain pre-morbid level of functioning through treatment
 - Helping to reduce the discomfort and disability associated with illness
 - Enable the patient to achieve maximum range of interest and activity
- 9. Halfway homes are:**
- Located within the hospital campus wherein patients take care of themselves
 - Transitory residential centers to integrate the individual into main stream of life
 - Innovative alternative to hospitalization with only day treatment program
 - Located within the hospital campus to reduce the disability of the patient
- 10. All of the following are misconceptions about mental illness, except:**
- Mental illness is curable
 - Marriage can cure mental illness
 - Mental illness is caused by supernatural power
 - Mentally ill patients are dangerous
- 11. Which of the following disorder is a self-limiting condition:**
- Postnatal depression
 - Postnatal blues
 - Postnatal psychosis
 - Postnatal anxiety disorders.

KEY

1. c 2. d 3. b 4. c 5. a 6. b 7. c 8. d 9. b 10. a
11. b

Appendices

APPENDIX 1

HISTORY TAKING FORMAT IN PSYCHIATRIC NURSING

1. Identification Data

Name: Age:

Sex:

Father/Spouse:

Address:

Education:

Occupation:

Income:

Marital status:

Religion:

Informant:

Information: Relevant/not relevant, adequate/not adequate

2. Presenting Chief Complaint

(With duration in chronological order, in patient's own words and informant's own words)

3. History of Present Illness

- Duration (days/weeks/months/years):

- » Mode of onset : Abrupt/acute/subacute/insidious (<48 hours/<1 week/1-2 weeks/within a few weeks)
- » Course : Continuous/episodic/fluctuating/deteriorating/improving/unclear
- » Intensity : Same/increasing/decreasing
- » Precipitating factors : Yes/no, if yes explain

- Description of present illness (chronological description of abnormal behavior, associated problems like suicide, homicide, disruptive behavior; thought content, speech, mood states, abnormal perception, biological functioning, social functioning, occupational functioning, changes in ADLs)

4. Treatment History

- Drugs (name of the drug, dose, route, side-effects, if any)
- ECT:
- Psychotherapy:
- Family therapy:
- Rehabilitation:

5. Past Psychiatric and Medical History

- Number of previous episodes/hospitalization (psychiatric) with onset and course:
- Complete or incomplete remission:
- Duration of each episode:
- Treatment details and its side effects if any:
- Treatment outcome:
- Details of any precipitating factors if present:
- Substance use details:
- Surgical procedures/accidents/head injury/convulsions/unconsciousness/DM/HTN/CAD/venereal disease/HIV positivity/any other

6. Family History

- Description (describe each family member briefly: age, education, occupation, health status, relationship with the patient, age at death, mode of death)
- Genogram.

7. Personal history

- Perinatal history

- | | | |
|---------------------------|---|---|
| » Antenatal period | : | Maternal infections/exposure to radiation/any other |
| Check-ups | : | |
| Any complications | : | |
| » Intranatal period | : | Type of delivery—normal/instrumental/cesarean |
| | : | Any complications |
| » Birth | : | Full-term/premature/postmature |
| » Birth cry | : | Immediate/delayed |
| » Birth defects | : | Yes or no, if yes, specify |
| » Postnatal complications | : | Cyanosis/convulsions/jaundice/neonatal infections/any other |

- Childhood history

- | | | |
|-----------------------------------|---|--|
| » Primary caregiver | : | |
| » Feeding | : | Breastfed/artificial mode of feeding |
| » Age at weaning | : | |
| » Developmental milestones | : | Normal/delayed |
| » Behavior and emotional problems | : | Thumb sucking/excessive temper tantrums/stuttering/head-banging/body rocking/nail biting/pica enuresis/morbid fears/night terrors/somnambulism |
| » Illness during childhood | : | Specifically for CNS infections/epilepsy/neurotic disorders/malnutrition |

- Educational history

- | | | |
|---|--------|---|
| » Age at beginning of formal education: | | |
| » Academic performance: | | (Specifically look for learning disability and attention deficit disorders) |
| » Extracurricular achievements, if any: | | |
| » Relationships with peers and teachers: | | |
| » School phobia: | yes/no | |
| » Look for conduct disorders, for example truancy/stealing: | | yes/no |
| » Reason for termination of studies: | | |

- Play history

- | | | |
|---|--|--|
| » Games played (at what stage and with whom): | | |
| » Relationships with playmates: | | |

- Emotional problems during adolescence

» Running away from home/delinquency/smoking/drug-taking/any other (specify)

- Puberty

» Age at appearance of secondary sexual characteristics:

» Anxiety related to puberty changes:

» Age at menarche:

» Reaction to menarche:

» Regularity of cycles, duration of flow:

» Abnormalities, if any (menorrhagia, dysmenorrhea, etc.):

- Obstetrical history

» LMP:

» Number of children:

» Any abnormalities associated with pregnancy, delivery, puerperium:

» Termination of pregnancy, if any:

» Menopause (including any associated problems):

- Occupational history

» Age at starting work:

» Jobs held in chronological order:

» Reasons for changes:

» Current job satisfaction: (including relationships with authorities, colleagues, subordinates)

» Whether job is appropriate to patient's background:

- Sexual and marital history

» Genogram (family of procreation—details of spouse and children):

» Type of marriage : Self-choice/arranged

» Duration of marriage :

» Interpersonal and sexual relations : Satisfactory/unsatisfactory

» Extramarital relationship if any specify:

- Premorbid personality

» Interpersonal relationships : Extrovert/introvert

» Family and social relationships :

» Use of leisure time :

» Predominant mood : Optimistic/pessimistic; stable/fluctuating; cheerful/despondent

» Usual reaction to stressful events :

» Attitude to self and others : Self-appraisal of abilities, achievements and failures

» Attitude to work and responsibility :

» Religious beliefs and moral attitudes :

» Fantasy life :

» Habits :

 - Eating pattern :

 - Elimination :

 - Sleep :

 - Use of drugs, tobacco, alcohol :

Regular/irregular

Regular/irregular

Regular/irregular

Daydreams—frequency and content

APPENDIX 2

MENTAL STATUS EXAMINATION FORMAT

1. General Appearance and Behavior

- *Appearance*: Looking one's age/looks older/younger than his/her age/underweight/overweight/physical deformity
- *Facial expression*: Anxious/blunted/pleasant/fearful
- *Level of grooming*: Normal/shabbily dressed/overdressed/idiosyncratically dressed
- *Level of cleanliness*: Adequate/inadequate/overtly clean
- *Level of consciousness*: Fully conscious and alert/drowsy/stuporous/comatose
- *Mode of entry*: Came willingly/persuaded/brought using physical force
- *Behavior*: Normal/over friendly/preoccupied/aggressive
- *Co-operativeness*: Normal/more than so/less than so
- *Eye-to-eye contact*: Maintained/difficult/not maintained
- *Psychomotor activity*: Normal/increased/decreased
- *Rapport*: Spontaneous/difficult/not established
- *Gesturing*: Normal/exaggerated/odd
- *Posturing*: Normal posture/catatonic posture/stooped/stiff/guarded
- *Other movements*: Normal/stereotype/tremors/extrapyramidal symptoms/abnormal involuntary movements
- *Other catatonic phenomena*: Automatic obedience/negativism/excessive cooperation/waxy flexibility/echopraxia/echolalia
- *Conversion and dissociative signs*: Pseudoseizures/possession states/any other
- *Compulsive acts or rituals or habits (for example nail biting)*:
- *Hallucinatory behavior*: Smiling or crying without reason/muttering or talking to self, odd gesturing.

2. Speech

- *Initiation*: Spontaneous-speaks when spoken to/minimal/mute
- *Reaction time (time taken to answer the question)*: Normal/delayed/shortened/difficult to assess
- *Rate*: Normal/slow/rapid
- *Productivity*: Monosyllabic/elaborate replies/pressured
- *Volume*: Normal/increased (loud)/decreased (soft)
- *Tone*: Normal variation/high pitch/low pitch/monotonous
- *Relevance*: Fully relevant/sometimes off target/irrelevant (answer the question appropriately)
- *Stream*: Normal/circumstantial/tangential/blocking/verbigeration/stereotypies verbal/flight of ideas/clang associations (flow and rhythm of speech)
- *Coherence*: Fully coherent/loosening of associations (in coherent)
- *Others*: Echolalia/perseveration/neologism
- *Sample of speech (in response to open-ended questions, verbatim in 2 or 3 sentences)*:

3. Mood and Affect

- *Subjective*:
- *Objective*:
- *Predominant mood state*: Irritable/labile/blunted/anxious/fearful/panic/aggressive/cheerful/depressed
- *Appropriate* (relevance to situation and thought congruent)/inappropriate

4. Thought

- *Stream (flow of thought)*: Normal/racy thoughts (pressure of thought)/retarded thinking (poverty of thought)/thought block/muddled or unclear thinking/flight of ideas/clang association/mutism

- *Form (formal thought disorder)*: Normal/not understandable/circumstantiality/tangentiality/neologism/word salad/ambivalence/perseveration (specify with a sample of speech).

Content

- Delusions: Specify type and give example—persecutory delusions/delusion of reference/delusion of influence or passivity/hypochondriacal delusions/delusion of grandeur/nihilistic delusions/delusion of infidelity/delusion of control/bizarre delusions
- Ideas: Worthlessness/helplessness/hopelessness/guilt/hypochondriacal/death wishes (suicidal ideations)
- Thought alienation phenomena: Thought insertion/thought withdrawal/thought broadcasting
- Obsessional/compulsive phenomena: Thoughts/images/ruminations/doubts/impulsive rituals
- Phobias (irrational fears):
- Any preoccupations:

5. Perception

- Illusions:
- Hallucinations (Specify type and give example): Auditory/visual/olfactory/Gustatory/Tactile
- Somatic passivity:
- Déjà vu/jamais vu:
- Depersonalization/derealization:

6. Cognitive Function (Neuropsychiatric Assessment)

- Consciousness: Conscious/cloudy/comatosed
- Orientation:
 - » Time: Appropriate time/day/night/date/day/month/year
 - » Place: Kind of place/area/city
 - » Person: Self/close associates/hospital staff
- Attention: Normally aroused/aroused with difficulty
 Digit forward
 Digit backward
- Concentration: Normally sustained/sustained with difficulty/distractible
 100-7
 40-3
 20-1
 Names of months (backwards)
 Names of weekdays (backwards)
- Memory:
 - » Immediate (same test as for attention):
 - » Recent: (recent happenings—last meal, visitors, etc.)
 - » Verbal recall: 3 unrelated objects
 5 unrelated objects, or imaginary address of 5 items
 - » Remote:
 - Personal events:
 - Impersonal events:
 - Illness-related events:
- Intelligence:
 - » General fund of information:
 - » Arithmetic ability: Mental arithmetic/written sums
- Abstraction:
 - » Normal/concrete
 - » Interpretation of proverbs (give a proverb and ask the inner meaning, e.g. feathers of a bird flock together/rolling stones gather no mass):

- » Similarities between paired objects:
- » Dissimilarities between paired objects:
- *Judgment:*
 - » Personal (future plans): Intact/impaired
 - » Social (perception of the society): Intact/impaired
 - » Test (present a situation and ask their response to the situation): Intact/impaired.

7. Insight

Insight is rated on a 6 point scale from 1 to 6:

1. Complete denial of illness
2. Slight awareness being sick
3. Awareness of being sick attributed to external or physical factor
4. Awareness of being sick but due to something unknown in himself
5. Intellectual insight
6. True emotional insight

Diagnostic Formulation

APPENDIX 3

NEUROLOGICAL EXAMINATION FORMAT

1. Level of Consciousness

- Alert/lethargic/stuporous/semi-comatose/comatose
- Score of Glasgow coma scale:

2. Mental Status Examination

- General appearance
- Speech
- Thought process
- Mood
- Cognitive functions
 - » Attention and concentration
 - » Serial 7
 - » Digit span—backward, forward
 - » Orientation
 - » Time
 - » Place
 - » Person
 - » Memory
 - » Immediate
 - » Recent
 - » Remote
 - » General knowledge
 - » Abstract reasoning
 - » Judgment
 - » Insight

3. Special Cerebral Functions: Agnosia/Apraxia/Aphasia

4. Cranial Nerve Examination

- Olfactory nerve: Sense of smell—present/absent
- Optic nerve: Inspection of eye—inflammation/cataract/foreign bodies/any abnormalities
 - » Visual acuity (Snellen's chart)
 - » Visual field examination:
 - Right eye
 - Left eye
 - » Ophthalmoscope examination
 - » Color vision: Present/absent
- Oculomotor, trochlear and abducent nerves
 - » Pupillary reaction to light: Reacting/not reacting
 - » Pupillary size: Equal/unequal
 - » Eye movement in six directions: Normal/abnormal
 - » Nystagmus: Present/absent
 - » Diplopia: Present/absent
- Trigeminal nerve
 - » Corneal reflex: Present/absent
 - » Facial sensory response: Present/absent
 - » Mandibular strength: Adequate/hypotonia
- Facial nerve
 - » Facial expressions: Normal/hypotonia
 - » Taste sensation: Present/absent

- Vestibule cochlear nerve
 - » Auditory acuity test
 - » Air conduction
 - » Bone conduction
- Glossopharyngeal and vagus nerve
 - » Gag reflex: Present/absent
 - » Swallowing reflex: Present/absent
 - » Position and movement of uvula and palate: Normal position/deviation
 - » Sensation of taste: Present/absent
- Spinal accessory nerve
 - » Sternocleidomastoid muscle strength: Normal/hypotonia
 - » Elevation of shoulders: Adequate strength/weakness
 - » Turning of head: Adequate/inadequate
- Hypoglossal nerve
 - » Tongue movement: Normal/abnormal

5. Motor Function assessment

- Muscle size
- Muscle strength
- Muscle tone
- Muscle coordination
- Gait
- Movements of all the joints
- Deformities
- Abnormal movements

6. Sensory Function Assessment

- Pain sensation: Present/absent
- Temperature sensation: Present/absent
- Touch sensation: Present/absent
- Vibration sensation: Present/absent

7. Assessment of Cerebellar Function

- Finger to finger test: Normal/abnormal
- Finger to nose test: Normal/abnormal
- Romberg test: Normal/unable to perform
- Tandem walking test: Normal/unable to perform

8. Assessment of Reflexes

- Superficial reflexes: Present/absent
- Abdominal/plantar/corneal/pharyngeal/cremasteric/anal
- Deep tendon reflexes: Present/absent
 - Biceps/triceps/brachioradial/patellar/Achilles
- Any abnormal reflexes: Present/absent

Summary

APPENDIX 4**PHYSICAL EXAMINATION FORMAT****1. Identification Data**

Name: H. No.:
Age: Sex: Marital status:
Occupation:
Address:
Chief complaints:

2. Present Medical History:**3. Past Medical and Surgical History:****4. General Examination:**

- Temperature:
- Pulse:
- Respiration:
- Blood Pressure:
- Cardiovascular system, peripheral pulsations:
- Respiratory system:
- Abdomen:
- Musculoskeletal system:
- Lymph nodes:
- Breasts:
- Pelvic examination:
- Any other signs:

APPENDIX 5**PROCESS RECORDING FORMAT****1. Identification Data:**

Name:	Age:	Sex:
Religion:	Marital status:	Educational status:
Occupation:	Income per month:	Languages known:
IP No.:	Ward:	Diagnosis:
Address:		
Date of admission:	Date and time of process recording:	
Brief summary of the patient problem:		

2. Place of Interaction:**3. Description of the Environment:****4. Reason for Selecting the Patient:****5. Objectives:**

- 1.
- 2.
- 3.

Nurses response		Patients response		Technique	Inference
Verbal	Non-verbal	Verbal	Non-verbal		

Conclusion : Fixing the time and place for the next interview
 Summary : - List of inferences
 - Care plans made according to inference
 - Any special difficulties faced during the inference
 - Techniques used to overcome difficulties

Signature

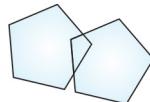
APPENDIX 6

MINI-MENTAL STATUS EXAMINATION (MMSE) FORMAT

Component description	Patient score	Points
1. Orientation		
– What is the year?	1	
– Season?	1	
– Date?	1	
– Day?	1	
– Month?	1	
– Which is our state?	1	
– Country?	1	
– Town or city?	1	
– Hospital?	1	
– Floor?	1	
2. Attention and Calculation		
Spell “world” backwards give 1 point for each letter that is in the right place (for example, DLROW = 5, DLORW = 3). Alternatively, do serial 7s (ask the person to count backwards from 100 in blocks of 7, i.e. 93, 86, 79, 72, 65). Stop after five subtractions. Give one point for each correct answer.	5	
3. Registration		
Name three objects (for example, apple, table, pen) taking one second to say each one. Then ask the individual to repeat the names of all three objects. Give one point for each correct answer. Repeat the object names until all three are learned.	3	
4. Recall		
Ask for the three objects repeated above (for example, apple, table, pen) Give one point for each correct object	3	
5. Language		
– Point to a pencil and ask the person to name this object (1 point) Do the same thing with a wrist watch (1 point)	2	
– Ask the person to repeat the following. No ‘ifs’ and/or ‘buts’ (1 point) Allow only one trial	1	
– Give the person a piece of blank white paper and ask them to follow a three stage command. Take a paper in your right hand, fold in half and put it on the floor (1 point for each part that is correctly followed)	3	
– Write ‘CLOSE YOUR EYES’ in large letters and show it to the patient. Ask him or her to read the message and do what it says (give 1 point if they actually close their eyes).	1	
– Ask the individual to write a sentence of his choice on a blank piece of paper. The sentence must contain a subject and a verb, and must make sense. Spelling punctuation and grammar are not important (1 point)	1	

- Show the person a drawing of two pentagons which intersect to form a quadrangle. Each side should be about 1.5 cm. Ask them to copy the design exactly as it is (1 point). All 10 angles need to be present and the two shapes must intersect to score 1 point. Tremor and rotation are ignored.

1



Total score

30

Adapted from: Folstein, et al. 1975.

APPENDIX 7**ALCOHOLISM HISTORY COLLECTION FORMAT****1. Demographic Data**

Name: Age: Sex:
Occupation: Income: Education:
Marital status: Married/Single/Widow
IP No.: Address:
Informant:

2. Chief Complaints (in chronological order with duration):**3. History of Present Illness**

- First drink causes:
- First experience with alcohol:
- The type and volume of first drink—Hard drink/regular drink:
- History of tolerance:
- History of craving:
- History of loss of control:
- History of withdrawal features—when abstinent from alcohol:
- History of blackouts:
- History of salience (Restricting all the activities and concentrating only on alcohol seeking behavior, not even going to work):
- What are the reasons for excessive consumption of alcohol?:
- Maintaining factors/reasons:
- Previous history of abstinence:
- Money spent for alcohol:
- Medical problems associated with alcoholism:
- Psychiatric problems associated with alcoholism:
- Comorbidity:
- History of any other substance abuse:
- Motivation level:
- Locus of control:

4. Family History

- Family history of similar problems:
- Interpersonal relationship in the family:
- Family history of psychiatric disorders:
 - » Psychosis
 - » Mood disorders
 - » Neurotic disorders
 - » Substance abuse
 - » Epilepsy
- Genogram (family of origin, three generations)

5. Personal History:

6. Marital History

- Role reversal
- Emotional disorders in children
- History of exposure to extramarital relationship
- Sexual dysfunction

7. Premorbid Personality

- Dependence/anankastic/passive aggressive/anti-social/any other
- Describe briefly premorbid personality

APPENDIX 8

CHILD AND ADOLESCENT PSYCHIATRY ASSESSMENT FORMAT

1. Demographic Data

Name: _____ Age: _____ Sex: _____
Address: _____
Income: _____ Residence: Urban/semi-urban/rural
Hospital No.: _____
Informant: Mother/Father/Others

2. Chief Complaints (with duration in brief):

3. History of Present Illness:

4. Family History:

- Nuclear/non-nuclear
- Consanguineous marriage/non-consanguineous marriage
- History of mental illness/epilepsy/mentally retarded/any other
- Genogram (three generations):

5. Personal History

- Antenatal history:
- Perinatal history:
- Postnatal history:
- Milestones:
- Current schooling:
- Habits:
- Interest and talents:
- Sexual history:

6. Past History

- Psychiatric
- Neurotic
- Others

7. Current Functioning

- Intelligence: Above average/average/below average
- School performance: Above average/average/below average
- Self-help: Age appropriate
 - » Toilet: Yes/No
 - » Dressing: Yes/No
 - » Eating: Yes/No
 - » Bathing/washing: Yes/No

8. Physical Examination

- Vision
- Hearing
- CNS
- Respiratory system

- Cardiovascular system
- Gastrointestinal system
- Genitourinary system

9. Treatment History till Date:**10. Mental Status Examination**

- Attention and concentration
- Activity level
- Motor behavior
- Speech and language ability
- General intelligence
- Mood and affect
- Thought processes
- Perception

Summary

APPENDIX 9

GERIATRIC HISTORY COLLECTION FORMAT

1. Demographic Data

Name:	Age:	Sex:
Occupation:	Income:	Education:
Marital Status: Married/single/widow	IP No.:	
Address:		
Informant:		

2. Chief Complaints:

3. Precipitating Factors: Head injury/infection/sensory handicaps/retirement/bereavement/any other

4. History of Present Illness

- Stress:
- Qualitative or quantitative changes in routine activities:
- Cognitive function:
- Habits and others:

5. Past Medical History

6. Past Psychiatric History

7. Family History

- Joint or nuclear family
- Monthly income of the family
- Socioeconomic status
- Genogram

8. Personal History

- Developmental history
- Educational history
- Occupational history pre-retirement
- Source of income: Employment/pension/assistance from family/other financial problems if any
- Residence:
 - » Living at home/alone/with spouse/with children
 - » Own/rented house
 - » Any problems with living situation

9. Marital History

- Family history of mental or physical history
- Sexual/menstrual history
- Genogram

10. Premorbid Personality

- Specific traits
- Social functioning
- Occupational functioning

- Biological functioning
- Interest/hobbies, alcohol and other drug abuse.

11. Community Involvement: Members of organization/club/political activities/voluntary work.

12. Social Support:

13. Attitude Towards Aging and Death:

14. Mental Status Examination:

15. Summary:

16. Investigations:

17. Treatment:

APPENDIX 10

NURSING CARE PLAN FORMAT IN PSYCHIATRIC NURSING

1. Identification Data

Name of the patient:	Age:	Sex:	Religion:
IP No.:	Ward:	Marital status:	Education:
Occupation:	Income per month:		
Address:			
Informant:			

2. Presenting Chief Complaints
3. History of Present Illness
4. Treatment History
5. Past Psychiatric and Medical History
6. Family History
7. Personal History
8. Mental Status Examination

- General appearance and behavior
- Speech
- Mood
- Thought
- Perception
- Cognitive function
- Insight
- Judgment
- Diagnostic formulation

9. Physical Examination
10. Nursing Management

- Nursing assessment (objective data, subjective data)
- List of nursing diagnosis

Nursing Care Plan

Assessment	Nursing diagnosis	Goal/ objective	Intervention	Implementation	Rationale	Evaluation

11. Health Education
12. Conclusion

APPENDIX 11

CASE STUDY/CASE PRESENTATION FORMAT IN PSYCHIATRIC NURSING

1. Identification Data

Name of the patient:	Age:	Sex:	Religion:
IP No.:	Marital status:	Education:	Occupation:
Address:			
Informant:			

2. Presenting Chief Complaints

3. History of Present Illness

4. Treatment History

5. Past Psychiatric and Medical History

6. Family History

7. Personal History

8. Mental Status Examination

- General appearance and behavior
- Speech
- Mood
- Thought
- Perception
- Cognitive function
- Insight
- Judgment
- Diagnostic formulation

9. Physical Examination

Book Picture of Disease Condition

- Introduction
- Definition
- Incidence
- Etiology

Book picture	Patient picture

- Psychopathology
- Clinical manifestations

Book picture	Patient picture

- Investigations and diagnoses

Book picture	Patient picture

- Treatment

Book picture	Patient picture

- Nursing management

- Nursing assessment
- List of nursing diagnoses
- Nursing interventions (according to book)
- Nursing evaluation.

Nursing Care Plan

Assessment	Nursing diagnosis	Goal/objective	Intervention	Implementation	Rationale	Evaluation

Health education:

Conclusion:

References:

APPENDIX 12

ELECTROCONVULSIVE THERAPY HISTORY COLLECTION FORMAT

1. Identification Data

Name of the patient: Age: Sex: Religion:
IP No.: Marital status: Education: Occupation:
Address:
Informant:

2. Presenting Chief Complaints

3. History of Present Illness

4. Treatment History

5. Past Psychiatric and Medical History

6. Family History

7. Personal History

8. Mental Status Examination

- General appearance and behavior
- Speech
- Mood
- Thought
- Perception
- Cognitive function
- Insight
- Judgment
- Diagnostic formulation

9. Physical Examination

10. Assessment of patient's and family's knowledge of indications, side effects, therapeutic effects and risks associated with ECT

11. Pre-ECT Care checklist

- Informed consent
- Assess vital signs
- Nil by mouth (6-8 hours)
- Withhold night dose of drugs
- Withhold oral medications in the morning
- Head shampooing
- Remove jewellery, prosthesis, dentures, contact lens, etc.
- Remove tight clothing
- Empty bladder and bowel just before ECT
- Pre-ECT medications

12. Intraprocedure Care Checklist

- Place the patient comfortably on the ECT table
- Stay with the patient
- Insert mouth gag
- Apply gel and electrodes
- Monitor voltage intensity and duration of electrical activity
- Monitor seizure activity
- Monitor vital signs

13. Postprocedure Care Checklist

- Place patient in sideline position
- Monitor vital signs
- Oxygen administration
- Assess for postictal confusion
- Use of side rails to prevent falls
- Reorient the patient after recovery
- Recording the case

APPENDIX 13

PSYCHOTHERAPY FORMAT

1. Demographic Data

Name of the patient: Age: Sex:
Religion: IP No: Marital status:
Education: Occupation:
Address:
Informant:

2. Brief Description of Present Illness

3. Brief Description of Mental Status Examination

4. Treatment History

5. Indications for Psychotherapy

6. Problems Identified for Work-up

7. Brief Description of Psychotherapy Given to the Patient

- Session no.
- Place
- Time
- Psychotherapy approach
- Techniques used by the therapist
- Plan for next session
- Home works, if any (given to the patient)
- Outcome of the session

Summary

APPENDIX 14**OCCUPATIONAL THERAPY FORMAT****1. Demographic data**

Name of the patient: Age: Sex:
Religion: IP No: Marital status:
Education: Occupation:
Address:
Informant:

2. Brief Description of Present Illness**3. Brief Description of Mental Status Examination****4. Treatment History****5. Objective for Occupational Therapy****6. Evaluation of the Patient**

Current level of functioning
Social functioning
Behavioral problems

7. Description of Occupational Therapy (Activities) Planned or Provided for Patient

Description of activities	Therapeutic value

Summary

APPENDIX 15**BEHAVIOR THERAPY FORMAT****1. Demographic Data**

Name of the patient:	Age:	Sex:
Religion:	IP No:	Marital status:
Education:	Occupation:	
Address:		
Informant:		

2. Brief Description of Present Illness**3. Brief Description of Mental Status Examination****4. Treatment History****5. Indications for Behavioral Therapy****6. Techniques Used by the Therapist****Summary**

APPENDIX 16**RECREATION/PLAY THERAPY FORMAT**

1. Demographic Data

Name of the patient:	Age:	Sex:
Religion:	IP No:	Marital status:
Education:	Occupation:	
Address:		
Informant:		

2. Brief Description of Present Illness**3. Brief Description of Mental Status Examination****4. Treatment History****5. Indications for Therapy****6. Advantages of Therapy for the Patient****Summary**

APPENDIX 17**DEADDICTION THERAPY FORMAT****1. Demographic Data**

Name of the patient:	Age:	Sex:
Religion:	IP No:	Marital status:
Education:	Occupation:	
Address:		
Informant:		

2. Presenting Chief Complaints**3. Description of**

- Signs and symptoms of alcohol dependency syndrome
- History of withdrawal symptoms
- History of alcohol intoxication
- Present medical history
- Present psychiatric history
- Family problems
- Occupational problems
- Present level of motivation
- Maintaining factors for alcoholism
- Previous history of deaddiction treatment
- Period of abstinence from alcohol
- Reasons for relapse
- Knowledge regarding adverse effects of alcoholism
- Present treatment in the hospital/rehabilitation center

Summary

APPENDIX 18**HEALTH EDUCATION FORMAT**

Name of the topic:

Group and number:

Place:

Date:

Time:

Duration of health education:

Name of the student:

Name of the supervisor:

Method of the teaching:

AV aids:

General objective:

Specific objective:

Specific objective	Content	AV Aids	Evaluation

References

APPENDIX 19**DRUG BOOK FORMAT**

Pharma-cological name and trade name	Dose and route	Mechanism of action	Indications	Contra-indications	Adverse effects	Nurses responsibility

References

APPENDIX 20**PSYCHIATRIC OPD LOG BOOK**

SI. No.	Name of the patient, age, sex, address	Occupation-and education	Chief complaints and diagnosis	Past history	Treatment	Health education

APPENDIX 21

DRUG GUIDE

HALOPERIDOL

Trade Names

Serenace, Triperidol, Senorm-LA, Haldol

Classification

Dopamine receptor antagonists—butyrophenone

Dose

Oral: 0.5–5 mg, Parental: 5–100 mg/mL

Mechanism of Action

An antipsychotic, antiemetic and antidykinetic agent that competitively blocks postsynaptic dopamine receptors, interrupts nerve impulse movement and increases turnover of dopamine in the brain. Peripheral effects include anticholinergic properties and alpha adrenergic blockage.

Indications

Acute psychotic episodes in schizophrenia and schizoaffective disorders, mania, depression with psychotic symptoms, delusional disorders, borderline personality disorder, and substance induced psychotic disorder, delirium and dementia, mental disorders due to a medical condition, pervasive developmental disorder, Tourette's syndrome, Huntington's disease.

Contraindication

Angle-closure glaucoma, central nervous system depression, myelosuppression, Parkinson's disease, severe cardiac or hepatic disease.

Side Effects

- *Frequent:* Blurred vision, constipation, orthostatic hypotension, dry mouth, peripheral edema
- *Occasional:* Difficulty urinating, decreased thirst, dizziness, decreased sexual function, drowsiness, nausea, vomiting, photosensitivity, lethargy
- *Serious reactions:* Extrapyramidal symptoms (EPS)—Akathisia, acute dystonia, tardive dyskinesia, and drug-induced Parkinsonism.

Nurse's Responsibility

- Assess patient behavior and emotional status
- Children are more susceptible to dystonias. Haloperidol use is not recommended for children younger than three years
- A decreased dosage is recommended for the elderly who are more susceptible to extrapyramidal and anticholinergic effects, orthostatic hypotension and sedation
- Use haloperidol cautiously in patients with cardiovascular disease, hepatic or renal dysfunction or a history of seizures. Haloperidol may be given undiluted by IV push
- Give IV push at a rate of 5 mg/minute
- Prepare haloperidol decanoate IM injection using a 21-gauge needle. Slowly inject the drug deep into the upper outer quadrant of the gluteus maximus
- Keep the patient recumbent (head low and legs raised) for 30–60 minutes after administration to minimize hypotensive effects
- Monitor the patient for fine tongue movements, mask like facial expression, rigidity and tremor
- The therapeutic serum level for haloperidol is 0.2 to 1 µg/mL and the toxic serum level is greater than 1 µg/mL

- Caution the patient against abruptly discontinuing haloperidol after long-term use
- Inform the patient that drowsiness generally subsides with continued therapy
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Urge the patient to avoid alcohol during haloperidol therapy
- Urge the patient to avoid exposure to sunlight and any condition that may cause dehydration or overheating because they may increase the risk of heat stroke
- Suggest taking sips of water or chewing sugarless gum to help relieve dry mouth
- Instruct the patient to rise slowly from a lying or sitting position
- Monitor blood pressure lying and standing frequently. Document and report significant changes.

CHLORPROMAZINE

Trade Name

Largactil, Thorazine

Classification

Dopamine receptor antagonists—phenothiazine

Dose

Oral: 300 to 1500 mg per day in divided doses, Parental: 25 to 100 mg per day IM only.

Mechanism of Action

Chlorpromazine blocks dopamine neurotransmission at postsynaptic dopamine receptor sites. Possesses strong anticholinergic, sedative and antiemetic effects, moderate extrapyramidal effects and slight antihistamine action.

Indications

Acute psychotic episodes in schizophrenia and schizoaffective disorders, mania, depression with psychotic symptoms, delusional disorders, borderline personality disorder, and substance induced psychotic disorder, delirium and dementia, mental disorders due to a medical condition, pervasive developmental disorder, Tourette's syndrome, Huntington's disease.

Contraindication

Comatose states, myelosuppression, severe cardiovascular disease, severe CNS depression, subcortical brain damage.

Side Effects

- *Autonomic side effects:* Dry mouth, constipation, urinary retention, orthostatic hypotension, impotence
- *EPS:* Akathisia, acute dystonia, Rabit syndrome, drug-induced Parkinsonism
- *Central nervous system side effects:* Seizures, sedation
- *Metabolic and endocrine side effects:* Weight gain
- *Allergic side effects:* Cholestatic jaundice, agranulocytosis, mild leukopenia
- *Cardiac side effects:* Tachycardia
- *Dermatological side effects:* Contact dermatitis, photosensitivity reaction

Nurse's Responsibility

- Assess patient behavior and emotional status
- Use chlorpromazine cautiously in patients with alcoholism, glaucoma, history of seizures, hypocalcemia (increases susceptibility to dystonias), impaired cardiac, hepatic, renal or respiratory function, benign prostate hyperplasia or urine retention
- Avoid skin contact with the oral concentrate and syrup to prevent contact dermatitis

- Do not give chlorpromazine by the subcutaneous route because severe tissue necrosis may occur
- To prevent irritation at the injection site, dilute the injection solution with sodium chloride
- Monitor the patient's blood pressure for hypotension, advise the patient to get up from the bed or chair slowly. Monitor blood pressure lying and standing frequently. Document and report significant changes
- Advise the patient to take sips of water frequently
- Apply glycerin to the lips
- Advise high fiber diet and more water intake
- Monitor patient for EPS
- Regularly check the patient's CBC, as ordered for evidence of blood dyscrasias
- Monitor the patient's serum drug level. The therapeutic serum level for chlorpromazine is 50 to 300 mcg/mL and the toxic serum level is greater than 750 µg/mL
- Advise the patient that urine may darken
- Inform the patient that drowsiness generally subsides with continued therapy
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Urge the patient to avoid alcohol and excessive exposure to sunlight while taking chlorpromazine
- Ensure that patient wears protective sun screens, clothing and sunglasses while spending in outdoors
- Evaluate the patient's fine tongue movement for signs of tardive dyskinesia. These symptoms are potentially irreversible. The drug should be withdrawn at the first sign which is usually vermiciform movements of the tongue.

FLUPHENAZINE HYDROCHLORIDE

Trade Name

Permitil, Prolixin, Prolixin Decanoate

Classification

Dopamine receptor antagonists—phenothiazine

Dose

Oral: 1-30 mg/day, Parental: 25 mg/mL once in 2 to 4 weeks

Mechanism of Action

A phenothiazine that antagonizes dopamine neurotransmission at synapses by blocking postsynaptic dopaminergic receptors in the brain.

Indications

Schizophrenia, mania with psychotic symptoms, organic brain syndrome, chronic schizophrenia.

Contraindications

Angle-closure glaucoma, myelosuppression, severe cardiac or hepatic disease, severe hypertension or hypotension.

Side Effects

- *Frequent:* Hypotension, dizziness and syncope (occur frequently after first injection, occasionally after subsequent injections and rarely with oral doses).
- *Occasional:* Somnolence, dry mouth, blurred vision, lethargy, constipation or diarrhea, nasal congestion, peripheral edema, urine retention.
- *Serious reactions:* EPS-Akathesia, acute dystonia, parkinsonian symptoms, tardive dyskinesia, abrupt discontinuation after long-term therapy may precipitate nausea, vomiting, gastritis, dizziness and tremors. Fluphenazine may lower the seizure threshold. Blood dyscrasias, particularly agranulocytosis and mild leukopenia may occur.

Nurse's Responsibility

- Assess patient behavior and emotional status
- Avoid skin contact with the oral concentrate and syrup to prevent contact dermatitis
- Monitor the patient's blood pressure for hypotension and complete blood count for blood dyscrasias
- Administer deep injection in large muscle mass
- Evaluate the patient's fine tongue movement for signs of tardive dyskinesia. These symptoms are potentially irreversible. The drug should be withdrawn at the first sign which is usually vermiciform movements of the tongue
- Inform the patient that drowsiness generally subsides with continued therapy
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established.

TRIFLUOPERAZINE HYDROCHLORIDE**Trade Name**

Stelazine, Terfluzine, Solazine, Flurazine

Classification

Dopamine receptor antagonists—phenothiazine

Dose

Oral: 2–5 mg/day up to 40 mg/day, Parental: IM 1–2 mg up to 10 mg/day

Mechanism of Action

A phenothiazine derivative that blocks dopamine at postsynaptic receptor sites. Possess strong extrapyramidal and antiemetic effects and weak anticholinergic and sedative effects.

Indications

Acute psychotic episodes in schizophrenia and schizoaffective disorders, mania, depression with psychotic symptoms, delusional disorders, borderline personality disorder, and substance induced psychotic disorder, delirium and dementia, mental disorders due to a medical condition, pervasive developmental disorder, Tourette's syndrome, Huntington's disease.

Contraindications

Angle-closure glaucoma, myelosuppression, severe cardiac or hepatic disease, severe hypertension or hypotension.

Side Effects

- *Frequent:* Hypotension, dizziness and syncope (occur frequently after first injection, occasionally after subsequent injections and rarely with oral doses).
- *Occasional:* Drowsiness during early therapy, dry mouth, blurred vision, lethargy, constipation or diarrhea, nasal congestion, peripheral edema, urine retention.
- *Serious reactions:* EPS—Akathesia, acute dystonia, parkinsonian symptoms, tardive dyskinesia, abrupt discontinuation after long-term therapy may precipitate nausea, vomiting, gastritis, dizziness and tremors. Trifluoperazine may lower the seizure threshold. Blood dyscrasias, particularly agranulocytosis and mild leukopenia may occur.

Nurse's Responsibility

- Assess patient behavior and emotional status
- Use trifluoperazine cautiously in patients with Parkinson's disease or seizure disorders
- Give oral drugs along with food to decrease GI effects
- Administer deep injection in large muscle mass
- Monitor the patient's BP for hypotension

- Observe the patient for extrapyramidal symptoms, such as gait changes, tremors, and abnormal movement in the trunk, neck or extremities
- Monitor the patient's WBC count for blood dyscrasias, such as anemia, neutropenia, pancytopenia and thrombocytopenia
- Monitor the patient for fine tongue movement, an early sign of tardive dyskinesia. These symptoms are potentially irreversible. The drug should be withdrawn at the first sign which is usually vermiciform movements of the tongue
- Assess the patient for signs of a therapeutic response
- Inform the patient that drowsiness generally subsides with continued therapy
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Instruct the patient not to take antacids within 1 hour of trifluoperazine
- Urge the patient to avoid alcohol and excessive exposure to artificial light and sunlight during trifluoperazine therapy
- Instruct the patient to rise slowly from a lying or sitting position to prevent hypotension. Monitor blood pressure lying and standing frequently. Document and report significant changes.

RISPERIDONE

Trade Name

Sizodon

Classification

Atypical antipsychotic—serotonin dopamine antagonists

Dose

Oral: 0.5–6 mg/day

Mechanism of Action

Antiserotonergic, antiadrenergic and antihistaminergic actions. It has less action as antidopaminergic, especially D2 receptors.

Indications

Positive and negative symptoms of schizophrenia, other psychosis, schizoaffective symptoms.

Contraindications

Hypersensitivity, heart diseases, epilepsy, hyperprolactinemia, parkinsonism, renal and hepatic impairment.

Side Effects

- CNS: Somnolence, seizures, headache
- CVS: Orthostatic hypotension, dizziness, tachycardia and syncope
- *Other adverse reactions:* Weight gain, constipation, erectile dysfunction, vomiting, rash, abdominal pain.

Rare reactions include tardive dyskinesia (characterized by tongue protrusion, puffing of the cheeks, and chewing or puckering of the mouth) and neuroleptic malignant syndrome (marked by hyperpyrexia, muscle rigidity, change in mental status, irregular pulse or blood pressure, tachycardia, diaphoresis, cardiac arrhythmias and acute renal failure).

Nurse's Responsibility

- Before beginning risperidone therapy assess for blood urea nitrogen levels and serum alkaline phosphatase, bilirubin, creatinine, renal and hepatic functions
- Assess for behavioral and emotional status
- The elderly are more susceptible to orthostatic hypotension. They may require a dosage adjustment because of age-related renal or hepatic impairment

- Monitor the patient's BP, heart rate, liver function test results, and weight gain
- Observe the patient for fine tongue movement, which may be the first sign of irreversible tardive dyskinesia
- Monitor the patient for neuroleptic malignant syndrome
- Take measures to reduce constipation
- Urge the patient to notify the physician if he or she experiences altered gait, difficulty in breathing, palpitations, pain or swelling in breasts, severe dizziness or fainting, trembling fingers, unusual movements, rash or visual changes
- Inform the patient that risperidone may cause dizziness or drowsiness. Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Instruct the patient to change positions slowly to minimize the drug's hypotensive effects
- Urge the patient to avoid alcohol during risperidone therapy.

OLANZAPINE

Trade Name

Zyprexa

Classification

Atypical antipsychotic—serotonin dopamine antagonists

Dose

Oral: 5–10 mg/day.

Mechanism of Action

Antagonizes alpha-adrenergic, dopamine histamine muscarinic and serotonin receptors. Produces anticholinergic, histaminic and CNS depressant effects.

Indications

Positive and negative manifestations of schizophrenia, schizoaffective disorders, bipolar mania.

Contraindications

Narrow angle glaucoma, paralytic ileus, urinary out flow obstruction.

Side Effects

Central nervous system: Somnolence, agitation, insomnia, headache, nervousness, hostility.

Cardiovascular system: Orthostatic hypotension, tachycardia, syncope, dizziness.

Other adverse reaction: Weight gain, constipation.

Rare reactions include seizures, neuroleptic malignant syndrome, EPS.

Nurse's Responsibility

- Obtain lever function test results, as ordered before beginning olanzapine treatment
- Assess the patient's behavior and emotional status
- Use olanzapine cautiously in patients with a hypersensitivity to clozapine, hepatic impairment, cerebrovascular disease, cardiovascular disease, history of seizures and conditions predisposing patients to hypotension such as dehydration, hypovolemia, use of antihypertensives
- Monitor the patient for blood pressure
- Instruct the patient to take olanzapine as ordered. Caution the patient against abruptly discontinuing the drug or increasing the dosage
- Inform the patient that drowsiness generally subsides with continued therapy
- Caution the patient to notify the physician, if she becomes pregnant or intends to become pregnant during olanzapine therapy
- Warn the patient to avoid tasks requiring mental alertness or motor skills until his response to the drug has been established.

- Advise the patient to avoid dehydration, particularly during exercise; exposure to extreme heat; and concurrent use of medications that cause dry mouth or other drying effects
- Suggest taking sips of tepid water and chewing sugarless gum to help relieve dry mouth
- Instruct the patient to maintain a healthy diet and exercise program to prevent weight gain
- Administer or instruct patient to take drug early in the day to reduce insomnia, instruct to avoid caffeinated drinks or food.

CLOZAPINE

Trade Name

Sizopine

Classification

Atypical antipsychotic—serotonin dopamine antagonists

Dose

Oral: Initially 25 mg, 1–2 times per day. This can be gradually increased to 300 mg per day in 2–3 divided doses.

Mechanism of Action

Antagonizes alpha-adrenergic, dopamine histamine muscarinic and serotonin receptors. Produces anticholinergic, histaminic and CNS depressant effects.

Indications

Positive and negative manifestations of schizophrenia, schizoaffective disorders, schizophrenia not responding to traditional antipsychotic drugs, patient who cannot tolerate the side effects of traditional antipsychotic, management of severely ill schizophrenic patients.

Contraindications

Bone marrow suppression, lactation, hypersensitivity, CNS depression, coma, below 16 years age.

Side Effects

- *Clozapine induced agranulocytosis:* Decreased WBC count specifically polymorphonuclear leukocytes, seizures, tachycardia, hypotension.
- Other side effects are sedation, fatigue, sialorrhea, weight gain, constipation, anticholinergic effects.

Nurse's Responsibility

- Great risk period is first 6 months, explain risks of treatment. Agranulocytosis is a life threatening side effect which should be informed to the family members
- Before starting therapy test blood for TC, DC, liver function test (LFT) and renal function test (RFT)
- For the first 6 months of continuous therapy, obtain patient's WBC count on a weekly basis, then biweekly for patients with acceptable WBC count. If the WBC is below 1500/mm³ clozapine should be stopped
- Instruct the patient to notify symptoms such as sore throat, fever, lethargy, weakness like symptoms to the physician promptly
- Take precautions for seizure
- Use clozapine cautiously in patients undergoing alcohol withdrawal and in those with cardiovascular disease, glaucoma, history of seizures, benign prostate hyperplasia, myocarditis, urine retention or impaired hepatic, renal or respiratory function
- Caution the patient against abruptly discontinuing clozapine
- Inform the patient that drowsiness generally subsides with continued therapy
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Urge the patient to avoid alcohol during clozapine therapy.

ARIPIPRAZOLE

Trade Name

Abilify, Aripiprex

Classification

Psychotropic drug—atypical antipsychotic, dopamine, serotonin agonist and antagonist

Dose

Available forms

Tablets: 10, 15, 20, 30 mg

Adults: 10–15 mg/day PO

Pediatric patients: Safety and efficacy not established

Mechanism of Action

Acts as an agonist at dopamine and serotonin sites and antagonist at other serotonin receptor sites; this combination of actions is thought to be responsible for the drug's effectiveness in treating schizophrenia, though the mechanism of action is not understood.

Pharmacokinetics

Usual administration is oral route. Metabolized in the liver, may cross placenta; may pass into breast milk, it excretes through urine and feces.

Indications

Used in the treatment of schizophrenia, bipolar disorder, major depressive disorder (as an add on to other treatment), tic disorders, and irritability associated with autism.

Contraindications

Contraindicated in the presence of allergy to aripiprazole, during lactation period. Use cautiously in the presence of suicidal ideation, pregnancy, cerebral vascular disease, known cardiovascular disease, seizure disorders, patients with Alzheimer's disease, dysphagia (risk for aspiration pneumonia).

Side Effects

Weight gain, headache, agitation, insomnia, anxiety, nausea and vomiting, akathisia (a sense of unease and restlessness that presents itself with anxiety), light-headedness, constipation.

Nurse's Responsibility

- Monitor Blood pressure
- Protect the patient from extreme of heat (avoid heavy exercise, dehydration)
- Provide plenty of oral fluids
- Explain about side effects
- Report severe dizziness, trembling, light-headedness, suicidal thoughts, and blurred vision.

PALIPERIDONE

Trade Name

Invega, Invega sustenna

Classification

Atypical antipsychotic

Dose

Paliperidone comes as an extended-release (long-acting) tablet to take by mouth once a day in the morning with or without food. Usual dose is 3 to 6 mg per day orally, 6 mg for subjects weighing less than 51 kg and 12 mg for subjects weighing more than 51 kg.

Mechanism of Action

Paliperidone is the primary active metabolite of the older antipsychotic risperidone. Specific mechanism of action is unknown; it is believed that paliperidone and risperidone act via similar, if not the same, pathways. The drug's therapeutic activity in schizophrenia is mediated through a combination of central dopamine type 2 (D2) and serotonin type 2 (5HT2A) receptor antagonism. Paliperidone was approved by the Food and Drug Administration (FDA) for treatment of schizophrenia on December 20, 2006.

Pharmacokinetics

The absolute oral bioavailability of paliperidone following administration is 100%. Peak plasma levels of drug occur 1 hour after administration. Paliperidone is 90% plasma protein bound. Excreted in urine.

Indications

Treatment for schizophrenia, schizoaffective disorders, bipolar affective disorder and depression.

Contraindications

- Allergic to any ingredient in paliperidone or to risperidone
- Moderate to severe kidney problems, liver problems
- History of irregular heart beat
- Taking certain antiarrhythmics (e.g. amiodarone, procainamide, quinidine, sotalol)
- Taking certain antipsychotic medicines (e.g. Chlorpromazine, thioridazine)
- Pregnancy and breast feeding
- History of seizures, heart problems, heart failure, abnormal electrocardiography (ECG)
- High blood cholesterol or triglycerides
- High or low blood pressure
- History of neuroleptic malignant syndrome, tardive dyskinesia, suicidal thoughts, alcohol abuse or dependency
- Reye syndrome, diabetes, Alzheimer disease, dementia, Parkinson's disease, high blood prolactine levels
- History of certain cancers (e.g. breast, pancreas, pituitary).

Side Effects

Constipation; diarrhea; dizziness; drowsiness; dry mouth; headache; light-headedness; mild pain, swelling, or redness at the injection site; mild stomach pain or discomfort; nausea; restlessness; trouble sleeping; vomiting; weakness; weight gain.

Nurse's Responsibility

Instruct the patient or family on following aspects:

- Drinking extra fluids while taking this drug are recommended
- Tell your doctor or dentist that you are taking paliperidone before taking any medical or dental care or emergency care or surgery
- Do not drive or perform unsafe tasks while taking drug because paliperidone may cause drowsiness, dizziness or light headedness
- Do not drink alcohol
- Do not change dose or stop medication without doctor's advise
- Do not become overheated in hot weather
- Diabetes patients should check blood sugar levels closely
- Inform doctor, any signs of infection like fever, sore throat, rash or chills
- Monitor weight regularly
- Take medicine at around the same time everyday. Swallow the tablet whole with plenty of water or other liquid
- Take the missed dose as soon as you remember it. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule. Do not take a double dose to make up for a missed one.

AMISULPRIDE

Trade Names

Amgrace, Cyam, Bipo Life, Zonapride, Zulpride, Solian

Classification

Second-generation atypical antipsychotic

Dose

It comes as a tablet to take by mouth on an empty stomach, IM injection should be given into large muscle. For adult less than 15 years, the recommended dose is 400–800 mg/day in divided doses PO. Maximum dose is 1.2 g/day. Intramuscular injection the recommended dose is 400 mg/day.

Mechanism of Action

Amisulpride, a substituted benzamide derivative, is a second-generation (atypical) antipsychotic. Amisulphide binds selectively to D2 dopaminergic receptors and D3 receptors, but does not have any affinity for D1, adrenergic, cholinergic, serotonergic or H1 (histaminergic receptors). It shows greater affinity for limbic dopaminergic receptors than for striatal structures suggesting better neurological tolerability compared with classical neuroleptics which block all dopamine receptors equally. High doses (400–800 mg) inhibit hyperdopaminergic symptomatology and control psychotic symptoms, low doses (50–300 mg) have an effect on negative symptoms.

Pharmacokinetics

Amisulpride is absorbed rapidly, within 3–4 hours of oral administration. Drug is excreted through urine mainly as unchanged drug, the elimination half-life is approximately 12 hours, plasma protein binding is low.

Indications

For the treatment of schizophrenia, schizoaffective disorders, bipolar affective disorders and other psychotic disorders.

Contraindications

Caution should be exercised in patients with history of diabetes, epilepsy, brain damage, Parkinson's disease, heart disease, stroke, dementia, high blood pressure, alcoholism, elderly, pregnancy and lactation period.

It should not be used in following patients: Who are allergic to amisulpride, breast cancer, tumor on their adrenal gland (prolactine dependent tumors), taking levodopa medicines, during pregnancy and lactation period, children before the onset of puberty.

Side Effects

Extrapyramidal symptoms, hyperprolactinemia, insomnia, anxiety agitation, weight gain, dizziness, restlessness, stiffness in arms or legs, increased salivation, changes in blood sugar level and cholesterol level, rash, changes in menstrual cycle.

Nurse's Responsibility

- Caution should be exercised in patients with history of sugar, epilepsy, brain damage, Parkinson's disease, heart disease, abnormal heart rhythm, disturbances in blood electrolytes level, stroke, dementia, high blood pressure, smoking habit, alcoholism, elderly, and during pregnancy
- Drug may cause drowsiness, advice patient not to drive a car or operate machinery while taking medication
- Inform patient and family members to consult doctor if patient develops abnormal movements particularly of the face, lips, jaw and tongue while taking medication
- Monitor blood sugar level, ECG, weight, waist circumference regularly, while taking medication

- Inform patient and family members about neuroleptic malignant syndrome and tardive dyskinesia symptoms like high fever, sweating, muscle stiffness, faster breathing and drowsiness or sleepiness. Consult doctor immediately if these symptoms appear
- Explain to the patient that if he forgets to take the drug, he may take it as soon as he remembers it. However, if it is nearly time for the next dose, skip the missed dose. Do not take a double dose to make up for a forgotten dose
- Advice patient not to stop drug abruptly, stopping treatment suddenly may cause withdrawal effects such as feeling sick, sweating, difficulty in sleeping, muscle stiffness or unusual body movements.

QUETIAPINE

Trade Name

Serequel

Dose

Children and adolescents 100–350 mg/day, Adults—300 to 400 mg in 2–3 divided doses in a day.

Classification

Atypical antipsychotic agent, Dibenzothiazepine

Mechanism of Action

Exact mechanism of action is unknown, it has been proposed that this drug's antipsychotic activity is mediated through a combination of dopamine type 2 (D2) and serotonin type 2 (5-HT2) antagonism.

Pharmacokinetics

Pharmacokinetics absorbed orally, protein binding plasma 83%, primarily metabolized in liver, excreted through urine and feces.

Indications

Treatment of schizophrenia, schizoaffective disorders, mania, bipolar disorders, autism, psychosis.

Contraindications

Use with caution in patients with Parkinson's disease, hemodynamic instability, prior myocardial infarction, hypercholesterolemia, thyroid disease, seizures, hepatic impairment, renal or respiratory diseases. Should not be used for patients with hypersensitivity to quetiapine, bone marrow suppression, blood dyscrasias, severe hepatic disease or coma.

Side Effects

Headache, somnolence, weight gain, tachycardia, palpitations, postural hypotension, dizziness, rash, abdominal pain, constipation, anorexia, weakness, in rare conditions diabetes mellitus, hyperlipidemia, hypothyroidism, vertigo.

Nurse's Responsibility

- Monitor for side effects
- Instruct the patient
- To take medication along with the food, regularly on same time
- Do not suddenly stop the medicine
- Drug may cause drowsiness avoid driving, doing other activities until you see how this medicine affects you
- Avoid alcohol, take plenty of oral fluids.

ZIPRASIDONE

Trade Name

Zeldex, Ziprasidone Hydrochloride, Ziprasidone Mesylate

Dose

Adults—20–100 mg twice daily orally, Intramuscular injection 10 mg in every 2 hours or 20 mg in every 4 hours.

Classification

Atypical antipsychotic D(3) dopamine receptor antagonist.

Mechanism of Action

Ziprasidone's antipsychotic activity is likely due to a combination of its antagonistic function at D2 receptors in the mesolimbic pathways and at 5HT2A receptors in the frontal cortex. Alleviation of positive symptoms is due to antagonism at D2 receptors while relief of negative symptoms is due to 5HT2A antagonism.

Pharmacokinetics

Well-absorbed orally, metabolized in the liver, excreted through feces and urine, protein binding 99%.

Indications

Schizophrenia, acute mania, bipolar affective disorder, also used for depression, anxiety, aggression, dementia, attention deficit hyperactivity disorder, obsessive compulsive disorder, autism, post-traumatic stress disorder.

Contraindications

Hypersensitivity to ziprasidone, recent myocardial infarction, history of arrhythmias, heart failure, use of antiarrhythmics. Use with caution in patients with seizures.

Side Effects

Somnolence, headache, nausea, hypertension, postural hypotension, extrapyramidal symptoms, rash, dysmenorrheal, constipation, abdominal pain.

Nurse's Responsibility

- Monitor serum potassium and magnesium levels
- Potential for extrapyramidal symptoms, fever, confusion, stiffness should be promptly evaluated for neuroleptic malignant syndrome
- Drug should not be administered to a patient who recently had heart attack or congestive heart failure.

IMIPRAMINE

Trade Name

Antidep, Tofranil

Classification

Tertiary tricyclic antidepressant drugs

Dose

75–300 mg per day orally

Mechanism of Action

The tricyclic antidepressants are also called as monoamino reuptake inhibitors (MARIs). Their main modes of action are:

- Blocking the reuptake of norepinephrine (NE) and serotonin (5-HT) at the nerve terminals, thus increasing NE and 5-HT level at receptor site
- Regulation of the β adrenergic receptors.

Indications

- Depressive episodes, depression with psychotic symptoms, dysthymia, reactive depression, secondary depression due to hypothyroidism, Cushing's syndrome, abnormal grief reaction.
- Childhood psychiatric disorders, enuresis, phobia, separation anxiety, somnambulism, night terrors.
- Other psychiatric disorders like panic attacks, agoraphobia, social phobia, obsessive compulsive disorder, aggression in elderly, post-traumatic stress disorder, depersonalization.
- *Medical disorders:* Chronic pain, migraine, peptic ulcer

Contraindications

Cardiac disorders, acute recovery period after MI, use within 14 days of MAOIs.

Side Effects

- *Autonomic:* Dry mouth, constipation, urinary retention, mydriasis, orthostatic hypotension, impotence, delirium, blurred vision, urinary hesitancy.
- *CNS:* Sedation, tremors, withdrawal syndrome, seizures.
- *CVS:* Tachycardia, arrhythmias, direct myocardial depression.
- *Allergic:* Agranulocytosis, cholestatic jaundice.
- *Other reactions:* Weight gain, tiredness, drowsiness, insomnia, acute organic syndrome.

Nurse's Responsibility

- Perform complete blood count, blood serum chemistry tests to specifically assess the blood glucose level, and liver and renal function tests prior to and periodically during long-term therapy
- Plan to perform a baseline ECG if the patient is at risk for arrhythmias
- Use of drug is not recommended for children younger than 6 years
- Expect to administer a lower dosage to elderly patients because they are at risk for drug toxicity
- Use cautiously in patients with cardiac disease, diabetes mellitus, glaucoma, hiatal hernia, history of seizures, history of urinary obstruction, hyperthyroidism, benign prostatic hyperplasia, renal or hepatic disease
- Make sure at least 14 days elapse between the use of MAOIs and imipramine
- Give with food or milk if GI distress occurs
- Do not crush or break film-coated tablets
- Closely monitor suicidal patients during early therapy. As depression lessens, the patient's energy level generally improves, increasing the likelihood of suicide attempts
- Assess the patient's pattern of daily bowel activity and stool consistency
- Assess the patient's appearance, behavior, level of interest, mood and sleep pattern before and during therapy
- Monitor the patient's BP and pulse rate to detect hypotension and arrhythmias
- Palpate the patient's bladder for evidence of urine retention
- Caution the patient against abruptly discontinuing medication
- Inform the patient that improvement may occur within 2 to 5 days of starting therapy but that the full therapeutic effect is likely to occur in 2 to 3 weeks
- Instruct the patient to change positions slowly to help prevent dizziness
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Inform the patient that taking sips of tepid water and chewing sugarless gum may relieve dry mouth
- Advise the patient to take high fiber diet.

CLOMIPRAMINE

Trade Name

Anafranil

Classification

Tertiary tricyclic antidepressant drugs

Dose

150–250 mg/day orally

Mechanism of Action

A tricyclic antidepressant that blocks the reuptake of neurotransmitters, such as norepinephrine and serotonin at CNS presynaptic membranes, increasing their availability at postsynaptic receptor sites.

Indications

Obsessive-compulsive disorder, depression, phobias, pain disorders.

Contraindications

- Cardiac disorders, acute recovery period after MI, use within 14 days of MAOIs.
- Should be avoided during pregnancy, the drug should be given cautiously in patients with hepatic and renal disease.

Side Effects

Somnolence, fatigue, dry mouth, blurred vision, constipation, sexual dysfunction, ejaculatory failure, impotence, weight gain, delayed micturition, orthostatic hypotension, diaphoresis, impaired concentration, increased appetite, urine retention, GI disturbances, seizures, orthostatic hypotension, dizziness, tachycardia, palpitation and arrhythmias and hyperpyrexia.

Nurse's Responsibility

Same as that for imipramine. (See Pg. 447)

AMITRIPTYLINE HYDROCHLORIDE

Trade Name

Elavil, Endep, Levate

Classification

Tertiary tricyclic antidepressant drugs

Dose

30–100 mg/day orally, may increase up to 150–300 mg/day.

Mechanism of Action

A tricyclic antidepressant that blocks the reuptake of neurotransmitters, such as norepinephrine and serotonin at CNS presynaptic membranes, increasing their availability at postsynaptic receptor sites.

Indications

Depression, relief of neuropathic pain, such as experienced by patients with diabetic neuropathy or post therapeutic neuralgia, treatment of bulimia nervosa.

Contraindications

Cardiac disorders, acute recovery period after MI, use within 14 days of MAOIs.

Side Effects

Dizziness, somnolence, dry mouth, orthostatic hypotension, headache, increased appetite, weight gain, nausea, unusual fatigue, unpleasant taste, blurred vision, confusion, constipation, arrhythmias, fine muscle tremors, anxiety, diarrhea, diaphoresis, heartburn, insomnia.

Nurse's Responsibility

- Perform CBC, blood serum chemistry tests, specifically to assess the blood glucose level, and liver and renal function tests before and periodically during long-term therapy
- Plan to perform a baseline ECG if the patient is at risk for arrhythmias
- Amitriptyline use is not recommended for children younger than 10 years. Children are more sensitive to an acute overdose and are at increased risk for amitriptyline toxicity
- Elderly patients are more sensitive to the drug's anticholinergic effects and are at increased risk for amitriptyline toxicity
- Use amitriptyline cautiously in patients with cardiac disease, diabetes mellitus, glaucoma, hiatal hernia, history of seizures, history of urinary obstruction, hyperthyroidism, and benign prostatic hyperplasia, renal or hepatic disease
- Make sure at least 14 days elapse between the use of MAOIs and clomipramine
- Give amitriptyline with food or milk if GI distress occurs
- Closely monitor suicidal patients during early therapy. As depression lessens, the patient's energy level generally improves, increasing the likelihood of suicide attempts
- Assess the patient's pattern of daily bowel activity and stool consistency
- Assess the patient's appearance, behavior, level of interest, mood and sleep pattern before and during therapy
- Monitor the patient's BP and pulse rate to detect hypotension and arrhythmias
- Palpate the patient's bladder for evidence of urine retention
- Instruct the patient to change positions slowly to help prevent dizziness
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Inform the patient that taking sips of tepid water and chewing sugarless gum may relieve dry mouth
- Advise the patient to take high fiber diet
- Inform the patient that the drug's full therapeutic effect may be noted in 2 to 4 weeks
- Inform the patient that he may develop sensitivity to sunlight
- Urge the patient to report any visual disturbances.

FLUOXETINE HYDROCHLORIDE

Trade Name

Auscap, Fluohexal, Lovan, Novo-Fluoxetine, Prozac

Classification

Antidepressant—Serotonin-Specific reuptake inhibitors

Dose

Initially, 20 mg each morning. If therapeutic improvement does not occur after 2 weeks, gradually increase to a maximum of 80 mg/day in two equally divided doses in morning and at noon.

Mechanism of Action

Selectively inhibits serotonin uptake in the CNS, enhancing serotonergic function.

Indications

Depression, obsessive-compulsive disorder, panic disorder and other anxiety disorders, bulimia nervosa, premenstrual dysphoric disorder, treatment of hot flashes.

Contraindications

Hypersensitivity, severe hepatic or renal impairment, pregnancy, lactation and history of seizures.

Side Effects

Headache, nervousness, insomnia, drowsiness, anxiety, seizures, rarely EPS, apathy, anorexia, nausea, diarrhea, dyspepsia, and sexual dysfunction.

Nurse's Responsibility

- Perform complete blood count (CBC), liver and renal function tests before and periodically during long-term therapy
- Use cautiously in patients with cardiac dysfunction, diabetes, or seizure disorder and in patients at high risk of suicide
- Give with food or milk if gastrointestinal (GI) distress occurs
- Avoid administration at night, instruct the patients to take the last dose of the drug before 4 pm to avoid insomnia
- Assess the patient's pattern of daily bowel activity and stool consistency
- Closely monitor suicidal patients during early therapy. As depression lessens, the patient's energy level generally improves, increasing the likelihood of suicide attempts
- Assess the patient's appearance, behavior, level of interest, mood and sleep pattern before and during therapy
- Inform the patient that the drug's full therapeutic effect may be noted in 2 to 4 weeks
- Warn the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Urge the patient to avoid alcohol
- Caution the female patient to notify the physician if she becomes pregnant
- Instruct the patient to report fatigue, headache, sexual dysfunction or tremor
- Suggest the patient to take sips of tepid water or chew sugarless gum to relieve dry mouth.

SERTRALINE HYDROCHLORIDE

Trade Name

Zoloft

Classification

Antidepressant—Serotonin-Specific reuptake inhibitors.

Dose

50–200 mg

Mechanism of Action

Selectively inhibits serotonin uptake in the CNS, enhancing serotonergic function. It blocks the reuptake of the neurotransmitter serotonin at CNS neuronal presynaptic membranes, increasing its availability at postsynaptic receptor sites.

Indications

Depression, obsessive-compulsive disorder, panic disorder and other anxiety disorders, bulimia nervosa, premenstrual dysphoric disorder, treatment of hot flashes.

Contraindications

Hypersensitivity, severe hepatic or renal impairment, pregnancy, lactation and history of seizures.

Side Effects

Headache, nervousness, insomnia, drowsiness, anxiety, seizures, rarely EPS, apathy, anorexia, nausea, diarrhea, dyspepsia, and sexual dysfunction.

Nurse's Responsibility

Same as that for Fluoxetine Hydrochloride (See Pg. 450)

TRANYLCYPROMINE SULFATE

Trade Name

Parnate

Classification

Antidepressants monoamine oxidase inhibitors (MAOI)

Dose

Oral: 10–60 mg per day

Mechanism of Action

An MAOI that inhibits the activity of the enzyme monoamine oxidase at CNS storage sites, leading to increased levels of the neurotransmitters epinephrine, norepinephrine, serotonin and dopamine at neuronal receptor sites.

Indications

Depression refractory to or intolerant of other therapy.

Contraindications

Congestive heart failure (CHF), children younger than 16 years, pheochromocytoma, severe hepatic or renal impairment, uncontrolled hypertension.

Side Effects

Frequently: Orthostatic hypotension, restlessness, GI upset, insomnia, dizziness, lethargy, weakness, dry mouth, peripheral edema.

Occasional: Flushing, diaphoresis, rash, urinary frequency, increased appetite, transient impotence.

Serious reactions: Hypertensive crisis occurs rarely and is marked by severe hypertension, occipital headache radiating frontally, neck stiffness or soreness, nausea, vomiting, diaphoresis, fever or chills, clammy skin, dilated pupils, palpitations, tachycardia or bradycardia and constricting chest pain.

Nurse's Responsibility

- Monitor blood pressure both lying and standing every 2 to 6 hours when initiating therapy
- Monitor liver function test and complete blood count
- Determine the patient's medical history. Ask the patient if he takes CNS depressants, meperidine and other antidepressants. Tranylcypromine should not be used within 14 days of taking selective serotonin reuptake inhibitors (SSRI)
- Use tranylcypromine cautiously within several hours of ingestion of a contraindicated substance, such as tyramine-containing food
- Assess the patient's behavior and emotional status
- Monitor the patient's blood pressure, temperature and weight
- Evaluate the patient for an occipital headache radiating frontally and neck stiffness or soreness which may be the first symptoms of an impending hypertensive crisis. If hypertensive crisis occurs administer phentolamine 5 to 10 mg IV as prescribed
- Discontinue tranylcypromine immediately if the patient experiences frequent headache or palpitations

- Tell the patient that depression may start to lift during the first week of therapy and that the drug's full therapeutic benefit will occur within 3 weeks
- Instruct the patient to change position slowly and to dangle the legs momentarily before standing to avoid dizziness.
- Urge the patient to avoid foods that require bacteria or molds for their preparation or preservation (such as yogurt and aged cheese); foods containing tyramine (such as bananas, broad beans, meat, liver, smoked or pickled meats and fish, papayas, figs, raisins, sour cream, soy sauce, beer, wine, and yeast extracts); and excessive amounts of caffeine-containing foods or beverages (including chocolate, coffee and tea).

LAMOTRIGINE

Trade Name

Lamictal

Classification

Central nervous system agent; anticonvulsant

Dose

Available forms—25 mg, 100 mg, 150 mg, 200 mg tablets; 2 mg, 5 mg, 25 mg chewable tablets.

Adults—25–200 mg/day PO in two divided doses

Pediatric patients—Safety and efficacy not established

Mechanism of Action

The exact mechanism of action is unknown; thought to act by inhibiting the release of glutamate, an excitatory neurotransmitter, at voltage-sensitive sodium channels. Stabilizing the neuronal membrane and modulating calcium-dependent presynaptic release of excitatory amino acids.

Pharmacokinetics

Usual administration is oral route. Metabolized in the liver, may cross placenta; may pass into breast milk, it excretes through urine.

Indications

- Adjuvant therapy in the treatment of partial seizures in adults with epilepsy
- Monotherapy in adults with partial seizures
- Generalized tonic—clonic, absence, or myoclonic seizures in adults, treatment of bipolar disorder.

Contraindications

- Contraindicated with allergy to drug, lactation and pregnancy
- Use cautiously with impaired hepatic, renal, or cardiac function; patients <16 year.

Side Effects

Skin rash, Stevens-Johnson syndrome, toxic epidermal necrolysis with multiorgan failure, dizziness, insomnia, headache, somnolence, ataxia, diplopia, blurred vision, nausea, vomiting.

Nurse's Responsibility

- Monitor renal and hepatic function before and during therapy
- Monitor patient for any sign of skin rash; discontinue lamotrigine immediately if rash appears
- Do not discontinue drug abruptly or change the dosage without medical advice
- Taper drug slowly over a two week period when discontinuing
- Advise the patient not to breast feed while taking drug
- Advise the patient for periodic ophthalmologic examination with long-term use

- Advise the patient to report yellowing of skin, abdominal pain, changes in color of urine or stools, fever, sore throat, mouth sores, unusual bleeding or bruising, rash.

ALPRAZOLAM

Trade Name

Alprax, Apo-Alpraz, Novo-Alprazol

Classification

Antianxiety agents, sedatives/hypnotics—benzodiazepines

Dose

Oral: Adults—0.25–0.5 mg, 2 to 3 times daily

Mechanism of Action

Antianxiety agents may increase the inhibiting effects of gamma aminobutyric acid (GABA), an inhibitory neurotransmitter. Benzodiazepines reduce anxiety by stimulating the action of the inhibitory neurotransmitter GABA in the limbic system. The limbic system plays an important role in the regulation of human behavior. Dysfunction of GABA transmission in the limbic system may be linked to the development of certain anxiety disorders.

Indications

Anxiety disorders, panic disorder, premenstrual syndrome, insomnia, irritable bowel syndrome.

Contraindications

Acute alcohol intoxication with depressed vital signs, acute angle closure glaucoma, myasthenia gravis, severe chronic obstructive pulmonary disease (COPD), hypersensitivity, pregnancy and lactation.

Side Effects

- *Frequent:* Ataxia, light-headedness, transient mild somnolence, slurred speech.
- *Occasional:* Confusion, depression, blurred vision, constipation, diarrhea, dry mouth headache, nausea.
- *Serious reactions:* Abrupt or too-rapid withdrawal may result in pronounced restlessness, irritability, insomnia, hand tremors, abdominal and muscle cramps, diaphoresis, vomiting and seizures. Overdose results in somnolence, confusion, diminished reflexes and coma.

Nurse's Responsibility

- Assess the patient for motor responses, such as agitation, tension and trembling, and autonomic responses, such as cold, clammy hands and diaphoresis
- Chronic use of alprazolam during pregnancy may produce withdrawal symptoms in the patient and CNS depression in the neonate
- Use alprazolam cautiously in patients with impaired renal or hepatic function
- Caution the patient not to stop taking alprazolam abruptly after long-term therapy
- Inform the patient that drowsiness usually disappears with continued therapy
- Instruct the patient to change positions slowly from recumbent to sitting, before standing to prevent dizziness
- Caution the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Urge the patient to avoid alcohol during therapy
- Encourage the patient to stop smoking because smoking reduces alprazolam's effectiveness
- Urge the female patient on long-term therapy to use effective contraception during therapy and notify the physician immediately if she becomes or even suspects to be pregnant
- Inform the patient that sour hard candy, gum, or sips of tepid water may relieve dry mouth.

CHLORDIAZEPOXIDE

Trade Name

Librium, Novopoxide

Classification

Antianxiety agents, sedatives/hypnotics—benzodiazepines

Dose

Oral: 15–100 mg per day in 3–4 divided doses. Parental: 25–50 mg IV or IM

Mechanism of Action

Antianxiety agents may increase the inhibiting effects of gamma aminobutyric acid (GABA), an inhibitory neurotransmitter. Benzodiazepines reduce anxiety by stimulating the action of the inhibitory neurotransmitter GABA in the limbic system. The limbic system plays an important role in the regulation of human behavior. Dysfunction of GABA neurotransmission in the limbic system may be linked to the development of certain anxiety disorders.

Indications

Alcohol withdrawal symptoms, anxiety, panic disorder, tension headache, tremors.

Contraindications

Comatose patients, pre-existing CNS depression, uncontrolled severe pain, narrow angle glaucoma, acute alcohol intoxication.

Side Effects

- *Frequent:* Pain at IM injection site, somnolence, ataxia, dizziness, confusion.
- *Occasional:* Rash, peripheral edema, GI disturbances.
- *Serious reactions:* Intravenous administration may produce painful swelling, thrombophlebitis and carpal tunnel syndrome. Abrupt or too-rapid withdrawal may result in pronounced restlessness, irritability, insomnia, hand tremors, abdominal or muscle cramps, diaphoresis, vomiting and seizures. Overdose results in somnolence, confusion, diminished reflexes and coma.

Nurse's Responsibility

- Assess the patient's BP, pulse rate and respiratory rate, rhythm and depth immediately before giving chlordiazepoxide
- Assess the patient for motor responses, such as agitation, tension and trembling, and autonomic responses, such as cold, clammy hands and diaphoresis
- Keep the patient recumbent for up to 3 hours after parenteral administration to reduce the drug's hypotensive effect
- Assist the patient with ambulation if he experiences ataxia or drowsiness
- Know the therapeutic serum level for chlordiazepoxide is 1 to 3 µg/mL and toxic serum level is greater than 5 µg/mL
- Inform the patient that intramuscular (IM) injection may produce discomfort
- Inform the patient that drowsiness usually disappears with continued therapy
- Instruct the patient to change positions slowly from recumbent to sitting, before standing to prevent dizziness
- Caution the patient to avoid tasks that require mental alertness or motor skills until his response to the drug has been established
- Warn the patient to avoid alcohol during therapy

- Encourage the patient to stop smoking during therapy because smoking reduces the drug's effectiveness.

DIAZEPAM

Trade Name

Valium, Valpam

Classification

Antianxiety agents, sedatives/hypnotics—benzodiazepines.

Dose

Oral: 2–10 mg, 2–4 times a day. Parental: 2–10 mg, may repeat in 3 to 4 hours if needed.

Mechanism of Action

May potentiate the effects of gamma-aminobutyric acid (GABA) and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in the limbic and cortical areas of the central nervous system (CNS). GABA inhibits excitatory stimulation which helps control emotional behavior. Diazepam suppresses the spread of seizure activity caused by seizure-producing foci in the cortex, thalamus and limbic structures.

Indications

Anxiety, skeletal muscle relaxation, preanesthesia, alcohol withdrawal, status epilepticus, control of increased seizure activity in patients with refractory epilepsy who are on stable regimens of anti-convulsants, treatment of panic disorder, tension headache, tremors.

Contraindications

Angle closure glaucoma, coma, pre-existing CNS depression, respiratory depression, severe uncontrolled pain.

Side Effects

Dizziness, drowsiness, lethargy, hangover, paradoxical excitation, mental depression, headache, hypotension, rashes, blurred vision, nausea, vomiting, diarrhea, constipation, venous thrombosis, phlebitis, respiratory depression, psychological dependency.

Nurse's Responsibility

- Assess the patient's BP, pulse rate and respiratory rate, rhythm and depth immediately before giving diazepam
- Assess the patient for motor responses, such as agitation, tension and trembling, and autonomic responses, such as cold, clammy hands and diaphoresis
- Keep the patient recumbent for up to 3 hours after parenteral administration to reduce the drug's hypotensive effect
- Inform the patient that drowsiness usually disappears with continued therapy
- Instruct the patient to change positions slowly from recumbent to sitting, before standing to prevent dizziness
- Administer with food to minimize gastric irritation
- Advise the patient to take medication exactly as directed. Abrupt withdrawal may cause insomnia, irritability and sometimes even seizures
- Explain about adverse effects and advise him to avoid activities that require alertness
- Caution the patient to avoid alcohol or any other CNS depressants along with benzodiazepines; also instruct him not to take any over-the-counter (OTC) medications
- If intramuscular (IM) administration is preferred give deep IM

- For IV administration do not mix with any other drug. Give slow IV as respiratory or cardiac arrest can occur; monitor vital signs during IV administration. Prevent extravasations, since it can cause phlebitis and venous thrombosis.

PHENERGAN

Generic Name

Promethazine HCl

Brand Name

Phenergan

Classification

Sedative/hypnotics

Dose

25–50 mg (sedation); 10–25 mg every 4 hours as needed (antiemetic) (1amp)

Mechanism of Action

Antiemetics, antihistamines, sedative/hypnotics. Selectively blocks H₁ receptors, diminishing the effects of histamine on cells of the upper respiratory tract and eyes, and decreasing the sneezing, mucus production, itching and tearing that accompany allergic reactions. Blocks cholinergic receptors in the vomiting center that are believed to mediate the nausea and vomiting caused by gastric irritation.

Indications

Preoperative sedation, treatment and prevention of nausea and vomiting, adjunct to anesthesia and analgesia.

Contraindications

Hypersensitivity, comatose patient, prostatic hypertrophy, bladder neck obstruction, narrow angle glaucoma.

Side Effects

- Confusion, disorientation, sedation, dizziness, extrapyramidal reaction, fatigue, insomnia, nervousness
- Bradycardia or tachycardia; hypotension or hypertension
- Constipation, drug-induced hepatitis, dry mouth
- Blood dyscrasias
- Blurred vision, diplopia, tinnitus, photosensitivity, rashes.

Nurse's Responsibility

- Assess level of sedation after administration
- Monitor pulse, respirations and blood pressure frequently
- Assess for nausea or vomiting before and after administration
- Give intramuscular (IM) injections deep into muscles, administration into subcutaneous muscle causes tissue necrosis
- Arteriospasms and gangrene of artery may occur when administered intra-arterially.

DONEPEZIL

Brand Name

Aricept

Classification

Acetylcholinesterase inhibitor

Dose

5–10 mg per day.

Mechanism of Action

The precise mechanism of action of donepezil in patients with Alzheimer's disease is not fully understood. In Alzheimer's disease, there is a substantial loss of the elements of the cholinergic system and it is generally accepted that the symptoms of Alzheimer's disease are related to this cholinergic deficit, particularly in cerebral cortex and other areas of the brain. In normal function, acetylcholine is an essential neurotransmitter and plays an important role in cognitive function, including memory storage and retrieval. Loss of cholinergic neurons of the central nervous system has been found to correlate with the severity of cognitive impairment. Donepezil inhibits acetylcholinesterase, an enzyme responsible for the destruction of one neurotransmitter, acetylcholine. This leads to increased concentrations of acetylcholine in the brain, and the increased concentrations are believed to be responsible for the improvement seen during treatment with donepezil. Cholinesterase inhibitors do not alter Alzheimer's disease but may stabilize the elder at the current level of dementia or lessen the symptoms.

Pharmacokinetics

It has an oral bioavailability of 100% and easily crosses the blood-brain-barrier. Biological half-life is about 70 hours. Excretes through urine.

Indications

Treatment of mild to moderate dementia of the Alzheimer's type.

Contraindications

Donepezil should not be used for people who are allergic to ingredients in donepezil or to another piperidine derivates, use with caution in people with cardiac disease, chronic obstructive pulmonary disease, asthma, severe cardiac arrhythmias, patients with gastrointestinal disorders and seizures.

Side Effects

Headache, generalized pain, fatigue, dizziness, bradycardia, nausea, vomiting, diarrhea, anorexia, abdominal pain, vivid dreams, weight loss, muscle cramping, joint pain, increased frequency of urination.

Nurse's Responsibility

- Assess cognitive ability of the patient
- Monitor heart rate as bradycardia may occur
- Emphasize the importance of taking the medication every day
- Monitor side effects like gastrointestinal disturbances and sleep disturbances
- Explain family members that donepezil may cause dizziness and the patient may need to take medication before going to bed
- Emphasize to take medicine along with food and drinking plenty of liquids
- Explain patient not to take alcohol, other medicines like sedatives, tranquilizers, mood stabilizer
- Advise small frequent meals, frequent mouth care, sucking hard candy or chewing gum may help to reduce nausea
- Advise the patient to intimate physician about suicidal thoughts, nervousness, loss of appetite, severe dizziness, vomiting, dark urine, yellow eyes or skin rash.

ACAMPROSATE**Trade Name**

Acamprol

Classification

Anti-craving medication

Dose

Acamprosate is available as 333 mg tablets. The recommended daily dose for adults is four to six tablets (1332 mg–1998 mg) in three divided doses. Usual practice is to start at half of these doses and increase by one tablet a week.

Mechanism of Action

Acamprosate enhances the GABA neurotransmitter system, which is reduced in persons with chronic exposure to alcohol and interferes with glutamate action in different pathways. Acamprosate also acts on the calcium channels and reduces central nervous system hyperexcitability caused by cessation of alcohol intake. Acamprosate is thought to work by decreasing craving related to conditioned withdrawal.

Indications

Treating alcoholism

Pharmacokinetics

Only 10% of acamprosate is absorbed, of which 90% is excreted unchanged into urine. It can be used in patients of alcohol dependence with mild to moderate liver dysfunction, since it is not metabolized in the liver.

Contraindications

Acamprosate is contraindicated in patients with known hypersensitivity to the drug, renal insufficiency or cirrhosis with severe hepatic dysfunction, but patients with mild to moderate liver dysfunction may take it safely. The safety during pregnancy and lactation has not been established.

Side Effects

Transient diarrhea, occasional headaches, dizziness, paraesthesia, decreased libido, confusion, rash and pruritus.

Nurse's Responsibility

Explain the following to family members and patient:

- Do not miss any doses
- Drug may cause dizziness, do not drive, operate machinery or any other dangerous activities until patient know how he reacts to acamprosate
- Do not drink alcohol while taking drug
- Alcohol dependent patients should be monitored for the development of depression or suicidal thoughts
- Monitor mood changes
- Contact or report to health care provider if any following effects occur or worsen: anxiety, restlessness or irritability, panic attacks, suicidal ideations, unusual changes in the behavior or mood.

Alcohol Deterrent Therapy

Deterrent agents are those which are given to desensitize the individual to the effects of alcohol and maintain abstinence. The most commonly used drug is disulfiram (tetraethylthiuram disulfide) or antabuse.

Disulfiram

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

Dosage

Disulfiram is supplied in tablets of 250 and 500 mg. The usual initial dose is 500 mg/day orally for the first 2 weeks, followed by a maintenance dosage of 250 mg/day. The dosage should not exceed 500 mg/day.

Mechanism of action

Disulfiram is an aldehyde dehydrogenase inhibitor that interferes with the metabolism of alcohol and produces a marked increase in blood acetaldehyde levels. The accumulation of acetaldehyde (to a level of 10 times more than that which occurs in the normal metabolism of alcohol) produces a wide array of unpleasant reactions called the disulfiram ethanol reaction (DER), characterized by nausea, throbbing headache, vomiting, hypotension, flushing, sweating, thirst, dyspnea, tachycardia, chest pain, vertigo, blurred vision and a sense of impending doom associated with severe anxiety. The reaction occurs almost immediately after the ingestion of even one alcoholic drink and may last up to 30 minutes.

Therapeutic Indications

The primary indication for disulfiram use is as an aversive conditioning treatment for alcohol dependence.

Side Effects

The adverse effects of disulfiram in the absence of alcohol consumption include fatigue, dermatitis, impotence, optic neuritis, mental changes, acute polyneuropathy and hepatic damage.

With alcohol consumption the intensity of the disulfiram-alcohol reactions varies with each patient. In extreme cases, it is marked by convulsions, respiratory depression, cardiovascular collapse, myocardial infarction and death.

Contraindications

- Pulmonary and cardiovascular disease
- Should be used with caution in patients with nephritis, brain damage, hypothyroidism, diabetes, hepatic disease, seizures, poly-drug dependence or an abnormal electroencephalogram
- Patients at high-risk of alcohol ingestion.

Nurse's Responsibility

- An informed consent should be taken before starting treatment
- Ensure that at least 12 hours have elapsed since the last ingestion of alcohol before administering the drug
- Patient must be instructed that ingestion of even the smallest amount of alcohol brings on a disulfiram-ethanol reaction with all its unpleasant effects; he should, therefore, be strictly warned not to consume any alcoholic drink
- The patient should also be warned against ingestion of any alcohol-containing preparations such as cough syrups, drops of any kind, and alcohol-containing foods and sauces. Advice against use of alcohol based after shave lotions and inhalation of paints, varnishes, etc. containing alcohol. Any topical applications containing alcohol should also be avoided
- Caution patient against taking CNS depressants or any over-the-counter (OTC) medications during disulfiram therapy
- Instruct patient to avoid driving or other activities requiring alertness until response to drug is known
- Patients should be warned that the disulfiram-alcohol reaction may continue for as long as 1 to 2 weeks after the last dose of disulfiram
- Patients should carry identification cards describing disulfiram-alcohol reaction and listing the name and telephone number of the physician to be called
- Emphasize the importance of follow-up visits to the physician to monitor progress in long-term therapy.

APPENDIX 22**ABBREVIATIONS**

5-HT	Serotonin
AA	Alcoholic Anonymous
ACTH	Adrenocorticotropic Hormone
ADHD	Attention Deficit Hyperactivity Disorder
AHNA	American Holistic Nurse's Association
AIDS	Acquired Immunodeficiency Syndrome
ALI	American Law Institute
AMEND	Association for Mentally Disabled
AMTA	American Massage Therapy Association
ANA	American Nurses Association
APA	American Psychiatric Association
ARDSI	Alzheimer's and Related Disorders Society of India
BAERs	Brain Stem Auditory Evoked Responses
BPAD	Bipolar Affective Disorder
CA	Chronological Age
CAM	Complementary Alternative Medicine
CBCL	Child Behavior Check List
CCRAS	Central Council for Research in Ayurveda and Siddha
CDT	Carbohydrate Deficient Transferrin
CID	Critical Incident Debriefing
CMHN	Community Mental Health Nurse
CNS	Central Nervous System
CRH	Corticotropin Releasing Hormone
CROMP	Centre for Rehabilitation of Mental Patients
CT	Computed Tomography
DIMHANS	Dharwad Institute of Mental Health and Neurosciences
DMHT	District Mental Health Team
DMPH	District Mental Health Programme
DOES	Disorder of Excessive Somnolence
DPN	Diploma in Psychiatric Nursing
DSM	Diagnostic and Statistical Manual
ECT	Electroconvulsive Therapy
EEG	Electroencephalogram
EMG	Electromyogram
EPS	Extrapyramidal Syndrome
GABA	Gamma aminobutyric Acid

GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Functioning
GAS	General Adaptation Syndrome
GGT	Gamma Glutamyl Transpeptidase
GHRH	Growth Hormone Releasing Hormone
GTS	Gilles de Tourette's Syndrome
HGH	Human Growth Hormone
HIV	Human Immunodeficiency Virus
HPA	Hypothalamic Pituitary Axis
HT	Healing Touch
ICD	International Statistical Classification of Disease
IEC	Information Education Communication
ILA	Indian Lunacy Act
INC	Indian Nursing Council
IQ	Intelligence Quotient
ISM&H	Indian System of Medicine and Homeopathy
ISMO	International Society for Mental Health Online
ISPN	Indian Society for Psychiatric Nurses
ITAQ	Insight and Treatment Attitude Questionnaire
LSD	Lysergic Acid Diethylamide
MA	Mental Age
MAO	Monoamine Oxidase
MAOIs	Monoamine Oxidase Inhibitors
MARIs	Monoamine Reuptake Inhibitors
MDP	Manic Depressive Psychosis
MHA	Mental Health Act
MMSE	Mini Mental Status Examination
MPA	Medico Pastoral Association
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
MSE	Mental Status Examination
NACO	National Aids Control Organization
NAMI	National Alliances for the Mentally Ill
NANDA	North American Nursing Diagnoses Association
NCCAM	National Centre for Complementary and Alternative Medicine
NE	Norepinephrine
NIMHANS	National Institute of Mental Health and Neurosciences
NMHP	National Mental Health Programme
NMS	Neuroleptic Malignant Syndrome

NOS	Nothing Otherwise Specific
NOSIE	Nurses Observation Scale for Impatient Evaluation
NREM	Non-Rapid Eye Movement Sleep
OCD	Obsessive Compulsive Disorders
OTC	Over-the-counter
PANSS	Positive and Negative Symptoms Scale
PCLN	Psychiatric Consultation Liaison Nurse
PDD	Pervasive Development Disorders
PET	Positron Emission Tomography
PPP	Post Partum Psychosis
PTSD	Post Traumatic Stress Disorders
RAS	Reticular Activating Symptom
REM	Rapid Eye Movement
SDD	Specific Development Disorders
SFRS	Schneider's First Rank Symptoms of Schizophrenia
SSRIS	Selective Serotonin Reuptake Inhibitors
TCAs	Tricyclic Antidepressants
TCL	Training in Community Living
THP	Trihexiphenadile
TLE	Temporal Lobe Epilepsy
TMD	Transitory Mood Disorder
TMS	Transcranial Magnetic Stimulation
TRADA	Total Response to Alcohol and Drug Abuse
TRH	Thyrotropin Releasing Hormone
TT	Therapeutic Touch
UNESCO	United Nations Educational, Scientific and Cultural Organization
VNS	Vagus Nerve Stimulation
WAIS	Wechsler Adult Intelligence Scale
WFMH	World Federation for Mental Health
WHO	World Health Organization
WISC	Wechsler Intelligence Scale for Children

Glossary

A

Abreaction: A treatment procedure whereby repressed painful experiences are voluntarily recalled to awareness. This ventilation gives a therapeutic effect.

Abstract thinking: Ability to appreciate nuances of meaning; multidimensional thinking with ability to use metaphors and hypotheses appropriately.

Addiction: Strong dependence, both physical and emotional, on alcohol or some other material.

Affect: A short-lived emotional response to an idea or an event.

Agitation: Presence of anxiety with severe motor restlessness.

Agnosia: Loss of comprehension of auditory, visual, or other sensations although the sensory sphere is intact.

Agoraphobia: Fear of being in a place from which escape might be difficult or embarrassing.

Akathisia: Motor restlessness, inability to sit still.

Alternative medicine: Practices that differ from usual traditional (allopathic) medicine.

Altruism: One curative factor of group therapy (identified by Yalom) in which individuals gain self-esteem through mutual sharing and concern. Providing assistance and support to others creates a positive self-image and promotes self-growth.

Alzheimer's dementia: Chronic, organic mental disorder or dementia due to atrophy of frontal and occipital lobes that involves a progressive, irreversible loss of memory, deterioration of

intellectual functions, apathy, speech and gait disturbances, and disorientation.

Ambivalence: The co-existence of two opposing drives, desires, feelings or emotions towards the same person, object or goal; a conflict to do or not to do.

Amnesia: Pathological impairment of memory.

Anterograde amnesia: Amnesia of events occurring after the episode which precipitated the disorder.

Retrograde amnesia: Amnesia of events occurring prior to the episode which precipitated the disorder.

Anhedonia: Inability to experience pleasure in any activity.

Anorexia nervosa: Disorder characterized by extreme concern with body weight, an intense fear of becoming fat, and maintenance of body weight below expected levels for height and age. Individuals often perceive themselves as heavier than they are, or place unrealistic value on body weight and shape.

Anxiety: Vague diffuse apprehension that is associated with feelings of uncertainty and helplessness.

Anxiolytic: Drug agent used to counteract or diminish anxiety.

Apathy: Lack of emotional feeling.

Aphasia: Absence or impairment of the ability to communicate through speech, writing, or signs, due to dysfunction of brain centers.

Apraxia: Inability to carry out normal activities despite intact motor function.

Autistic thinking: Preoccupations totally removing a person from reality.

Automatic obedience: The patient obeys every command though he has first been told not to do so.

Automatism: Undirected behavior that is not consciously controlled, as seen in complex partial seizures.

Avolition: Lack of motivation.

B

Biofeedback: Method of teaching patients to recognize tension within the body and to respond with relaxation.

Blackout: Sudden loss of consciousness; an episode of forgetting all or part of what occurred during or following a period of alcohol intake.

Blunted affect: A reduction in emotional experience.

Borderline personality disorder: A disorder characterized by a pattern of intense and chaotic relationships, with affective instability, fluctuating and extreme attitudes regarding other people, impulsivity, direct and indirect self-destructive behavior, and lack of a clear or certain sense of identity, life plan, or values.

Bulimia nervosa: Eating disorder characterized by periods of significant overeating (binge-eating) and inappropriate methods of compensating for the overeating to prevent weight gain such as self-induced vomiting, use of laxatives or diuretics, and excessive exercises.

C

Cataplexy: Temporary loss of muscle tone and weakness precipitated by a variety of emotional states.

Catharsis: The expression of ideas, thoughts and suppressed material accompanied by an appropriate emotional response that produces a state of relief in the patient.

Catastrophic reaction: Disorganized behavior due to severe shock or threatening situation with which the person cannot cope. In dementia, catastrophic reactions are over reactions to seemingly normal, non-threatening situations. For example, physical

acting out and hostile behavior such as hitting, kicking; uncontrollable emotional outbursts such as shouting, screaming.

Circumstantiality: A pattern of communication that is demonstrated by the speaker's inclusion of many irrelevant and unnecessary details in his speech before he is able to come to the point.

Clang association: Client uses two words with a similar sound, i.e. his choice of words is determined by their sound and not by their meaning, which often reduces the intelligibility of speech. It may lead to punning (humorous use of words to suggest different meanings) and rhyming, and is often seen in manic patients.

Cognitive therapy: Based on cognitive model of how individuals respond in stressful situations to their subjective perception of the event. Therapy strives to assist the individual to reduce anxiety responses by altering the cognitive distortions.

Compulsion: Pathological need to act on an impulse that, if resisted, produces anxiety; repetitive behavior in response to an obsession or performed according to certain rules, with no true end in itself other than to prevent something from occurring in the future (the patient fears something bad will occur in future if he does not indulge in such behaviors).

Concrete thinking: Thought processes are focused on specifics rather than generalizations. These individuals are unable to comprehend abstract meanings.

Confabulation: The unconscious filling of memory gaps by imagined or untrue experiences due to memory impairment. It is most often associated with organic pathology.

Conscious: Being aware and having perception of the environment; having the ability to filter that information through the mind with the awareness of doing so.

Conversion: Process by which a psychological thought, event, or memory is transferred to a physical or sensory symptom.

Craving: Strong inner drive to use a substance in situations of substance dependence.

Crisis: Psychological disequilibrium in a person who confronts a hazardous circumstance that

constitutes an important problem which for the time he or she can neither escape nor solve with usual problem-solving resources.

Cyclothymia: A chronic mood disturbance involving numerous episodes of hypomania and depressed mood, of insufficient severity or duration to meet the criteria for bipolar disorder.

D

Defense mechanism: Methods for protecting the ego from anxiety associated with conflicting urges and restrictions of the id and superego.

Deinstitutionalization: The removal of mentally ill individuals from institutions and the subsequent plan to provide care for these individuals in the community setting.

Dejavu: A subjective feeling that an experience, which is occurring for the first time, has been experienced before.

Delirium: State of mental confusion and excitement that happens in a short period of time and is characterized by disorientation for time and place, usually with illusions and hallucinations.

Delirium tremens (DTs): Form of withdrawal from alcohol in which the person experiences, among other symptoms, tremors, hallucinations, delirium, and diaphoresis.

Delusion: A false, unshakeable belief, which is not amenable to reasoning and is not in keeping with the patient's socio-cultural and educational background.

Bizarre delusion: An absurd, totally implausible, strange false belief in a person's mind.

Delusional mood: Occasionally, when a person first develops a delusion, the first experience is a change of mood, often a feeling of anxiety with the foreboding that some sinister event is about to take place, and the delusion follows. In German, this change of mood is called *Wahnstimmung*, a term usually translated as delusional mood.

Delusional perception: In some occasions when a person first develops a delusion, the first change may be attaching a new significance to a familiar percept without any reason. For example, a new arrangement of objects on a colleague's desk may be interpreted as a sign that the patient has been

chosen to do God's work. This is called delusional perception.

Delusion of control: This refers to the belief that the patient's will, thoughts or feelings are being controlled by external forces.

Delusion of grandeur: An individual's exaggerated conception of his importance, power or identity, a belief that he is somebody special, or is born with a special mission in life, or is related to the most important people of his time.

Delusion of guilt: Belief that one is a sinner and is responsible for the ruin of his family or society.

Delusion of infidelity (Delusion of jealousy): This is the delusion that one's lover is unfaithful to him/her.

Delusion of persecution: A belief that he is being attacked, harrassed, spied, cheated or conspired against.

Delusion of reference: It is the delusion that events, objects, behavior of others have got a particular or unusual significance for oneself, usually of a negative nature. For instance, the person may falsely believe that others are talking about him (such as, the belief that people on television or radio are talking about the person).

Erotomania: A delusional belief that the other person is deeply in love with him/her. The supposed lover is usually inaccessible and of much higher social status (also known as Clerambault-Kandinsky Complex).

Mood-congruent delusion: Delusion with mood appropriate content (for example, a depressed patient believes that he is responsible for the destruction of the world).

Mood-incongruent delusion: Delusion with content that has no association to mood or is mood neutral (for example, a depressed patient has delusions of thought control or thought broadcasting).

Nihilistic delusion: The delusional belief that others, oneself or the world do not exist. Most commonly seen in major depressive episode.

Primary (Autochthonous) delusion: One that appears suddenly and with full conviction, but without any previous events leading up to it. Such delusions are suggestive of schizophrenia.

Secondary delusions can be understood as derived from some preceding morbid experience.

Somatic delusion: Belief involving functioning of the body. For example, belief that the brain is rotting or melting.

Systematized delusion: False belief or beliefs united by a single event or theme.

Dementia: Global impairment of cognitive functioning that is progressive and interferes with social and occupational abilities.

Depersonalization: A person's subjective sense of being unreal, strange or unfamiliar.

Derealization: A subjective sense that the environment is strange or unreal; a feeling of changed reality.

Disorientation: Inability to be cognizant of time, direction or location, and person.

Dopamine: Catecholamine neurotransmitter; a precursor in the synthesis of norepinephrine important in understanding the pathology of schizophrenia and parkinsonism.

Dyslexia: Learning disorder in the reading domain.

Dystonia: Muscle rigidity that affects posture, gait, eye movements.

E

Echolalia: Pathological repetition by imitation of the speech of another.

Echopraxia: Pathological repetition by imitation of the behavior of another.

ECT: Electroconvulsive therapy.

Ego: In Freudian theory, one of the three major divisions in the model of the psychic apparatus that possesses consciousness and memory, and serves to mediate between the id and the superego or conscience.

Egocentric: Self-centered; preoccupied with one's own needs and lacking interest in others.

Ego-dystonic: Distressing to the individual.

Encopresis: Involuntary passage of feces in inappropriate places after age of voluntary control has been established.

Enuresis: Involuntary passage of urine after age of voluntary control has been established.

Euphoria: Excessive feeling of happiness or elation.

Eustress: Positive and motivating stress shown by one's confidence in the ability to master a challenge or stressor.

Exhibitionism: A paraphilic disorder characterized by a recurrent urge to expose one's genitals to a stranger.

Extra pyramidal symptoms (EPS): A variety of responses that originate outside the pyramidal tracts and in the basal ganglion of the brain. Symptoms may include tremors, chorea, dystonia, akinesia, akathisia, and others. May occur as a side effect of some antipsychotic medications.

F

Fetishism: Erotic stimulation or sexually arousing fantasies involving contact with non-living objects, such as articles of dress or a braid of hair.

Flat affect: Absence or near absence of any sign of affective expression; voice monotonous, face immobile.

Flight of ideas: Rapid shift between topics that are unrelated to each other. The client's thoughts and conversation move quickly from one topic to another, so that one train of thought is not completed before another appears. These rapidly changing topics are understandable because the links between them are normal, a point that differentiates them from loosening of associations. Flight of ideas is characteristic of mania.

Folie à deux: A psychotic reaction in which two closely related persons, usually in the same family, mutually share the same delusions.

Formal thought disorder: Disturbance in the form of thought rather than the content of thought; thinking characterized by loosened associations, neologisms, and illogical constructions; thought process is disordered, and the person is defined as psychotic.

Free-floating anxiety: Occurs when a person is unable to connect the anxiety to a stimulus.

Fugue: Dissociative disorder in which there is an inability to recall one's past or identity accompanied by sudden and unexpected travel away from home.

Functional: Having a psychological rather than an organic pathology.

G

Generalized amnesia: Inability to recall important personal information usually of a traumatic or stressful nature that is too extensive to be explained by ordinary forgetfulness.

Geriatric psychiatry: A speciality of psychiatry which deals with mental health problems of the elderly.

Grandiose: Unrealistic or exaggerated sense of self-worth, importance, wealth, or ability.

Grief: Emotional process of coping with a loss.

Group therapy: Process of helping patients to develop an understanding of and insight into their feelings, behaviors, and roles in relationships through involvement and interactions with others who have similar problems.

H

Hallucinations: A false sensory perception in the absence of an actual external stimulus. Hallucinations may be described in terms of their sensory modality as visual, auditory, olfactory, gustatory, tactile.

Auditory hallucinations: These are by far the commonest, and may be experienced as noise, music or voices. Voices may seem to address the patient directly (second-person hallucinations) or talk to one another referring to the patient as 'he' or 'she' (third-person hallucinations). Third-person hallucinations may be experienced as voices commenting on the patient's intentions or actions. Such commentary voices are strongly suggestive of schizophrenia.

Command hallucination: False perception of orders that a person may feel obliged to obey or unable to resist.

Gustatory hallucination: False perception of taste, such as unpleasant taste, caused by an uncinate seizure; most common in medical disorders.

Mood-congruent hallucination: Hallucination in which the content is consistent with either a depressed or a manic mood (for example,

depressed hears voices saying that the patient is a bad person; a manic hears voices saying that the patient is of inflated worth, power and knowledge).

Mood-incongruent hallucination: Hallucination in which the content is not consistent with either depressed or manic mood (for example in depression, hallucinations not evolving such themes as guilt, deserved punishment, or inadequacy; in mania, hallucinations not involving such themes as self-inflated worth or power).

Olfactory hallucination: False perception of smell; most common in medical disorders.

Somatic hallucination: False sensation of things occurring in or to the body, most often visceral in origin (also known as cenesthetic hallucination).

Tactile (Haptic) hallucination: False perception of touch or surface sensation, as from an amputated limb (phantom limb); crawling sensation on or under the skin (formication).

Visual hallucination: False perception involving sight consisting of both formed images (for example, people) and unformed images (for example, flashes of light); most common in medically determined disorders.

Holistic: Philosophy that individuals are complete organisms and function as complete units that cannot be reduced to the sum of their parts.

Hypnagogic hallucinations: These hallucinations occur when falling asleep, generally considered as non-pathological.

Hypnopompic hallucinations: Hallucinations occur when the subject is awakening, often occurring in healthy individuals.

Hypnosis: A treatment for disorders brought on by repressed anxiety. The individual is directed into a state of subconsciousness and assisted, through suggestions, to recall certain events that he or she cannot recall while conscious.

Hypochondriasis: Persistent abnormal anxiety that one has a disease although medical evidence has proven otherwise. It is exaggerated concern with one's physical health, not based on organic pathology.

Hypomania: A mild form of mania. Symptoms are excessive hyperactivity, but not severe enough to

cause marked impairment in social or occupational functioning or to require hospitalization.

I

Id: One of three divisions of the psyche that is the obscure, inaccessible part of our personality that serves as collection of instinctual drives continually striving for satisfaction in accordance with the pleasure principle.

Ideas of reference: Belief that some events have a special personal meaning.

Illogical thinking: Thinking containing erroneous conclusions and internal contradictions.

Illusion: The misinterpretation of a real, external sensory experience. It is mental misperception of actual sensory stimuli.

Insight: Insight means the capacity to appreciate that one's disturbance of thought and feeling are subjective and invalid. Loss of insight has traditionally been considered to occur in psychosis, while its retention characterizes neurosis.

Intellectual insight: Understanding of the objective reality of a set of circumstances without the ability to apply the understanding in any useful way to master the situation.

True insight: Understanding of the objective reality of a situation, coupled with the motivation and the emotional impetus to master the situation.

Intelligence Quotient(IQ): Intelligence of a person measured through psychological testing. Normal IQ is 90–110; an IQ of below 70 denotes mental retardation.

Interpersonal: Concerning the relations and interactions between persons.

J

Jamaisvu: Failure to recognize events that have been encountered before.

Judgment: Judgment is the mental act of comparing and evaluating alternatives for the purpose of deciding on a course of action. Judgment is said to be disturbed when the individual deviates from what is generally held as valid, and holds obstinately to its content, although it interferes with his adaptation.

L

Labelle indifference: A symptom of conversion disorder in which there is a relative lack of concern that is out of keeping with a severity of the impairment.

Labile affect: Rapidly shifting emotions, unrelated to external stimuli.

Leave of absence: Mentally ill patients when detained in a hospital, may be given time limited leave, to leave the hospital with permission to visit family members.

Libido: A term used in psychoanalytic theory for sexual drive.

Limbic system: The part of the brain that is sometimes called the “emotional brain”. It is associated with feelings of fear and anxiety; anger and aggression; love, joy, and hope; and with sexuality and social behavior.

Loosening of associations: A pattern of spontaneous speech in which things said lack a meaningful relationship, or there is idiosyncratic shifting from one frame of reference to another; it is usually the general lack of clarity in the client's conversation that makes the most striking impression.

Loosening of association takes several forms: Knight's move or derailment refers to a transition from one topic to another, either between sentences or in mid-sentence, with no logical relationship between the two topics. When this abnormality is extreme it disrupts not only the connections between sentences and phrases, but also the finer grammatical structure of speech. It is then called word salad. One effect of loosened associations on the client's conversation is sometimes called talking past the point (also known by the German term vorbeireden). In this condition, the patient seems always about to get near to the matter in hand, but never quite reaches it. Incoherence is a marked degree of loosening of association in which the patient shifts ideas from one to another without logical connection and the patient's talk cannot be understood at all.

M

Maladaptation: A failure of the body to return to homeostasis following a physiological and/or psychological response to stress, disrupting the individual's integrity.

Malingering: Deliberate simulation or exaggeration of an illness or disability that in fact is non-existent or minor.

Mania: A type of bipolar disorder in which the predominant mood is elevated, expansive, or irritable. Motor activity is frenzied and excessive. Psychotic features may or may not be present.

Manipulation: A behavior pattern characterized by exploitation of interpersonal contact; indiscriminate use of interpersonal relationship to meet one's own end without any consideration for the other person in the relationship.

Mannerism: Ingrained, habitual involuntary movement.

Mental health: The successful adaptation to stressors from the internal or external environment.

Mental illness: Maladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviors that are incongruent with the local and cultural norms, and interfere with the individual's social, occupational, and/or physical functioning.

Mental retardation: Intellectual functioning significantly below average with IQ of 70 or below.

Milieu: Environment or setting.

Monoamine inhibitor: Group of drugs that inhibit monoamine oxidase; effective in treating depression.

Mood: Emotion that is prolonged to the point that it colors a person's entire psychological thinking.

Munchausen syndrome: A disorder in which sufferers habitually attempt to hospitalize themselves with self-inflicted pathology.

N

Narcissism: Obsessive and exclusive interest in one's own self.

Narcoanalysis: A procedure by which a chemical is injected into a person (for example, slow IV injection of pentothal), while encouraging him to ventilate the unconscious desires and motives which he cannot recollect during conscious state. It is a therapeutic and a diagnostic procedure commonly used in neurotic disorders.

Negativism: Motiveless resistance to all attempts to be moved or to all instructions.

Neologism: A word newly coined or an everyday word used in a special way, not readily understood by others.

Neuroleptic malignant syndrome (NMS): A rare but potentially fatal complication of treatment with neuroleptic drugs. Symptoms include severe muscle rigidity, high fever, tachycardia, fluctuations in blood pressure, diaphoresis, and rapid deterioration of mental status to stupor and coma.

Neurotransmitter: A chemical that is stored in the axon terminals of the presynaptic neuron. An electrical impulse through the neuron stimulates the release of the neurotransmitter into the synaptic cleft, which in turn determines whether or not another electrical impulse is generated.

Norepinephrine: Hormone produced by the adrenal medulla similar in chemical and pharmacological properties to adrenaline (epinephrine), but primarily a vasoconstrictor with little effect on cardiac output.

O

Obsession: Pathological persistence of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort; associated with anxiety.

Oedipus complex: Attachment of the child to the parent of the opposite sex, accompanied by envious feelings towards the parent of the same sex.

Over valued idea: Unreasonable, sustained false belief maintained less firmly than a delusion.

P

Panic attack: Intense feeling of fear or terror that occurs suddenly and intermittently without warning.

Parasuicide (Deliberate self-harm): Any act deliberately undertaken by a person which mimics the act of suicide, but which does not result in a fatal outcome.

Paralalia: Repetitious, sometimes continuous repetition of one word.

Paranoid: An adjective applied to individuals who are over-suspicious.

Parole: Permission given to mentally ill patients to go home for performing certain rituals or attend family functions.

Passive-aggressive: Anger expressed in an indirect and subtle way that acts on hostile feelings.

Passivity phenomenon: The delusional belief that an external agency is controlling the self.

Pedophilia: Unnatural desire for sexual relations with children.

Perseveration: Persistent repetition of words or themes beyond the point of relevance. Also, persistent repetition of the same word or idea in response to different questions.

Personality disorder: Extreme pathological and maladaptive behavior patterns that are destructive to the person and others.

Phobia: Persistent, irrational, exaggerated and invariably pathological dread of a specific stimulus or situation; results in a compelling desire to avoid the feared stimulus.

Post-traumatic stress disorder (PTSD): A syndrome of symptoms that develop following a psychologically distressing event that is outside the range of usual human experience (for example, rape, war). The individual is unable to put the experience out of his or her mind, has nightmare, flashback, and panic attacks.

Poverty of speech: Decreased speech production.

Pressure of speech: Rapid production of speech output, with a subjective feeling of racing thoughts.

Primary gain: Relief that is felt when anxiety is converted into physical symptoms of a disorder.

Pseudodementia: Clinically, similar to dementia, but has a non-organic cause and is reversible.

Psychiatrist: Physician who specializes in the study, treatment, and prevention of mental disorders.

Psychometry (Psychological testing): The science of testing and measuring mental and psychological ability, efficiency, potentials and functioning.

Psychopathology: The study of significant causes and processes in the development of mental disorders.

Psychotropic: Drugs that affect psychic function, behavior, or experience.

R

Rapport: Establishing a meaningful conversation.

Reinforcement: Stimulus used in operant conditioning that increases the probability that a given behavior associated with the stimulus will be repeated.

Relapse: Recurrence of a disorder or symptom after apparent recovery.

Remission: A temporary diminution of the severity of disease. It is a stage of lesser intensity.

Reuptake: Deactivation of neurotransmitters by their entry into the presynaptic compartment from the synaptic cleft.

Rorschach test: A psychological test to disclose conscious and unconscious personality traits and emotional conflicts by eliciting patients' associations to a standard set of inkblots.

S

Secondary gain: Attention that is received from others as a result of physical symptoms.

Sexual dysfunction: Degree of persistent or recurrent symptoms, subjective distress, or decrease in the quality of sexual stimulation during any phase of the sexual response cycle.

Sexual sadism: Individual receives sexual excitement from observing psychological or physical suffering by the victim, while receiving additional satisfaction from the feelings of complete control over the victim.

Social phobia: Excessive and persistent irrational fear of specific objects or situations that actually pose little threat of danger.

Somatic delusion: A belief that one's body is changing and responding in some unusual way.

Somatic passivity: Patient believes that sensations are being imposed upon his body by an outside force.

SSRIs: Serotonin-specific reuptake inhibitors; used in the treatment of depression.

Stereotypes: Persistent mechanical repetition of speech or motor activity.

Stress: Condition that results when a threat or challenge to one's well-being requires a person to adjust or adapt to the environment.

Stupor: A state in which the individual does not react to his surroundings and appears to be unaware of them. Commonly seen in catatonic and depressive disorders.

Stuttering: Repetitive or prolonged sounds or syllables with pauses and monosyllabic broken words.

Substance: Refers to any drug, medication, or toxins that share the potential for abuse.

Substance abuse: Maladaptive recurring use of a substance accompanied by repeated detrimental effects as a result of continued use.

Substance dependence: Maladaptive pattern of substance use leading to clinically significant impairment or distress with continuance in using the substance regardless of the adverse substance-related problems they may be experiencing.

Substance intoxication: Overindulgence or being poisoned by a drug or toxic substance.

Sundowning syndrome: A phenomenon in dementia in which the symptoms of restlessness and confusion seem to worsen in the late afternoon, evening or during night hours.

Superego: One of three psychodynamic concepts which includes all internal norms and values of society acquired during early development through interactions with parents as figures of societal authority.

Synaptic cleft: Point of junction between two neurons in a neural pathway where neurotransmitters trigger receptor response.

Systematic desensitization: A treatment for phobias in which the individual is taught to relax

and then asked to imagine various components of the phobic stimulus on a graded hierarchy, moving from that which produces the least fear to that which produces the most.

T

Tangentiality: A form of thinking/speech in which the client tends to wander away from the intended point, and never returning to the original idea.

Tardive dyskinesia: Syndrome of symptoms characterized by bizarre facial and tongue movements, a stiff neck, and difficulty swallowing. It may occur as an adverse effect of long-term therapy with some antipsychotic medications.

Thematic apperception test (TAT): A psychological test used as a diagnostic tool consisting of 30 cards, to assess personality and psychopathology.

Thought block: A sudden interruption in the thought process before the thought is completed. After a pause, the subject cannot recall what he had meant to say. This may be associated with thought withdrawal. Thought block is strongly suggestive of schizophrenia.

Thought broadcast: The delusional belief that one's thoughts are being broadcast or projected into the environment.

Thought insertion: The delusional belief that thoughts are being put into one's mind. These thoughts are recognized as being foreign.

Thought withdrawal: The delusional belief that one's thoughts are taken away by some external agent, often associated with thought block.

Tic: Sudden, repetitive, arrhythmic, stereo-typed motor movement or verbal speech.

Tolerance: Condition that develops through continued use of a substance as the brain adapts to repeated doses of the drug with declining effect when it is taken repeatedly over time.

Transference: A process in which feelings, attitudes and wishes originally linked with significant figures in one's early life are projected onto the therapist.

U

Unconscious: Level of consciousness at which thoughts, wishes, and feelings are not retrievable to conscious awareness.

Unipolar: Having depressive episodes but does not experience mania or hypomania.

V

Vascular dementia: Vascular disorder in which there are multiple large and small cerebral infarctions leading to symptoms of dementia. Symptoms of dementia appear within the first year of existing neurologic symptoms (Also referred to as multi-infarct dementia).

Verbigeration: Senseless repetition of some words or phrases over and over again.

Voyeurism: Recurrent urges and sexually arousing fantasies involving the act of observing unsuspecting people, usually strangers, who are either naked in the process of disrobing, or engaged in sexual activity.

W

Waxy flexibility: A condition by which the individual with schizophrenia passively yields all movable parts of the body to any efforts made at placing them in certain positions.

Wechsler Intelligence Scale: A test for assessing intellectual functioning.

Wernicke-korsakoff syndrome: Mental disorder characterized by amnesia, clouding of consciousness, confabulation, memory loss, and peripheral neuropathy. The disorder is associated with thiamine and niacin vitamin deficiency seen in chronic alcoholism.

Withdrawal: Maladaptive change in behavior accompanied by physiological and psychological alterations that occur as the blood or tissue concentrations of a substance decline in a person who has engaged in heaved prolonged use of substance.

Word approximation (Paraphasias): Commonly used words used in a new or unconventional way. Often the meaning is evident though the usage may be peculiar (for example, describing 'stomach' as 'food vessel').

Word salad: Meaningless and incoherent mixture of words or phrases.

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