International Standard Colored Edition

Textbook of Mental Health Nursing

for GNM Nursing Students

(As per the New Syllabus of INC for GNM)

2nd Edition

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- A Thoroughly Revised and Updated Edition
- Reviewed by the Most Eminent Faculties PAN India
- 200+ Illustrations and Tables Added
- A Perfect Amalgamation of Theoretical and Clinical Aspects
- Includes DSM-5 Diagnostic Criteria
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Eleena Kumari

Nursing Knowledge Tree
An Initiative by CBS Nursing Division

Textbook of
Mental Health Nursing
for GNM Nursing Students

(As per the New Syllabus of INC for GNM)

Second Edition

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Who

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Preface to the Second Edition

"Unless the Lord builds the house, those who build it labour in vain"

Psalm 127:1

With the development in the field of psychiatry, a new era of innovations in mental health nursing has evoked the need for change in the curriculum of subject being taught to nursing students. Changing scenario in health care and the new revised syllabus for the subject—mental health nursing, propel to bring the 2nd edition of the book titled "Textbook of Mental Health Nursing for GNM Nursing Students".

In this edition, I have updated the content as per the recent advancements in the field of Nursing. The whole book is thoroughly revised and presented in full color format.

The book includes updated text with DSM-5 diagnostic criteria, latest NMHP and new amended mental health practice laws. While writing it the requirements of GNM students for learning the subject mental health nursing as a beginner have been kept in mind. The text is made simple and easy to understand. The Units are furnished with fine illustrations and diagrams to make them more clear for a learner.

I bow my head to The Almighty Who had been a great help at all times. I could not be more grateful for the blessing of wisdom from my Lord. I pay my immense regards and love for my family whose support has always been mandatory and fruitful.

Last but not least, I extend my special thanks to **Mr Satish Kumar Jain** (Chairman) and **Mr Varun Jain** (Managing Director), M/s CBS Publishers and Distributors Pvt Ltd for their wholehearted support in publication of this book. I have no words to describe the role, efforts, inputs and initiatives undertaken by **Mr Bhupesh Aarora** [Sr. Vice President – Publishing & Marketing (Health Sciences Division)] for helping and motivating me.

I sincerely thank the entire CBS team for bringing out the book with utmost care and attractive presentation. I would like to thank Ms Nitasha Arora (Publishing Head and Content Strategist – Nursing), and Dr Anju Dhir (Product Manager cum Commissioning Editor – Medical) for their editorial support. I would also extend my thanks to Mr Shivendu Bhushan Pandey (Sr. Manager and Team Lead), Mr Manoj K Yadav (Production Manager), Mr Ashutosh Pathak (Sr. Proofreader cum Team Coordinator) and all the production team members for devoting laborious hours in designing and typesetting the book.

Eleena Kumari

Preface to the First Edition

"Unless the Lord builds the house, those who build it labour in vain"

Psalm 127:1

With the development in the field of psychiatry, a new era of innovations in mental health nursing has evoked the need for change in the curriculum of subject being taught to nursing students. Changing scenario in health care and the new revised syllabus for the subject—mental health nursing, propel to bring the first edition of the book titled "Textbook of Mental Health Nursing for GNM Nursing Students". The book is strictly in adherence with the INC syllabus and consists of all the details which are required for the beginners, academicians as well as practicing nurses.

The book includes updated text with DSM-5 diagnostic criteria, latest NMHP and new amended mental health practice laws. While writing it the requirements of GNM students for learning the subject mental health nursing as a beginner have been kept in mind. The text is made simple and easy to understand. The Units are furnished with fine illustrations and diagrams to make it more clear for a learner.

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All the suggestions and critical evaluation by readers and academicians are highly appreciated.

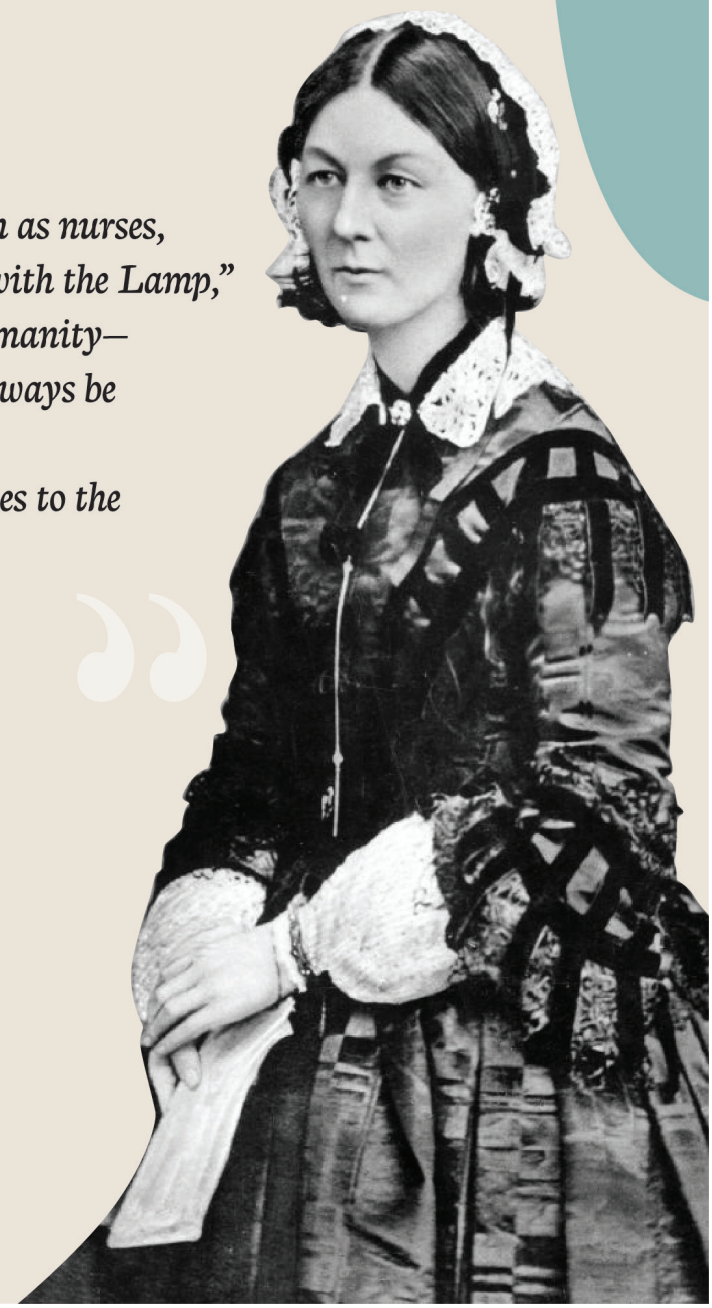
Eleena Kumari

CBS Nursing Knowledge Tree

Extends its Tribute to

Florence Nightingale

For glorifying the role of women as nurses,
For holding the title of " The Lady with the Lamp,"
For working tirelessly for humanity–
Florence Nightingale will always be
remembered for her
selfless and memorable services to the
human race.



Florence Nightingale
(May 1820 – August 1910)

Nursing Knowledge Tree

An Initiative by CBS Nursing Division

"Coming together is a beginning. Keeping together is progress. Working together is success."

It gives us immense pleasure to share with you that the Nursing Knowledge Tree—An Initiative by CBS Nursing Division, has successfully established itself in the field of nursing as we have been able to stand as a strong contender by sharing approximately 50% of the market share. This growth could not have been possible without your invaluable contribution as our reader, author, reviewer, contributor and recommender, and your outstanding support for the growth of our titles as a whole. You people are the pillars of our series and we are so glad that you all have strengthened our basic foundation.

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- Increased our social presence by participating in more than **200+ National Conferences, CME's, College Exhibitions and Webinars** in previous years.
- We have come out with **Nursing Next Live**, an EdTech platform, the Next Level of Nursing Education, where we bring learning to people, instead of people going for learning. Through NNL App we are providing various study modules/plans covering All Subjects/ All Topics, Video Lectures, Question Banks, E-notes and a Variety of Tests. Students can choose the plan according to their needs and requirements.
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Let's join hands together and share our ideas and knowledge. Be the part of this Revolution. We are looking forward to your cooperation in future as well. Share your CVs at **bhupesharora@nursingnextlive.in** or scan the given QR code and fill the form or you can talk to me directly at +9555353330.

With Best Wishes
Mr Bhupesh Aarora
Sr. Vice President – Publishing & Marketing
(Health Sciences Division)

Syllabus for GNM

Mental Health Nursing for GNM

Placement- SECOND YEAR **Time 70 hours**

Course Description

This course is designed to help students develop the concept of mental health and mental illness, its causes, symptoms, prevention, treatment modalities and nursing management of mentally ill for individual, family and community.

General Objectives

Upon completion of this course, the students shall able to:

- Describe the concept of mental health and mental illness and the emerging trends in psychiatric nursing.
- Explain the causes and factors of mental illness, its prevention and control.
- Identify the symptoms and dynamics of abnormal human behavior in comparison with normal human behavior.
- Demonstrate a desirable attitude and skills in rendering comprehensive nursing care to the mentally ill.

Total Hours – 70

Unit	Learning Objectives	Content	Hr.	Teaching learning activites	Methods of assessment
I	Describe the concept of mental health and mental illness in relation to providing comprehensive care to the patients.	**Introduction** • Concept of mental health and mental illness • Misconceptions related to mental illness • Principles of mental health nursing • Definition of terms used in psychiatry • Review of defense mechanisms • Mental health team	5	Lecture cum discussion Structured discussion Group interaction	Short answers Objective type
II	Narrate the historical development of Psychiatry and psychiatric nursing.	**History of Psychiatry** • History of Psychiatric Nursing - India and at international level • Trends in Psychiatric Nursing • National mental health programme	4	Lecture cum discussion	Short answers Objective type

Contd...

Unit	Learning Objectives	Content	Hr.	Teaching learning activites	Methods of assessment
III	Describe mental health assessment	**Mental Health Assessment** • Psychiatry history taking • Mental status examination • Interview technique	4	Lecture cum discussion Demonstration	Short answers Objective type Return Demonstration
IV	Describe therapeutic relationship Demonstrate skills in process recording	**Therapeutic nurse-patient relationship:** • Therapeutic nurse-patient relationship: Definition, components and phases, Importance • Communication skills, definition elements, types, factors influencing communication, barriers (therapeutic impasse)	5	Lecture cum discussions Role play Videos Demonstration of process recording	Short answers Return demonstration
V	List various mental disorders and describe their mental and psychiatric and nursing management.	**Mental Disorders and Nursing Interventions** • Psychopathophysiology of human behavior • Etiological theories (genetics, biochemical, psychological, etc.) • Classification of mental disorders. • Disorders of thought, motor activity, perception, mood, speech, memory, concentration, judgment • Prevalence, etiology, signs and symptoms, prognosis, medical and nursing management • Personality and types of personality related to psychiatric disorder • Organic mental disorders: Delirium, Dementia • Psychotic disorders: ▪ Schizophrenic disorders ▪ Mood (affective) disorders: Mania depression, Bipolar affective disorders (BPAD) • Neurotic disorders: Phobia, anxiety disorders, obsessive compulsive disorders, depressive neurosis, conversion disorders, dissociative reaction, psychosomatic disorders, post-traumatic stress disorder • Substance use and de-addiction: alcohol, tobacco and other psychoactive substance • Child and adolescent psychiatric disorders; ▪ Sleep disorders ▪ Eating disorders ▪ Sexual disorders • Nursing Management: Nursing process and process recording in caring for patients with various psychiatric disorders	25	Lecture cum discussions Case study Case Presentation Process recording Videos Role plays Field visits De-addiction centers, Alcohol Anonymous group, Adolescent clinics, Child guidance centers, etc.	Short answers Essay types Case Study Case Presentation

Contd...

Unit	Learning Objectives	Content	Hr.	Teaching learning activites	Methods of assessment
VI	Describe the Bio–psychosocial therapies and explain the role of the nurse	**Bio–Psycho and Social Therapies** • Psychopharmacology–Definition, classification of drugs, antipsychotic, antidepressant, antimanic, antianxiety agents, anti-parkinsons • Psychosocial therapies—individual therapies, group therapy, behavior therapy, occupational therapy, family therapy, milieu therapy • Role of nurse in these therapies. • Somatic therapy – Electroconvulsive therapy, insulin therapy, • Role of nurse in these therapies.	12	Lecture cum discussions Seminar Videos Demonstration Field visits-Rehabilitation centers, Day care centers Role plays	Short Answers Essay types Return demonstration Quiz Drug study
VII	Describe the concept of preventive community mental health services. Enumerate the nurse's role in National mental health programme	**Community Mental Health** • Concept, importance, scope • Attitudes, stigma and discrimination related to the mentally ill • Prevention of mental illness (Preventive Psychiatry) during childhood, adolescent, adulthood and old age. • Community mental health services • Role of nurse in national mental health programme and psychiatric care in community	5	Lecture cum discussion Role play Videos	Short answers Essay type Assignment
VIII	Explain different psychiatric emergencies and their management Demonstrate skills in crisis intervention	**Psychiatric Emergencies and Crisis Intervention** • Types of psychiatric emergencies: Over active, under active patient, violent behavior, • Suicide, adverse drug reactions, withdrawal symptoms, Acute psychosis, etc. • Crisis and its intervention: AIDS, Adolescent crisis	5	Lecture cum discussion Videos, Role play Demonstration	Short answers Objective Type Essay type
IX	Describe the legal aspects to be kept in mind in the care of mentally ill patients	**Forensic Psychiatry/Legal Aspects** • India Lunatic Act 1912 • Narcotic Drugs and Psychotropic Act 1965, 1985 • Mental Health Act 1987, 2014 • Admission and discharge procedures • Standards of psychiatric nursing practice • Rights of mentally ill patients • Legal responsibilities in the care of mentally ill patients.	5	Lecture cum discussions Demonstration	Short answers Essay type Objective Quiz

Contents

Unit

1

INTRODUCTION

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Describe the concept of mental health and mental illness in relation to providing comprehensive care to the patients.

UNIT OUTLINE

- Concept of Mental Health
- Principles of Mental Health Nursing
- Definitions of Terms Used in Psychiatry
- Review of Defense Mechanisms
- Mental Health Team

KEY POINTS

- Mental health is the capacity to work and love.
- A mentally healthy person does have an IQ of ≥70.
- Psychological disturbances due to distress in life do cause changes in personality, behavior, emotions and thinking which are known as mental illnesses.
- Consistency is the major contribution to patient's security
- Therapeutic nurse patient relationship must be ensured.
- Ego defense mechanisms are the protective psychological efforts to exhibit coping of an individual from anxiety which arises from awareness of internal and external dangers or stressors.
- Mental health services demand multidisciplinary approach which signifies that a number of professionals need to offer their particular services in coordination to bring out the best from mentally sick patients.

CONCEPT OF MENTAL HEALTH

Mental Health

Who is a mentally healthy person? What are the parameters of mental health? The answers to these questions will make you understand concept of mental health and mental illness.

According to **Sigmund Freud**, "Mental health is the capacity to work and to love". In simple terms, a person who is able to carry on with his life activities (communication, mobility, education, job, social and personal relationships, etc.) and to love self and others is a mentally healthy person and the individual who fails to do so is suffering from mental illness.

We can simply view mental health as the absence of mental sickness. The individual who does not possess any mental pathology is considered to be a mentally healthy person.

According to **Abraham Maslow (1970)**, an individual who is mentally healthy will be in continuous search of self-actualization, i.e., a person who is mature, emotionally stable, evolved human.

Characteristics of a Mentally Healthy Person

- A mentally healthy person does have **an IQ of ≥70**.
- A mentally healthy person will be in **touch of reality** which signifies his orientation to his surroundings and behavior in accordance of nature demands.
- A mentally healthy person is a **creative being**.
- A mentally healthy person **accepts his potentials and flaws too**.
- A mentally healthy person **desires privacy**.
- A mentally healthy person is **spontaneous**.
- A mentally healthy person is **a problem solver**.
- A mentally healthy person is **independent and autonomous**.
- A mentally healthy person is **able to maintain good interpersonal relations**.
- A mentally healthy person is **emotionally stable**.
- A mentally healthy person **feels worthy, wealthy and appreciates beauty of life**.
- A mentally healthy person is **a man of principles and ethics**.
- A mentally healthy person **lacks orthodoxy in thoughts and beliefs**.

Mental Illness

It is difficult to define mental illness comprehensively because many of the symptoms of mental sickness are considered normal in many societies. For example, many cultures manifest rigidity and orthodox nature in their thoughts and behavior which are not considered to be signs of mental health. A mentally healthy person is flexible on the other hand. For example, in some cultures, people do practice strict hygienic rituals but they cannot be considered to be mentally sick patients of obsessive compulsive disorder (OCD).

Basically, we can conclude that psychological disturbances due to distress in life do cause changes in personality, behavior, emotions and thinking which are known as mental illnesses. Following are the most common mental disorders are:

- Depression
- Mania
- Bipolar affective disorder (BPAD)
- Schizophrenia
- Psychoactive substance use
- Childhood psychological disturbances
- Mental retardation and other learning disorders, etc.

Mental illness causes much distress to mentally sick people and their care-givers and family members as well. According to WHO, depression will be the biggest mental health problem worldwide in future.

Misconceptions Related to Mental Illness

Myths and misconceptions about mental disorders have developed a negative attitude and stigma toward mentally sick people. Community usually discriminates and isolates people with mental sickness and never allows or appreciates their decision making. The most common misconceptions related to mental illness are as follows:

- **Mental illness is not curable and is life-long:** Mental illness is just like any other chronic medical disorder such as diabetes mellitus, hypertension, etc. Moreover, in foreign setup, depression is considered to be a medical diagnosis nowadays. If a mental sickness is diagnosed early and given prompt treatment, chances of recurrence and relapse are minimized to an extent. Like physical disorders, mental illness is also manageable and treatable.
- **Sinful and wicked persons are more prone to get mental illness:** The most common etiological factor of any mental illness is distress, which is prevalent in every sphere of life. Most people do not know how to deal with life stress in a positive way and do not have an empathetic friendship or family to support them in their life challenges. Therefore, it may result in mental sickness and not because of their wickedness and other sinful work.
- **Mentally ill are intellectually disabled persons:** This is purely a myth. Many of the mentally sick persons have proved it wrong. Following persons may astonish you with their work and success.
  - John Nash is a Nobel Prize winner in Mathematics who was suffering from paranoid schizophrenia.
  - Deepika Padukone and Anushka Sharma are established actresses who have been treated for depression.
  - Ileana D'cruz is an award winning Indian actress, was treated for body dysmorphic disorder.
  - Angelina Jolie does not need any introduction, had depression in her teens and early 20's.
  - Princess Diana was treated for depression and bulimia.

- Honey Singh was treated for bipolar disorder.

  No wonders, if these famous personalities can achieve success in life, every mentally sick has the potential to reach heights if treated and cared.

- **Mentally ill are threat to society:** People with mental sickness are not always pose a threat to others. Excited patients can also be managed with restraining and appropriate treatment.
- **Mentally ill needs to be isolated from community:** The ideal treatment for a mental sickness is on an OPD basis and person should be living in society and given life skills management in community only. But stigma related to mental illness does not allow community to practice deinstitutionalization. It is not mandatory for a mentally sick to be hospitalized and be isolated from community. Even, patients improve so quickly, if they get support from family and friends in the course of mental illness.
- **Mentally sick person's brain is damaged:** Few of the mental illnesses are organic in nature which are due to brain injuries or structural abnormalities of brain. But it cannot be generalized that mentally sick person's brain is damaged. Mental disorders may result from functional pathology of psychology.
- **Mentally sick people are demon possessed and it is the result of sins of past life:** This is another misconception related to mental illness but it is not true. The symptoms of mental sickness such as delusions and hallucinations are due to abnormal levels of neurotransmitters in brain.
- **Mental sickness is inborn illness:** Mental retardation is the only mental sickness which can be diagnosed at birth, if it is confirmed through brain imaging. Otherwise, no one is mentally sick from birth.

PRINCIPLES OF MENTAL HEALTH NURSING

Principle can be defined as set rules which should not be altered. If we add to the principles, we subtract from them. Therefore, they must be followed as mandatory rules of mental health care. The basic nature of every principle is to respect the individuality and dignity of every mentally sick client. Principles of mental health nursing are as follows:

- **Accept the patient as he is**

"Most people need love and acceptance a lot more than they need advice". **—Bob Goff**

A nonjudgmental attitude of nurse conveys feeling of acceptance to patient. Nurse must not label patient's statements/conduct/history as good or bad. Nurse must listen to patent's expression of thoughts in a dignified manner. Honor and respect is the key to show the client that he/she has been accepted.

Follow the given rules to demonstrate acceptance:

- Be nonjudgmental and nonpunitive
- Active listening
- Show sincere interest in client
- Honesty
- Do not talk about private issues unless you have reached that level of comfort with patient.
- Allow patient to make choices.

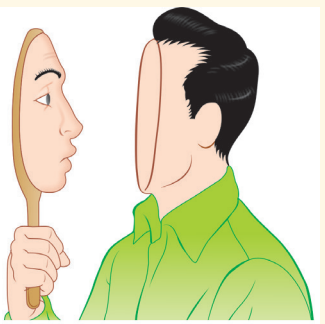
- No vain talk/use therapeutic communication techniques of reflection and interpretation.
- Talk with a purpose always.
- Demonstrate empathy.

- **Use self-understanding as a therapeutic tool**

"Self-understanding rather than self-condemnation is the way to inner peace and mature conscience". **—Joshua L Liebman**

A nurse must know his/her strengths, weaknesses, potentials and emotions, and how they are affecting others. A nurse should have a strong self-concept.

A nurse should be mentally strong and sound to deal with mentally sick patients. A nurse cannot serve from an empty vessel so she should have peace, emotional stability and courage to distribute the content among psychiatric patients.

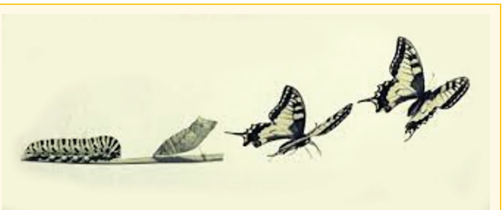


- **Consistency is the major contribution to patient's security**
  - Constant behavior as simple as following a ward routine is so much effective in adding to patient's security.
  - Consistency in conduct (no switch from friendly to aggressive and then to over friendly and again strict and rigid approach) is always appreciated by patients. It helps them to develop trust in nurse because they feels secure in nurse's consistent behavior.

"We are what we repeatedly do. Excellence, then, is not an act, but a habit". **—Aristotle**

Habits once developed, are difficult to change. So to ensure drug compliance and limit setting on patient's behavior will add to treatment.

Patients usually demonstrate obedience if nurses practice consistency.



- **Reassurance should be given in a subtle and acceptable manner**

Everyone needs a little reassurance sometimes. **—Unknown**

A mental health nurse should practice expertise in giving reassurance to a mentally sick client.

Patient's situation is understood and analyzed how it is bothering to him/her.

Reassurance means to clarify all the doubts and fears of patients. For example, everyone in the ward will be given equal facilities without any discrimination.

- **Patient's experience is changed through emotional experience and not by rational interpretation**

"Genius is the ability to renew one's emotions in daily experience".
—Paul Cezanne

When we talk about psychological disturbances, patient's IQ is not the matter of concern rather "Emotional quotient" is the priority issue. It means advice and rationale will not work with mentally sick patient. The patient will only follow nurses' commands, if nurse appears good and trustworthy to him/her. A nice compliment, a social smile and careful attention to patient's problems will bring better results. Care and concern of nurse will bring lasting results in patient's behavior.

- **Unnecessary increase in patient's anxiety should be avoided**

"Nobody realizes that some people expend tremendous energy merely to be normal". **—Albert Camus**

Following rules if followed strictly, can avoid unnecessary anxiety in mentally sick patients:

- Do not show your own anxiety.
- Make realistic goals with patient.
- Do not say contradictory ideas to patient.
- Do not label patient's behavior as good or bad.
- Do not pay extra attention to patient's deficits.

- **Use objective observation to comprehend patient's behavior**

Example of Observations

Observation A

- Subjective
  - Personal opinions and feeling
  - No facts
  - It is hard to tell what really happened between the two boys

Observation B

- Objective
  - Factual
  - Leaves aside personal felling
  - The observe descries only what is actually seen/hard

- A nurse must be objective in her observation. No personal opinions, judgments or emotions to be mixed with objectivity of situation.
- All the information should be factual (based on facts).

- **Therapeutic nurse–patient relationship must be ensured**
  - Nurse–patient relationship is the most important work to be pondered over in care of mentally sick patients.
  - Mentally sick clients are having problems due to distress in life in most of the cases. Now, their mind is fragile and only kind and affectionate words and relationships are welcomed. Therefore, a kind and therapeutic nurse–patient relationship is the great principle to be followed to have effective mental health nursing.

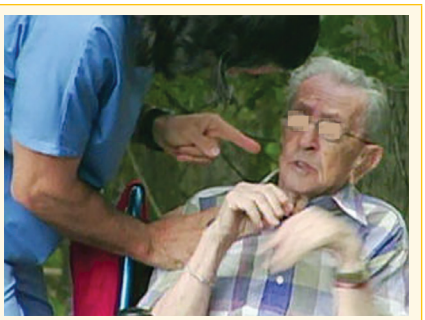
"There is no human relationship more intimate than that of nurse and patient, one in which the essentials of character are more rawly revealed".
—Dorothy Canfield Fisher

- Attend to patient's emotional needs.
- Provide care with a patient centered approach.
- Use therapeutic communication techniques.

- **Avoid physical and verbal force as much as possible**

"Emotional abuse is just as bad as physical abuse. Worse! You can heal broken bones; you can't heal a broken mind". **—Dia Reeves**

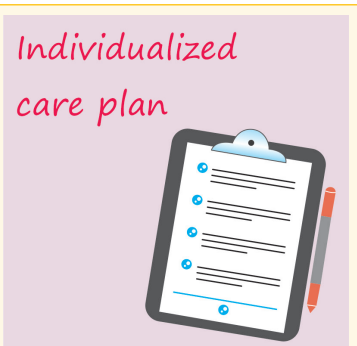
- Avoid punishment as an approach to behavior modification.
- Avoid verbal abuse with patients. Talk with a language of kindness.
- Nurse's polite behavior and generosity can improve patient's mental sickness.



- **Nursing care is centered on the patient as an individual/a unique person and not on the control of symptoms**

Individualized care that treats the whole person.

- Two patients may be experiencing headache in the same ward. But the etiology may not be same, so we should use different approach to treat the same symptom. Care should be based on individualistic approach because same symptom may be having different meaning and significance to different patients.



- **Explain all procedures and routines in accordance with patient's level of understanding**

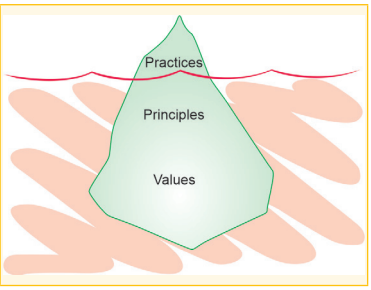
"Everybody has different understanding level. What I can tell you, can only be up to what you can understand".
—HZ Mevlana

While explaining routine procedures to the mentally sick, a nurse must consider attention span of patient (only 20 minutes), level of anxiety and decision making ability. All talk must be without use of medical terminology. Use regional language as far as possible. Give instructions in a slow manner.

- **Procedures are modified but basic principles remain same**

"A person who values his privileges above his principles soon loses both". **—Dwight D Eisenhower**

Oral medication/assessment of blood pressure is a routine procedure in medical field. But in psychiatry, this procedure is modified accordingly to deal with mentally sick patients without altering basic principles.



DEFINITIONS OF TERMS USED IN PSYCHIATRY

A	
Abreaction	Painful repressed feelings are expressed through hypnosis and/or suggestion by relieving the experience.
Adaptation	Adaptation is the ability of an individual to adjust with physical and psychological environment for growth.
Affect	Outward expression of inward emotions.
Aggression	An expression of anger emotion with energy to initiate a fight either results in harming oneself or others in opposition.
Agoraphobia	Agoraphobia is an irrational fear of those spaces from which escape is difficult.
Akathisia	A feeling of restlessness accompanied by an inability to sit still.
Akinesia	Absence of voluntary movement.
Amnesia	Loss of memory; permanent or transient.
Anger	A strong hostile emotion.
Anhedonia	An inability to feel pleasure.
Anxiety	An apprehensive feeling of impending doom.
Aphasia	Aphasia is inability to understand and form language.

Contd...

Aphonia	Aphonia is an inability to speak.
Apraxia	Apraxia is a motor disorder in which an individual is unable to perform a purposeful activity.
Assertiveness	A behavior which enforces protection of one's own rights without violating the rights of others.
Associative looseness	Associative looseness is a thinking disorder in which ideas and thoughts of an individual are so vague and diffuse and do not to have any logical sequence.
Ataxia	Staggered gait under the effect of alcohol or other toxic substances.
Attitude	Attitude is an individual's opinion, idea or emotion toward an object, person or event.
Autism	Autism is a psychological childhood disorder in which a child lacks social skills, verbal and nonverbal communication and has differently abled unique potentials beyond understanding.
B	
Belief	An opinion which is accepted as truth.
C	
Catastrophic thinking	Catastrophic thinking refers to thoughts of negative outcomes in future which may result in panic attacks.
Catatonia	A psychopathological state of stupor, stereotypic activity or negativism.
Catharsis	Catharsis is the means by which there is release of strong negative emotions to have relief in mind.
Circumstantiality	Circumstantiality is a psychopathological conversation in which an individual gives so many unnecessary details before reaching the goal.
Clang association	Similar sounding words are associated to form a speech, e.g., rat, cat, mat, bat, tat.
Cognition	The mental faculty of thought process to acquire knowledge, discernment and insight.
Compensation	An ego defense mechanism in which an individual relieves his/her anxiety by an over achievement in another area.
Confidentiality	Confidentiality is an ethical principle or commitment between a therapist and a patient which states that the information of patient will not be shared to others unless it is for mental welfare of patient.
Cyclothymia	Cyclothymia is a mood disorder characterized by mood swings alternatively between depression and hypomania.
D	
Déjà vu	An individual is having the feeling that he has already experienced the present situation.
Delirium	Delirium is a reversible disturbed state of mind characterized by cloudiness of consciousness.
Delusion	A false, fixed belief which is not in accordance with one's intelligence and cultural background.
Dementia	Dementia is a progressive degenerative disorder characterized by forgetfulness and decline in mental ability.

Contd...

Depersonalization	Depersonalization is a feeling of being detached from oneself in which victim states that he has been changed or is in a dream.
Derealization	Derealization is a feeling that the world is not real or has been changed.
Detoxification	Detoxification is the process in which an individual's body is being freed from toxic substances medically through physiological means.
Distraction	An extreme agitated state of mind.
Dysthymia	A chronic mild depression usually more than 2 years.
Dystonia	Dystonia is a movement disorder in which an individual's muscles contract uncontrollably resulting in involuntary repetitive movements or abnormal posturing.
E	
Echolalia	Repetition of spoken words of another person.
Echopraxia	Imitation of actions of another person.
Ego	The part of the mind which keeps balance between id (pleasure) and superego (morality) and is based on reality principle.
Empathy	The ability to understand another person's thoughts and emotions is known as empathy.
Exhibitionism	It is a psychopathological disorder in which there is a compulsion to show one's genital organs publicly.
F	
Fetishism	It is a sexual disorder having a psychological basis in which an individual's gratification is with a specific object, activity or part of the body.
Flight or fight	It is also known as acute stress reaction. It is a physiological reaction which occurs in the body as a result of real or potential danger.
Flooding	It is also known as implosive therapy. In this therapy, an individual who is having phobia is flooded with the phobic stimuli on a continuous basis until they no longer elicit anxiety.
Free association	It is a technique to bring out repressed emotions on surface. The individual is encouraged to freely speak his mind; whatever topic comes to his mind and shifting from one topic to another.
Frotteurism	A sexual disorder in which an individual obtains pleasure by touching or rubbing against a person without consent.
Fugue	In severe distress, person usually exhibits a wandering behavior, leaves home (familiar places) and adopts a new identity; individual is not able to memorize his original identity.
G	
Grief	An emotional reaction involving physiological and social responses as a result of an actual or perceived loss.
Gynecomastia	Enlargement of breast in males.
H	
Hallucination	Wrong perception in the absence of stimuli.

Contd...

Homosexuality	An individual feels sexual urge toward the same gender is known as homosexuality.
Hypersomnia	Excessive sleep usually a symptom of depression.
Hypnosis	It is an induced semiconscious state of mind where an individual is highly responsive to suggestion and direction; repressed and suppressed emotions and memories are brought out then.
Hypochondriasis	Overconcern and worry about bodily health which is psychopathological in nature.
Hypomania	It is a mild form of mania characterized by triad symptoms of elated mood, increased psychomotor activity and pressure of speech but symptoms are not severe enough to be called mania.
Hysteria	A dramatically presentation of bodily symptoms for gain.
I	
Id	It is the component of mind which dominates by pleasure principle and seeks immediate gratification to satisfy needs.
Identification	An ego defense mechanism in which an individual adopts character of another person to increase self-esteem of oneself.
Illusion	A wrong perception in the presence of stimuli.
Insomnia	It is a sleep disorder in which an individual is unable to initiate and/or maintain sleep.
Introjection	An ego defense mechanism in which an individual takes values and beliefs of another person's personality as his own personality.
Isolation	An ego defense mechanism in which an individual isolates one's thought/memory/feeling from conscious emotional tone.
K	
Kleptomania	It is a conduct disorder in which an individual feels a compulsive urge to steal objects necessarily not of his use.
L	
La belle indifference	It is a symptom of conversion disorder in which patient does not have any concern about bodily symptoms and lacks any emotion in relation to them.
Libido	It is an instinctual/psychic energy which drives human mind to fulfill his desires and needs such as hunger, thirst and sex.
M	
Maladaptation	An individual who is incapable of maintaining equilibrium (physically and psychologically) as a result of distress is known as maladaptive person. His failure to do so is maladaptation.
Mania	It is a mood disorder characterized by elated mood, increased motor activity and pressure of speech severe enough to be clinically diagnosed.
Masochism	It is a sexual disorder in which an individual obtains pleasure by afflicting oneself, i.e., through one's pain and suffering.
Meditation	It is a method of progressive relaxation in which a person sits in a quiet place and concentrates on one object, thought or idea.

Contd...

Melancholia	It is a severe form of major depression in which symptoms are so intense and all the contacts and interests with reality are lost altogether.
Mental imagery	It is a method of bringing relaxation by imagining a scenario which is relaxing to mind. For example, a beach.
Milieu	Milieu refers to an individual's social environment which is used as a therapeutic tool.
Modeling	It is a method in which an individual learns behavioral techniques by imitating alone.
Mood	An individual's present emotional tone is known as mood.
Mourning	The psychological response of an individual to adapt with a real or perceived loss. For example, loss of a loved one.
N	
Narcissism	It is the part of one's personality which obtains pleasure by strong admiration of one's own qualities and potentials.
Narcolepsy	Narcolepsy is a sleep disorder characterized by sleep attacks during day time that usually last from seconds to minutes.
Negativism	A strong resistance to follow commands and suggestions and a conduct contrary to what is expected.
Negligence	It is a conscious effort to not take proper care and concern of an object, person or event.
Neologism	Neologism refers to invention of a new word or expression which has a particular meaning for the inventor but do not possess any dictionary meaning.
P	
Palilalia	It is a speech disorder in which an individual repeats one's own sounds or words.
Panic	An attack of profound anxiety characterized by intense fear, agitation and a feeling of impending doom.
Paralanguage	It is the nonverbal communication in regard of gestures, pitch, tone, rate, rhythm and audibility of spoken words.
Paranoia	Paranoia refers to extreme suspicion and delusion of persecution.
Paraphilias	It is also known as sexual perversion or sexual deviation in which an individual focuses of on sexual drives and drifts from real human beings to atypical objects, fantasies or nonconsenting persons.
Parasomnia	Parasomnia is a sleep disorder characterized by unusual behaviors, dreams, emotions, perceptions and abnormal movements during sleep. For example, nightmares sleep walking, night terrors.
Pedophilia	It is a sexual disorder characterized by having intense sexual urges and desires, sexual fantasies for a prepubescent child.
Perseveration	Repetition of the same answer to different questions is known as perseveration.
Phobia	Phobia is a neurotic disorder in which a person has an irrational and excessive fear/anxiety toward an object, situation or a life event.
Posturing	An individual adopts bizarre postures voluntarily which is known as posturing.
Priapism	Priapism refers to the painful penile erection.

Contd...

Projection	An ego defense mechanism in which an individual projects those ideas and thoughts onto another individual which are painful and unacceptable to him.
Pseudocyesis	It is a conversion reaction in which an individual has signs of pregnancy, when in reality is not pregnant.
Psychodrama	To resolve interpersonal conflicts, individuals are asked to play the life situations dramatically to gain insight into actual problem.
Psychomotor retardation	Slowing down of motor activity due to psychopathology.
Psychosis	No touch with reality cause severe impairment in social and personal functioning is a mental condition known as psychosis.
Pyromania	An individual is having an uncontrollable urge to ignite fires.
R	
Rape	Rape is an aggressive sexual activity without consent of partner which can cause physical and mental trauma to the victim.
Rapport	A sense of mutual respect and trust between two persons as a result of share of emotions and thoughts.
Regression	An ego defense mechanism in which an individual reverts back to previous developmental stage because he/she is not able to cope up with present demands and obligations.
Ritualistic behavior	As a compulsive act to alleviate the anxiety, an individual repeatedly performs a purposeless activity. For example, hand washing.
S	
Sadism	It is a sexual disorder in which an individual considers affliction and physical suffering of the partner to be sexually exciting.
Scapegoating	It is a phenomenon in which an unsuccessful marital relationship is blamed to a third party (usually a child).
Schemas	Schemas are also called core beliefs. When a child learns morals and ethical principles as a result of learning through imitation and interaction with family, friends and community, it results in formation of core beliefs of an individual which are further reinforced later in life.
Self-concept	An individual is made up by his physical self (body image); personal self (identity) and self-esteem and together they constitute self-concept.
Self-esteem	Self-esteem is a measure of an individual's estimation of self-worth in his own eyes.
Silent rape reaction	Silent rape reaction is characterized by complete mute about the rape incident, i.e., a person does not talk about rape at all.
Somatization	When psychological conflicts are manifested in somatic complaints, this mechanism is known as somatization.
Stereotyping	A stereotyping is the adoption of a specific behavior by an entire group.
Stimuli	Stimuli are reflex provoking energy. It is that energy which is responsible for a reflex/response.

Contd...

Stress	Stress is the result of failure to cope up with present demands. A stressful person feels nervous and restlessness.
Stressor	A stressor is that chemical/biological/psychological agent which is capable of causing stress.
Sundowning	The symptoms of dementia are worse during noon and evening times; this phenomenon is known as sundowning syndrome.
Superego	Superego is that part of the personality which is based on morality principle and constitutes conscience and cultural obligations of an individual.
Symbiotic relationship	This is a normal behavior between a mother and an infant in which separation causes anxiety.
Sympathy	Sympathy is the emotion of an individual which feels sorrow for the pain and affliction of another person.
Systematic desensitization	As name suggests, this therapy implies systematically desensitizing an individual toward a phobic stimulus.
T	
Tangentiality	Tangentiality is a psychopathological conversation in which an individual gives so many unnecessary details and never reaches the goal.
Tardive dyskinesia	It is an adverse reaction of psychotropic drugs which is manifested clinically by a stiff neck, bizarre facial and tongue movements and dysphasia.
Temperament	Temperament is unique with every individual; it is the way with which an individual reacts to his internal and external environment.
Token economy	It is a behavioral modification technique in which token is given to an individual for desired conduct and at a specific time, these token can be exchanged for settled privileges.
Transsexualism	It is a psychopathology in relation with gender of an individual which is characterized by dissatisfaction with one's gender identity and an extreme desire to adopt opposite gender. In transsexualism, the diseased person may take help of surgical intervention to serve his/her purpose of adopting opposite gender.
Transvestism	It is also a psychopathology of gender identity in which an individual dresses himself/herself of an opposite gender. For example, a boy wears clothing of a girl.
Trichotillomania	Trichotillomania is also named as hair pulling disorder in which an individual is having a compulsive urge to pull his hairs.
V	
Voyeurism	It is a sexual disorder in which an individual gains sexual pleasure by watching naked people or sexual activity of people.
W	
Waxy flexibility	Waxy flexibility is a symptom of mental disorder in which a patient adopts an immobile posture and does not change it unless another person intervenes.
Word salad	Word salad refers to mixture of random words or phrases which are not comprehensible and are joined together in an unorganized fashion.

REVIEW OF DEFENSE MECHANISMS

Anxiety is the hallmark symptom of every mental disorder which signifies that every mental sickness starts with anxiety, i.e., an apprehension/an unpleasant threatening emotion in a person's mind about an unknown danger in the future. This unknown danger is uncertain; it may or may not happen. But a person feels anxiety and to deal with this anxiety and relieve its symptoms, person's mind will automatically take efforts. These efforts are the coping mechanisms which function at the psychological level (may be in conscious awareness of a person or may operate unconsciously). The coping mechanisms used by an individual to avoid emotional conflicts and are known as ego defense mechanisms.

Ego defense mechanisms are the protective psychological efforts to exhibit coping of an individual with anxiety which arises from awareness of internal and external dangers or stressors.

Every individual has its own unique way to practice individual's defenses or coping patterns to deal with psychological conflicts. This uniqueness of use of coping mechanisms is because of unique psychology of every individual. Not all individuals will use same defense mechanism to deal with same problem. For example, one may use denial and another may use, Intellectualization. This choice of defense mechanism is because of different adaptation level of the individual. The individual may operate on different adaptation levels of ego defense mechanisms.

Defense Levels and Individual Defense Mechanisms

Table 1 shows a list of defense levels and individual defense mechanisms:

Table 1: **Defense levels and individual defense mechanisms**

Defense levels	Individual defense mechanisms
High adaptation level • Mature defenses • These defenses operate at optimum level • An individual uses these defenses at conscious level which means person is aware of emotions, ideas and consequences of usage of defense mechanism	• **Anticipation:** Dealing with stressors by predicting the consequences associated with it and then overcome with realistic solutions. For example, **retirement planning**. • **Affiliation:** Dealing with stressors by taking help and support from others who are advisers/counselors/family/friends, etc. For example, **support groups, spiritual counseling**. • **Altruism:** Helping and supporting other humans who may or may not be suffering with the same psychological stressors. In this way, person experience inner mental peace and contentment. For example, a boy who has suffered a relationship breakup is helping other boys who had breakups • **Humor:** Always finding a funny side of every situation to avoid lose control and triggering the mind to see the positive aspects of a negative situation. For example, **when entering an examination hall, to avoid anxiety, a student may crack a joke like, "today weather is so hot and all the question papers will burn before reaching the hall".** • **Self-assertion:** Person is praising and boasting about oneself in an aggressive manner, here he/she is purposefully keeping oneself above others to get recognition and approval of others. For example, **"I am not like an ordinary player; you really have to practice hard to compete with me."**

Contd...

Defense levels	Individual defense mechanisms
	• **Self-observation:** Acknowledging and studying one's own behavior, thoughts and emotions in order to comprehend oneself and respond in an appropriate manner. For example, **keeping journal, diary, bibliotherapy.** • **Sublimation:** Dealing with the stressful conflicts and emotions in an acceptable manner. For example, **doing vigorous exercise in gym to control anger impulses.** • **Suppression:** Forgetting the painful memories/information consciously. For example, **forgetting scolding of a teacher as soon as teacher leaves the class.**
Mental inhibitions (compromise formation) level • These are immature defense mechanisms. • A person uses these defenses to avoid threatening emotions in the mind.	• **Displacement:** As name suggests itself, person's actual emotions are displaced onto another person or object which is seemingly less threatening. For example, **a student who has got enough scolding from a teacher for failure in examination may displace his anger by throwing all books in his hostel room or may even fight with his roommate for no good reason.** • **Dissociation:** The name itself suggests the functioning of defense mechanism; here person is dissociated (separated) from the actual world/situation or reality on a momentary basis. The person will again come into reality when someone else will bring him into consciousness again from a state of day dreaming. For example, **after hearing news about disqualification in an entrance exam, person may become completely quiet and stare at wall and allow his mind to wander to mentally prepare himself to accept the reality.** • **Intellectualization:** Avoiding psychological conflicts with the use of logical explanations and reasoning. Reacting in a calm manner focusing on intelligent aspect only. For example, **a person who is having a strong sexual instinct toward a teenage may justify it by giving a logical explanation that it is acceptable to marry even children in some cultures and I am going to marry her, not having any intention to exploitation or abuse.** • **Isolation of affect:** Here, a person attempts to avoid a painful emotion by detaching himself from it. For example, **acting indifferent toward people or situations you do not like.** • **Reaction formation:** To avoid psychological conflicts, a person will behave contrary to actual feelings and thoughts. For example, **presenting gifts to a boss, when you really do not like him.** • **Repression:** It is considered to be basis of all other defense mechanisms sometimes. Here, an individual forgets painful memories and thoughts at an unconscious level contrary to suppression where it happens at the conscious level. For example, **forgetting the road accident in which amputation of leg happened; forgetting the death event of a loved one.** • **Undoing:** In a computer, undo means reverting back to the previous situation. But in life, undoing is not possible to that extent. Nevertheless, an individual tries to reverse a thought and emotions by performing an exact opposite action. For example, **to avoid guilt feelings of an extramarital affair, a husband brings flowers to wife.**

Contd...

Defense levels	Individual defense mechanisms
Minor image-distorting level • In these defense mechanisms, a person distorts his/her image of self or others to keep his/her self-esteem. • Unhealthy defense mechanisms.	• **Devaluation:** Underestimating one's worth or importance in order to pay for the balance of psychological conflicts. Here, an individual labels all of the events and people involved in the situation as completely bad and starts underestimating the worth of his own capabilities and attributes. For example, **I am not good enough to have a relationship; I am too hard to love; it has happened rightly with me because I have done all wrong in my life. Things will never be right for me.** • **Idealization:** On the contrary to devaluation where a person underestimates his worth and potentials, idealization is the mental mechanism in which an individual exaggeratedly overestimates his worth and attributes. For example, **I am overqualified for this job. I am so pretty to be a housewife. I am worthy of being treated as a king.** • **Omnipotence:** This defense mechanism is an unhealthy delusional defense in which an individual is having the feeling of being almighty, extremely powerful, beautiful/handsome to the maximum and irresistible. It is a symptom of mania and personality disorder in most of the cases. For example, **a manic patient may offer you a job by explaining about his extreme riches.**
Disavowal level • In these defense mechanisms, a person does not allow unacceptable unpleasant emotions and thoughts to enter in the conscious awareness of mind.	• **Denial:** Individual rejects and denies the reality and actual situations because they are too painful for him to handle. For example, **an individual who has suffered liver disorders because of alcoholism but denies he have an addiction of alcohol still.** • **Projection:** Attributing one's own ideas and thoughts; emotions to another person because they are unacceptable to the individual and he/she is not able to cope up with those emotions. For example, **an individual quarrels with his/her spouse but proclaims that other person is mad at him/her.** • **Rationalization:** This defense mechanism is used by intelligent persons. They justify their behavior and emotions by substituting acceptable logical reasons. For example, **everyone cheated in the exam hall so if I did the same; it is no big deal.**
Major image-distorting level • Like minor image distortion, here person distorts his/her image but distortion is severe enough and gross in nature comparatively. • Unhealthy defense mechanisms	• **Autistic fantasy:** An individual uses daydreaming and fantastical thinking to cope with distress and avoids real social interactions to live in fantasy and daydreams. For example, **an individual, who has been rejected for a relationship proposal, may fantasies about an ideal situation into a fantasy world based on his favorite movie.** • **Projective identification:** This is the defense which is used by an individual who is in a deep relationship with another person be it a parent, lover or therapist. It is used to get rid of unwanted parts of self and unconsciously thought of as being forced into the other person. For example, **an individual may ask help from a therapist when actually it is not needed and the therapist helps and in that case the individual feels complete control over the situation.**
	• **Splitting of self-image or image of others:** When an individual perceives the situation as completely unbearable and feels hopeless about its outcome then the defense he/she uses is to view events and/or people as either all bad or all good. • This defense often leads to two other defenses either idealization (viewing all well) or devaluation (viewing all badly).

Contd...

Defense levels	Individual defense mechanisms
Action level • In these defense mechanisms, defense is active in nature, i.e., a person actually takes action to avoid stressors.	• **Acting out:** This is defense mechanism in which an individual performs an action instead of bearing and controlling the driven impulse. For example, **antisocial behavior by a drug addict; he/she never control the impulse of addiction but fight and argue with the one who rejects such behavior.** • **Apathetic withdrawal:** Apathy means dulled emotional tone. An individual psychologically allows the body to shut down several functions. He/she does not react to external stimuli. For example, **catatonic stupor.** • **Complaining followed by rejection of help:** Here, an individual feels satisfied after complaining about his problems again and again and asks for help, but rejects help when it is given. For example, **I do not need your help, my problems are worse than you think in your mind. You will not understand.** • **Passive aggression:** Expressing anger indirectly onto others and expecting others to understand. For example, **throwing utensils in the kitchen for husband to understand that wife is angry about his late coming.**
Level of defensive dysregulation • This level is pathological adaptation to distress which leads to psychologically harmful responses to reality. • The individual loses all of his/her contact with reality.	• **Delusional projection:** The individual exhibit false fixed thoughts, emotions and impulses which are not in accordance with reality, intelligence and in cultural background. For example, **an individual proclaims that this world is coming to an end (nihilistic delusion).** • **Psychotic denial:** A more severe form of denial without any contact with reality accompanied by psychosis. For example, **a mentally sick client denies his/her symptoms to avoid initiating anxiety and nervousness in others. A wife denies relapse of psychotic symptoms at home just to avoid anxiety in spouse.** • **Psychotic distortion:** Psychologically, reality is perceived differently usually wrong perception to deal with the psychological pain. For example, **a lover does not complain about unfaithful behavior of partner but expecting change.**

MENTAL HEALTH TEAM

Mental health services demand multidisciplinary approach which signifies that a number of professionals need to offer their particular services in coordination to bring the best out of mentally sick patients.
A team implies working together for a common goal.

Following professionals are to be there for an ideal mental health services setup.

- Psychiatrist
- Psychologist
- Clinical psychologist

- Counselor
- Addiction counselor
- Mental health social worker
- Psychiatric nurse
- Psychotherapist
- Behavioral therapist
- Occupational therapist
- Vocational supports trainer

Psychiatrist

A psychiatrist is the team leader who is having a specialization in mental health and holds MD degree for professional practice in a mental hospital.

Roles and Responsibilities of a Psychiatrist

- Counseling
- Mental care of psychiatric patients
- Medical care of psychiatric patients for physical diseases and symptoms, etc.
- Mental assessment (psychiatric history and mental status examination)
- Diagnosis of the patient is also the responsibility of a psychiatrist
- Psychotropic medication ordering on the basis of need of a psychiatric patient
- Referral to a member of health team
- Admission and discharge of a psychiatric patient.

Psychologist

A psychologist is a specialized professional who owns training in study of human behavior and is an expertise in explaining feelings, thoughts and behavior of a mentally sick patient. A psychologist holds a doctorate in psychology.

Roles and Responsibilities of a Psychologist

- Assessment of psychological factors in causation of a mental sickness
- Personality assessment
- Assessment of psychological problems and their origin. For example, depression, phobia, anxiety, marital problems, psychosexual issues, etc.
- Counseling
- Helping the mentally sick to develop an insight into mental illness
- In most of the clinical setups, psychologist is not responsible for prescribing medications.

Clinical Psychologist

Clinical psychologist also holds a specialization in mental health. He/she is also an important member of mental health care team.

Roles and Responsibilities of a Clinical Psychologist

- Counseling therapy
- Assessment of mental disorders
- Family therapy
- Cognitive behavioral therapy (CBT)

Counselor

Counseling is the today's established profession. Many of the scholars have obtained specialized degrees in different approaches of counseling such as marital counseling, parent counseling, addiction counseling and grief counseling, etc.

The best quality counselors possess is "nonjudgmental attitude". Nonjudgmental approach can do wonders for a mentally sick or a person with psychological problems. Other factors which can bring life to a psychologically handicapped person are active listening and respect for a patient.

Roles and Responsibilities of a Counselor

- Counseling using various approaches and theories
- Counseling needs to be one session per week.
- Counseling should be short term to avoid dependency and social relation with counselor.

Addiction Counselor

This is a specialized field of counseling for drug addicts. Addiction counselors are expertise in counseling and treatment of those who are having alcohol, drugs and gambling addictions.

Before initiating addiction counseling, it is mandatory for a drug addict to go through a detoxification program.

Roles and Responsibilities of an Addiction Counselor

- Individual counseling
- Group counseling
- Group therapy
- Examine the triggering factors that lead to addiction
- Goals and target setting
- Establish new healthy behavior

The addiction counseling program is for 6–8 weeks and followed by an aftercare service.

Mental Health Social Worker

A mental health social worker is also a functional important member of a mental health team. The most important key function of a mental health social worker is "psychoeducation". In psychoeducation, a mental health professional explain about mental illness to individuals and their family members.

Roles and Responsibilities of a Mental Health Social Worker

- Psychoeducation
- Coping strategies teachings

- Case management
- Maximizing quality of life of mentally sick patients
- Social welfare, job training and employment with NGOs to help mentally sick to be a part of the community.

Psychiatric Nurse

An important central role as an important member of the mental health team is played by psychiatric nurse. A psychiatric nurse works in clinics, community centers and in a hospital. Nurses provide physical and psychological care to mentally sick patients. Nurses provide 24 hours services to the mentally sick patients in emergency and in regular care in wards.

Roles and Responsibilities of a Psychiatric Nurse

- Physical and psychological care services
- Family and patient psychoeducation
- Individual counseling
- Group therapy
- Admission and reception of a mentally sick patient
- Educating student nurses and community groups
- Follow-ups and discharge planning
- Mental health services in OPDs and day care centers

Psychotherapist

A psychotherapist do helps mentally sick patients to encourage expression of thoughts and emotions of a mentally sick, be it positive or negative emotions and thoughts embedded in the soul and mind of a patient.

Roles and Responsibilities of a Psychotherapist

- Helps in expression of fear, anxiety, suspicion and negative emotions
- Counseling
- Listening carefully to patient's problems
- Teaching problem-solving skills to mentally sick patients

Behavioral Therapist

Behavioral therapist does behavioral modification by teaching mentally sick to deal with their problems in a different way with different coping strategies.

Roles and Responsibilities of a Behavioral Therapist

- Systematic desensitization
- Treatment of behavioral disorders such as eating disorders and phobias
- Helping patients to control undesirable habits and irrational fears
- Aversive conditioning.

Occupational Therapist

An occupational therapist provides occupational therapy to those who are incapable to coping with everyday activities and activities of daily living to earn a livelihood.

Following are the patients who get help from occupational therapist

- Mentally disabled
- Physically differently abled
- Patients having learning disorders
- Patients having congenital disorders
- Patients having neurodegenerative disorders

An occupational therapist helps these patients to have a productive and satisfying lifestyle to manage personal and social affairs in community.

Vocational Supports Trainer

This important member of health team will inculcate skills and training for employment and earning. To be a vocational supports trainer, one may or may not have specific medical training. Following are the skills which are being trained to mentally sick patients.

- Metal work
- Office procedures
- Arts and crafts
- Life-skills
- Wood work

ASSESS YOURSELF

Long/Short Answer Questions

1. Define the following terms:
   a. Illusion
   b. Hypnosis
   c. Phobia
   d. Hallucination
   e. Delusion
   f. Rationalization
   g. Echolalia
   h. Projection
   i. Defense mechanism
   j. Déjà vu
   k. Denial
   l. Suppression
   m. Tangentiality
   n. Perseveration
   o. Echopraxia
   p. Affect
2. Enlist characteristics of a mentally healthy person.
3. Write a short note on misconceptions toward mental illness.
4. Explain about principles of psychiatric nursing.
5. Differentiate between mental health and mental illness.
6. Write a short note on ego defense mechanisms.
7. What is meant by mental health and mental illness?
8. Explain five ego defense mechanisms and explain briefly one defense mechanism with example.

Multiple Choice Questions

1. Cloudiness of consciousness is a symptom of which disorder?

a. Dementia
b. Depression
c. Delirium
d. Mania

2. What is an ego defense mechanism?

a. Protective psychological efforts to exhibit coping of an individual from anxiety
b. A martial art
c. A method for completion of developmental stage
d. A mechanism for initiating a fight

3. The part of personality which is based on pleasure principle:

a. Superego
b. Ego
c. Id
d. Conscience

4. The conscience is the constituent of which part of personality?

a. Self-concept
b. Self-image
c. Self-esteem
d. Superego

5. Which of the following is not a member of mental health team?

a. Psychiatrist
b. Lab technician
c. Psychologist
d. Psychiatric nurse

6. An individual quarrels with his/her spouse but proclaims that other person is mad at him/her. Here, the individual is using which of the following defense mechanisms?

a. Identification
b. Projection
c. Displacement
d. Denial

7. A more severe form of denial without any contact with reality accompanied by psychosis. This is known as:

a. Withdrawal
b. Delusional projection
c. Passive aggression
d. Psychotic denial

8. A manic patient may offer you a job by explaining about his extreme riches. It is known as:

a. Elated mood
b. Delusion
c. Omnipotence
d. Psychotic distortion

9. Anticipation is:

a. Dealing with stressors by predicting the consequences associated with it and then overcome with realistic solutions
b. Psychologically, reality is perceived differently usually wrong perception to deal with the psychological pain
c. Attributing one's own ideas and thoughts; emotions to another person because they are unacceptable to the individual and he/she is not able to cope up with those emotions
d. Dealing with stressors by taking help and support from others who are advisers/counselors/family/friends, etc.

10. Extreme suspicion and delusion of persecution is known as:

a. Psychodrama
b. Illusion
c. Paranoia
d. Reaction formation

11. Outward expression of inward emotions is known as:

a. Aggression
b. Mood
c. Affect
d. Attitude

12. Helping and supporting other humans who may or may not be suffering with the same psychological stressors is known as:

a. Helping attitude
b. Affection
c. Altruism
d. Care

13. Defense mechanism in which an individual performs an action instead of bearing and controlling the driven impulse is known as:

a. Acting out
b. Aggression
c. Displacement
d. Catharsis

14. Justifying one's behavior and emotions by substituting acceptable logical reasons is known as:

a. Repression
b. Rationalization
c. Projection
d. Introjection

15. Person is praising and boasting about oneself in an aggressive manner, here he/she is purposefully keeping oneself above others to get recognition and approval of others. This phenomenon is known as:

a. Self-observation
b. Humor
c. Controlling of impulses
d. Self-assertion

ANSWERS KEY

1. c **2.** a **3.** c **4.** d **5.** b **6.** b **7.** d **8.** c **9.** a
10. c **11.** c **12.** c **13.** a **14.** b **15.** d

Unit

2

HISTORY OF PSYCHIATRY

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Know about the historical development of psychiatric nursing.
- Describe trends and national mental health program.

UNIT OUTLINE

- History of Psychiatric Nursing
- Trends in Psychiatric Nursing
- National Mental Health Programme

KEY POINTS

- Dorothea Dix proposed to establish mental hospitals to be run by states for treatment of mentally sick based on Pinel Revolution and York Retreat.
- Linda Richards (1882) opened Boston City College which was specifically designed to train nurses to train them in care of mentally sick patients.
- In 1973, American Nurses Association (ANA) developed standards of care in psychiatric nursing.
- The Bhagavad Gita is also an exemplary form of crisis intervention psychotherapy.
- Indian Lunacy Act was come into being in 1912.
- CIP was the first institution in India to start diploma in psychological medicine.
- India developed NMHP in 1980s and is among the very first countries to develop and launch a national level programme for mental diseases.
- 13.7% of India's general population is suffering from a variety of mental illnesses and 10.6% requires immediate intervention.

HISTORY OF PSYCHIATRIC NURSING

History is a mirror through which we can see the past till present and it also illuminates the future. Let us look into the mirror of history to have a better visualization of present and future.

International Level

Mentally sick people have been identified since ancient times without the understanding of mental disorder. The **first predecessor** was a Greek sanctuary at Epidaurus.

In the **fourth century**, institutions specifically for mentally ill were established in Byzantium and Jerusalem.

Christians and Muslim religions then took the lead and established refugee places for mentally ill and treated them with **religious coloring**, i.e., variety of rituals in accordance with religious practices.

In 8th century, **first psychiatric hospitals** were established in medieval Islamic world. First psychiatric hospital was built in Baghdad (705 AD) and then at Fes and Cairo.

In London (1247), **first modern mental hospital** named as Bethlehem hospital was established.

Till 18th century, mentally ill were not treated human. They got neglected, restrained, abused, were given poor nutrition and kept in torn clothing chained hands and feet. There was a lack of finance as well as mental hospitals so the result was over-crowding in mental hospitals and poor mental health care.

Pinel Revolution changed the focus of mental health care. He mandates the humane approach for caring mentally sick patients.

York Retreat established by William Tuke also focused on kind and tolerant approach with mentally sick.

Dorothea Dix proposed to establish **mental hospitals to be run by states** for treatment of mentally sick based on Pinel Revolution and York Retreat. Dorothea Dix is said to be first nurse to be recognized to work with residents; she was in charge of Union Army Nurses during American Civil war.

Dr William Ellis was the first person who proposed for a better pay and training for those nurses who work with mentally sick patients.

Linda Richards (1882) opened Boston City College which was specifically designed to train nurses to take care of mentally sick patients.

Johns Hopkins University (1913) offered psychiatric nursing as a part of curriculum in nursing.

The first psychiatric nurses worked with much difficulty in over-crowded hospitals with no proper facilities for mental health care and less staff. Till 1950, nurses who care for mentally sick patients were called attendants.

Discovery of chlorpromazine, i.e., anti-psychotic drug also revolutionized modern psychiatry in mid **1950s.**

Deinstitutionalization of mentally ill patients was known as Antipsychiatry movement led by Goffman, Szaz and others which resulted in the concept of **Community psychiatry.** Deinstitutionalization means mentally sick person will not be treated in institutions but in community.

In 1963, President John F. Kennedy, encouraged deinstitutionalization with Community Mental Health Act and allowed use of psychiatric drugs.

In 1973, American Nurses Association (ANA) developed standards of care in psychiatric nursing.

From 1975–1983, more of the improvements in mental health care and mental hospitals were made. A new training syllabus for psychiatric nurses was major achievement in 1982.

In late 19th & 20th century, extensive educational upgrades for psychiatric nurses came into existence; MSc Nursing, M Phil and Doctorate in Psychiatric nursing.

National Level

Ancient Vedic Times

In scripture of ancient India, mental disorders such as schizophrenia and bipolar disorders are mentioned. The Bhagavad Gita is also an exemplary form of crisis intervention psychotherapy. In those ancient times, psychiatric illness was considered as a punishment for sin and witchcraft. Therefore, mentally ill were used to be restrained with chains and kept in jails and asylums in ancient times.

Pre-Colonial Times

During the time of King Ashoka, hospitals were established for mentally sick patients. In the Moghul period, during the time of Mohammad Khilji (1436–1469), mental asylums came into existence. In 1700s, lunatic asylums in Calcutta, Madras and Mumbai were developed because of the influence of British enterprise. Under rule of first Governor General Warren Hastings, first mental hospital at Calcutta was established.

Colonial Times

In 1745, the earliest mental hospital for 30 in-patient capacity was established in Mumbai. Following are the hospitals established in this era for mentally sick patients:

- First asylum in Calcutta (1787)
- Private lunatic asylum and then Government run lunatic asylum at Monghyr in Bihar (1795)
- First asylum in south India in Madras (1794)

Indian Lunacy Act was also enacted in 1858 which was modified in 1888. Although there were a number of mental asylums, but psychiatric patients were ill-treated and most of the interventions were to control the symptoms of mental illness only.

In 1912, previous Lunacy Act was repealed and Indian Lunacy Act, 1912 came into being. In 1918, mental asylum at Ranchi was established which is till date in existence and now is known as **Central Institute of**

Psychiatry (CIP). CIP was the first institution in India to start diploma in psychological medicine. CIP got the largest library on the subject of mental health in India.

After Independence

The Indian government did not focus on establishing new mental asylums rather it kept its focus on improvement of the existing hospitals and care of mentally sick in an efficient, organized and humane manner.

Till 1960, CIP and Mental Asylum, Madras started many specialized services in child and adolescent psychiatry and better OPD and IPD services.

- **Bhore committee:** Established all India Institute of Mental Health which is nowadays one of the pioneer institutes of mental health, famous as NIMHANS (National Institute of Mental Health and Neurosciences).
- **Mudaliar committee:** This committee was headed by Dr AL Mudaliar. This committee was focused to assess the performance of health professionals in health sector. This committee submitted a report of lack of trained professionals and facilities in mental health care areas and began a movement for establishment of mental hospitals and proper care with mental facilities throughout India.
- **National health policy:** It states the slogan, **"Health for All by 2000"** which signifies the inclusion of mentally ill patients' care and treatment which were not taken care of in the beginning. In 1982, Central Council of Health and Family Welfare developed the model. **District Mental Health Programme:** In 1987, Mental Health Act came into existence.

These national policies and programmes have levelled up the care of mentally sick patients and standards of psychiatric nurses.

Till date, various diploma and degree courses of mental health care came into existence and are successfully run by established institutions of nursing.

The highest qualification in psychiatric nursing is the doctorate degree which is offered by INC and other reputed nursing institutions.

List of Mental Hospitals in India

- Central Institute of Psychiatry, Ranchi
- NIMHANS, Bangalore
- Institute of Behavior and Allied Sciences, New Delhi
- Vidyasagar Institute of Mental Health and Neurosciences, New Delhi
- Institute of Mental Health, Amritsar
- Post Graduate Institute of Medical Education and Research, Chandigarh
- Post Graduate Institute of Medical Science, Rohtak
- Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS)Yerwada Mental Hospital, Pune
- Government Mental Hospital, Thane
- Jagruti Rehabilitation Center, Pune
- Mental Hospital, Indore
- Noor Manzil Mental Hospital, Lucknow
- Institute of Mental Health and Hospital, Agra

These are some of the famous mental hospitals which are providing training to student psychiatric nurses. This is an evidence for improvement of mental health care in India.

TRENDS IN PSYCHIATRIC NURSING

What is a trend in a profession?

Trend is a manner or fashion of a profession in which it is developing, progressing or making growth.

Why do we need to learn about trends of psychiatric nursing?

The need for learning psychiatric nursing trends is having this basis that if we want to know how and how much one profession is growing and in which direction.

Trend is the flow of a profession, e.g., Sutlej River has its origin in Lake Rakshastal in Tibet, enters India in Himachal Pradesh state heading towards west-southwest for about 360 kilometers to meet Beas River in Punjab state. In the same way, every profession has its origin and growth in different countries. So, it is mandatory to learn about trends of professional nursing.

Old Trends

- **Confinement:** In ancient times, mentally sick patients were confined in asylums. They were ill-treated and were beaten and scolded for symptoms of mental sickness. They were considered to be possessed by demons, were not given any food to survive.
- **Institutionalization:** For the safety of community and people and to avoid dangers from excited patients, the second trend which came into being was Institutionalization. In foreign countries, modern mental hospitals were established. In India, since times of Emperor Ashoka, mental hospitals were established and flourished to take care of mentally sick patients.
- **Burr holes and insulin therapy:** In previous times, surgeons used to make burr holes in cranium to slow down the activity of brain to control the symptoms of mental sickness. In insulin therapy, a hypoglycemic state was induced in a mentally sick patient to slow the brain and control symptoms. This is an age old trend which is obliterated now.
- **Deinstitutionalization:** The next trend, which came into being was deinstitutionalization. Mentally sick patients were allowed to survive at homes in community and were treated in community health center. This trend is still in existence but many families do not cooperate with mentally sick and demand institutionalization.
- **Electro-convulsive therapy:** ECT is a treatment of choice for major depression, catatonic schizophrenia, etc. In previous years, only electrical current was passed with no use of anesthetics/muscle relaxants. Now the trend has been changed and ECT is quite effective with lesser side-effects along with use of anesthetics and muscle relaxant.

New Trends

- **Psychopharmacology:** The first drug discovered in psychiatry was chlorpromazine. Now many more psychotropic drugs are discovered with lesser side-effects. Psychopharmacology is still a trend in psychiatric field.
- **Definite curriculum in psychiatric nursing:** As a part of curriculum, psychiatric nursing is taught in GNM, BSc nursing courses. Now a post-graduation degree course and doctorate degree in psychiatric nursing is in trend.

Case Management Approach

Now, every mental disorder is being treated using multidisciplinary approach. A mental health team is now dealing with mental sicknesses.

New Etiology of Mental Sickness

New researches in field of psychiatry have poured light on the etiological factors of mental disorders. This new etiology of mental disorders had begun a new approach to deal with mentally ill patients.

Legal Aspects in Psychiatric Nursing

Now legal aspects in psychiatric nursing are actually functioning in mental health care area. M'Naghten Rule, Admission and discharge rights, Mental Health Act, Confidentiality Acts, etc. are legal aspects of psychiatric nursing.

Code of Ethics in Professional Care

Ethical principles of confidentiality, fidelity, autonomy, non-maleficence, beneficence, negligence/malpractice are functional and is now in new trends of psychiatric nursing.

New Fields of Psychiatric Nursing

Many new fields of psychiatry have emerged as new trends in psychiatric nursing. For example, child psychiatry, obstetrical psychiatry, adolescent psychiatry, marital and relationship psychiatry.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

DSM-5 is a new edition of international classification of mental disorders. In previous years, DSM-IV TR, i.e., 4th edition text revised of DSM was in use.

NATIONAL MENTAL HEALTH PROGRAMME

The directorate general of health services has launched National Mental Health Programme (NMHP) in 1982. NIMHANS under directorship of Dr P Satish Chandra has done a research study to assess prevalence of mental illness in India. The findings of the study revealed that 13.7% of India's general population is suffering from a variety of mental illnesses and 10.6% requires immediate intervention. The magnitude of mental diseases in India is demanding well qualified mental health professionals and a national mental health programme.

India developed NMHP in 1980s and is among the very first countries to develop and launch a national level programme for mental diseases.

In 1982, NMHP was started with following three components: Treatment of mentally ill

- Rehabilitation
- Prevention and promotion of positive mental health

Aims of NMHP

- Prevention and treatment of mental and 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 of NMHP

- 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 population.
- To encourage application of mental health knowledge in general health care and in social development.
- To promote community participation in the mental health services development and to stimulate efforts toward self-help in the community.

Although NMHP was started at a great level but due to lack of mental health facilities and not knowing the magnitude of mental disorders, it was not a success. NMHP strategies were revised in 2003 and now includes two schemes:

1. Modernization of State Mental Hospitals
2. Up-gradation of Psychiatric Wings of Medical Colleges/General Hospitals

Components of NMHP

- **District and sub-district level activities under NHM:**
  District Mental Health Program
  - Provision of at least basic mental health care services at community health center
  - Mental health IPD and OPD services
  - Out-Reach Component: 4 satellite clinics per month at CHCs/PHCs

  Targeted interventions:
  - Life skills education for special population
  - Counseling services in schools and colleges
  - Work stress management
  - Suicide prevention programme
  - Training and education of mental health care personnel at District and Sub-district levels
  - Organizing awareness camps regarding mental illness
  - Spreading awareness to discourage stigma in community by involving leaders, faith healers and teachers, etc.
  - Community Participation (Involvement of Volunteers and NGOs)
  - Meeting manpower demands (Mental health team members on contract basis)

  Till date, 241 districts have implemented the revised strategy of NHMP and it is still expanding all over the nation.

- **Public private partnership (PPP):** NHMP revised strategy has implemented PPP model activities by joining hands with private sector providing mental health care facilities. Government has approved financial support for functional NGOs, day care centers and residential care centers.

  Services by mental health care centers:
  - Rehabilitation services
  - Helping mentally sick to be a productive part of community
  - Treatment and recovery services for mentally sick patients
  - Psychopharmacology & Psychotherapy
  - Residential services for chronically ill psychiatric patients in residential centers
  - OPD and IPD services
  - Guidance and Counseling

  Services and manpower requirements:

Services	Manpower
Community health centers (CHC) • OPD • IPD • Emergency care • Counseling	Medical officer Clinical psychologist/psychiatric social worker
Primary health centers (PHC) • OPD • Counseling • Mental health promotion	Community health workers (2)

- **Mental health helpline:** A 24-hour helpline to create awareness about mental health and management of crisis and mental sickness; workplace stress and information on medico-legal issues is also available under NMHP which is linked with mental hospitals (Government sector/private sector) and NGOs.
- Postgraduate training of mental health care professionals
- NIMHANS and CIP; National institutes have been upgraded with extensive neurological and neuro-surgical facilities
- Support for research and survey in mental health
- Standardized training and workshops for mental health care professionals

ASSESS YOURSELF

Long/Short Answer Questions

1. Write a short note on NMHP.
2. Discuss briefly trends of psychiatric nursing.

Multiple Choice Questions

1. Who among the following recommends humane approach for mentally sick patients?

a. Dorothea Dix
b. Emperor Ashoka
c. NMHP
d. Mudaliar Committee

2. NMHP was revised in the year:

a. 1994 b. 2003
c. 2000 d. 1989

3. In NMHP, PPP stands for:

a. Public private partnership b. Purchasing power parity
c. Point to point protocol d. Pakistan people party

4. New trend in psychiatry is:

a. DSM-IV b. DSM-TR
c. DSM-IV TR d. DSM-5

5. The first psychotropic drug discovered was:

a. Lithium b. Risperidone
c. Chlorpromazine d. Sodium valproate

6. Which of the following was the first institution in India to start diploma in psychological medicine?

a. NIMHANS b. CIP
c. Noor Manzil Mental Hospital, Lucknow d. Institute of Mental Health and Hospital, Agra

7. Which of the following is an exemplary form of crisis intervention psychotherapy?

a. Bhagavad Gita b. The Qur'an
c. The Torah d. Vedas

ANSWERS KEY

1. a **2.** b **3.** a **4.** d **5.** c **6.** b **7.** a

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Unit

3

MENTAL HEALTH ASSESSMENT

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Know the symptomatology of mental disorders.
- Describe and perform mental health assessment.

UNIT OUTLINE

- Psychiatric Nursing History
- Mental Status Examination
- Interview Technique

KEY POINTS

- Mental health assessment means to assess complete mental functioning of an individual.
- Psychiatric nursing history is an assessment technique by which relevant information of client is collected by using a paper and pen.
- Psychiatric nursing history collects present and past lifespan details of an individual.
- Mental status examination is very crucial component of mental health assessment. It helps to identify variations from normal behavior.
- Mental status examination will help a student nurse to learn about various symptoms of mental sickness.
- Echolalia, i.e., imitating the words/sentences of student nurse (Examiner).
- Echopraxia, i.e., imitating the actions/posture of the student nurse (Examiner).
- Stereotype movement, i.e., repeated purposeless movement.
- Tics, i.e., a kind of twitching or jerky movement of a group of muscles, especially facial muscles.
- Mannerisms, i.e., a habitual behavior, e.g., biting fingernails.
- Interview technique is the method of reaching client's emotions by way of expressing them out through verbalization with an empathetic therapist (student nurse).
- Interview must be planned, private and confidential.
- A student nurse must practice a non-judgmental attitude while doing mental health assessment.

INTRODUCTION

- **Mental health** signifies an individual's ability to adapt to life circumstances in a positive way, however, stressful events it may contain. To be positive in a negative situation and tuning the mind to see good aspects of a bad situation is the prominent feature of a mentally healthy person.
- **Assessment is** gathering information about a client's illness. Many professionals use mental health assessment techniques to find out damaged mental faculties (cognition, judgment, abstract thinking, intelligence, insight, etc.) for diagnosis and further evaluation of a mentally sick. A detailed psychiatric nursing history can do wonders in mental health assessment. As a routine evaluation, following are three major assessment techniques a student nurse must learn and implement.
  1. Psychiatric nursing history
  2. Mental status examination
  3. Interview technique

PSYCHIATRIC NURSING HISTORY

Psychiatric nursing history is an assessment technique by which information related to presenting clinical features, past and present psychiatric illness, possible causative and associated factors and familial predisposition is collected by using a paper and pen.

It is a routine method of data collection. The components of psychiatric nursing history are as follows:

- General identification data
- Presenting complaints
- History of presenting illness

- Past psychiatric illness
- Past medical illness
- History of substance use
- Family history of psychiatric illness
- Lifespan history
  - Birth history (birth order)
  - Breastfeeding/bottle feeding
  - Caretaker (affectionate/strict/over-protective)
  - Toilet training
  - School history/performance
  - Peer group history
  - Play history
  - Pubertal history
    - Age at menarche
    - Reaction toward pubertal changes
    - Heterosexual relations/interaction with opposite gender
  - Adulthood history
    - College history
    - Work history
    - Relationship history (marriage/sexual contacts)

General Identification Data

This includes demographic information of the mentally sick client such as name of client, age, gender, marital status, educational status, occupation and working status, religion of client, cultural background, living conditions. The student nurse should record date, time, location of history collection and client's willingness to share information.

A Sample Chart

General Identification Data	Client's responses
Name of client	Mr Mohan
Age	40
Gender	Male
Educational status	Graduate in Arts stream
Occupation and working status	Clerk, not working
Religion of client	Hindu
Cultural background	Punjabi
Living conditions	Living with family in a two room set with attached washroom and separate kitchen
Date and time of history collection	February 3, 2016 at 10:00 am
Location of history collection	Interview room in OPD
Client's willingness to share information	Client came on his own without any force
Diagnosis of client	Phobia (cynophobia, i.e., fear of dogs)

Presenting Complaints

These are complaints of the client which brings him to hospital for evaluation. Presenting complaints of the client should be recorded in client's own words (verbatim) and should explain why client has come to psychiatric hospital and what were the most distressing signs and symptoms.

A Sample Chart

Sample questions by student nurse	Client's responses
What brings you here in a psychiatric hospital?	• I am not able to go out of my home as there are barking street dogs on the way. • Sound of barking dogs stresses me a lot. • I don't like my boss. • I don't like my workplace. Everybody over there is so loud. • I feel insecure outside home.
What bothers you the most?	• Sound/sight of barking dogs • Headache after confronting boss and work environment.

In case, client is not able to answer or is not willing to participate, history should be collected from client's significant relative with same questions. Make sure, source of information is reliable.

History of Presenting Illness

This is the most important section of psychiatric nursing history. This includes the chronological order of presenting complaints from the onset of disorder till date. The student nurse collects information about onset of illness, precipitating factors and clinical features.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
What are the symptoms of mental illness?	Two weeks before, I was trembling in front of my boss, my body was sweating and my hands were shaking. Headache was there. After lunch break, I couldn't continue that day and stepped out from my office. Along the way, two dogs were fighting and it frightened me much that I fell down on ground and was taken home by one passerby.	Bodily symptoms did appear two weeks before consultation • Perspiration • Trembling • Tremors of hands • Headache • Syncope
When did symptoms first appear? (onset of illness)	Six months back when I joined the office for the post of a clerk.	July, 2015
What initiated distress in you? What happens after joining the job? (precipitating factors)	I was very happy to join the office until I got individualized assignments by boss. My boss is a very strict and rigid person. At workplace, he shouted on me several times for small mistakes. He was very loud and I couldn't bear his voice.	• Rigid behavior of boss • Work stress • Loud voice • Barking dogs

Contd...

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
	When I used to leave office, street dogs also scared me and their barking makes me anxious every time.	
Previous treatment	I used to have a painkiller for headache without prescription. Usually, I manage it by avoiding sound/sight of dogs, going to office, taking off.	Client took over the counter medications for symptomatic relief. • Defense mechanism • Avoidance

Past Psychiatric Illness

It includes all previous episodes of psychiatric illness, episode durations, prognosis, relapse and remissions, etc.

A Sample Chart–I

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Episodes of psychiatric illness	This is the first psychiatric evaluation.	Episode: First
Did medication bring you any relief?	My headache was persisting; painkillers didn't help so I came to hospital.	No response with previous treatment

In case, there is more than one episode of psychiatric illness, mention each episode in detail as follows:

A Sample Chart–II

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Episode of psychiatric illness	This is the third episode of psychiatric evaluation. • **In 2001**: On a sunny day, I did go for a morning walk. There in one corner of a street, four dogs were wandering and ran after a bike rider. Dogs were barking so loud and I was very anxious with profuse perspiration. I felt trapped and was finding a way to escape the street. Since then, I used to avoid sight/sound of barking dogs. • **In 2014**: In college, one of the professors did scold me in a very loud manner and criticized me a lot. I started shivering, trembling and finally fell on ground. My blood pressure fell down. I was taken to emergency department and symptomatic treatment was done.	Episode: Third No treatment was taken except avoiding confrontation with dogs. Immediate relief from symptoms was there.

Contd...

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
	• **In 2016**: Two weeks before, I was trembling in front of my boss, my body was sweating and my hands were shaking. Headache was there. After lunch break, I couldn't continue that day and stepped out from my office. Along the way, two dogs were fighting and it frightened me much that I fell down on ground and was taken home by one passerby. I couldn't join office again because I am so afraid to go outside and see any of the dogs on street. On suggestion of a friend, I came in psychiatric OPD for consultation.	

Past Medical Illness

The student nurse must collect history related to past medical illnesses, if any. This will help to rule out any medical condition whose symptoms may resemble picture of a psychiatric illness. For example, weight loss may happen in hyperthyroidism (a medical illness) as well as in anxiety disorder (a psychiatric illness).

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Do you have any medical illness?	No, I do not have any medical illness. I do have hypertension since 12 years.	No past history of any medical illness Past history of HTN since 12 years.
When was it diagnosed?	In 2004	Patient illness was diagnosed in 2004.
Are you on any medication? Name with dosages.	Yes, I take Amlong 25 mg once a day on a regular basis.	Client is on Amlong 25 mg OD.

History of Substance Use

Many of the symptoms of psychiatric illnesses may arise due to substance use. To have a clear picture of psychiatric illness, a student nurse must ask about any substance use and since when. It will help to know, whether symptoms are because of a psychiatric illness or a direct effect of a substance use.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Do you have any addiction? • Alcohol • Opium • Cannabis, etc.	No, I do not have any addiction. I do have a habit of drinking alcohol on a regular basis.	No past history of any addiction. Past history of alcohol intake.

Contd...

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Dosage	120 mL daily	Client takes 120 ml of alcohol as a routine.
Any over the counter medication taken?	No	No use of any over the counter medication

Family History of Psychiatric Illness

- **Family tree:** It is preferable to make family tree of two generations to screen any family history. A sample family tree is shown in Figure 1.

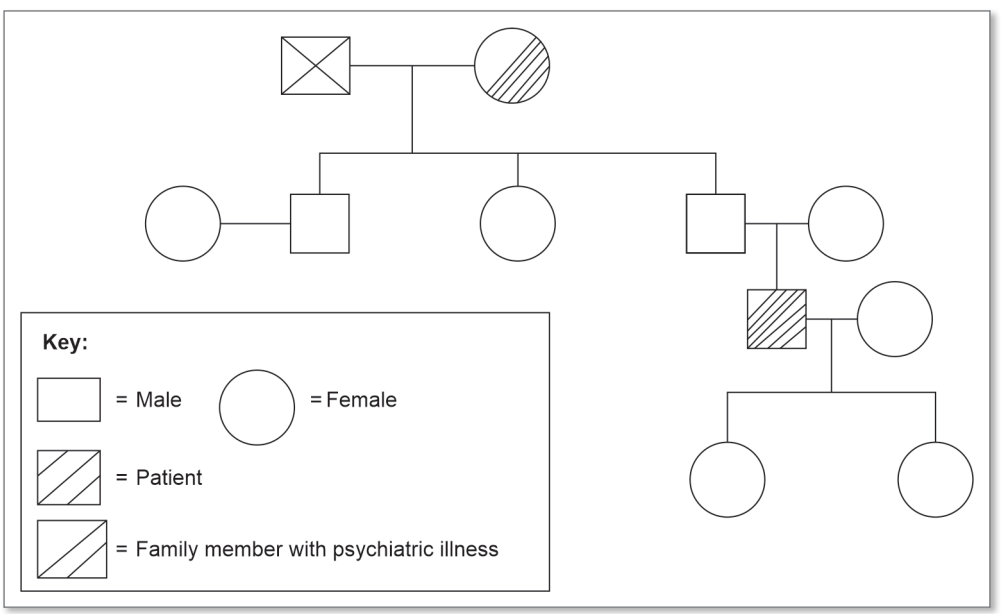

Fig. 1: Family tree

- **Genetic predisposition, if any:** The student nurse must ask the client if any other family member is suffering from any other or similar psychiatric illness.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Is any other family member has/had any other or similar kind of psychiatric illness?	• No other family member is having any psychiatric illness. • Yes, my grandmother was also having phobia of barking dogs.	There is a family history of cynophobia.

Lifespan History

- **Birth history**
  Birth order = _____
  Wanted/unwanted = _____
  Any birth injury = _____
  Cry after birth = Immediate/delayed, present/absent
  Any perinatal infection or complications, if any = _____
- **Breastfeeding/bottle feeding:** Whether child was breastfed or bottle-fed. According to psychoanalytical theory, a child needs to complete his task of oral stage by sucking. If the child doesn't complete the task, he is more prone to have addictions and other psychological problems in later life. Therefore, it is very important for a student nurse to evaluate feeding pattern of a client.
  Note: Breastfeeding and bottle feeding both will satisfy the psychological need of sucking, the key is to know, whether it was satisfied or not.
  The student nurse must enquire about timing of weaning or if child was weaned late, which can cause dependency habits later in life.
- **Caretaker (affectionate/strict/over-protective):** The student nurse should ask following questions in regard of caretaker of child at home.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
Who was the caretaker of child at home?	Mother/grand mother/father/ other significant figure/maid (female or male)	Mother was caretaker so primary influencer on child psychology
How was care taker of child? • Affectionate • Strict • Overprotective	• Affectionate • Strict • Over-protective (extra caring)	• Affectionate caretaker will help build up child's personality and make him independent. • Strict and rigid behavior can create childhood burdens. • Extra caring and protective behavior can cause adjustment problems.

- **Toilet training:** In anal stage of psychosexual development, ego (balance between one's desires and doing what is right) develops. The child continuously struggles between Id (doing what gives you pleasure at any cost) and superego (doing what is morally right and acceptable to society). He symbolizes it with stool retention and defecation.

  Defecating in his own way here and there without feeling guilty about making clothes and toilet seat dirty will give pleasure to a child. On the other hand, retention of stool can prevent scolding from mother and acceptable in home.

  Therefore, a child at this stage may have fixation in Id or superego which can have psychological problems later in life.

A very strict and rigid toilet training can result in dominating superego and gives psychological burdens of sin and guilt, etc.

A very liberal toilet training can result in dominating Id and gives child a psychology of being served first without caring for others.

Therefore, it is very important to ask about toilet training to know about fixations in development.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
How was toilet training at home? Note: This question may be better answered by a caretaker.	• Strict • Liberal • Rewarding	• Strict toilet training may result in delusions of sin and guilt, etc. • Liberal toilet training may result in dominating, demanding and eccentric (me-centered) personalities. • A rewarding toilet training will help gain independent and adapted behavior.

- **School history/performance:** At this stage, when a child joins school, there is a new environment and separation from home and family especially mother. Every child reacts differently to this separation. Here, a student nurse can find out roots of anxiety disorder.
  At school, performance of child (rewarding or punishment) can shape his behavior later in life.
  A student nurse must enquire about separation, anxiety and school performance.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
What was child's reaction towards school?	• Separation anxiety • Happy • Temper tantrums	• Roots of psychological problems.
How was school performance?	• Brilliant • Poor • Average	• Brilliant performer will be confident and optimistic. • Poor performer may be timid and submissive personality.
Note: Research findings support average performers to be more mentally healthy in comparison with brilliant and poor performers.		

- **Peer group history:** Many of the psychological disorders demonstrate influence of having or not having friends in childhood. For example, schizophrenic patients usually have a history of not having many friends and remaining alone.

  Therefore, it is very important to ask about peer group of a client.

A Sample Chart

Sample question by student nurse	Patient's responses	Student nurse inference of patient's history
How many friends do you have/had?	• None • Many and close • Few and close • Many and superficial • Few and superficial	• Less or no friends signify problems in sustaining relations and lack of trust and sharing, etc. • Close friends signify someone with whom feelings and thoughts can be shared and trust is developed. • Superficial friends signify lack of trust and intimacy.

- **Play history:** Play is a way of expression for a child. A child who plays is more expressive and adaptive and has more signs of a mental health. Play has a way to express out.
  The student nurse should also collect play history of the client.

A Sample Chart

Sample questions by Student Nurse	Client's responses	Student Nurse Inference of client's history
Do/Did you play? What do you play?	• Yes • No • Indoor games • Outdoor games	Play is a sign of mental health and expression in a positive way. Can help in planning recreational therapy.

- **Pubertal history:** Pubertal history is as important as childhood history. Although every mental disorder is having roots in childhood, the disorder has growth in puberty in adolescent period. The student nurse may ask following questions in regard with puberty.
  - Age at menarche
  - Reaction towards pubertal changes
  - Heterosexual relations/interaction with opposite gender
    A successful adaptation in this transitional period will promote mental health as an adult and failure will result in psychological problems.
- **Adulthood history:** The adulthood history includes following headings:
  - College history
  - Work history
  - Relationship history (marriage/sexual contacts)
  - Any addiction

  Note: Adulthood history may help a student nurse to find out pre-morbid personality.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
• Did you go to college? • How did you like it? • How well you performed in academics and co-curricular activities?	• Yes • No • I was an average student, likes to dance in college parties.	Client was a loner in college. Client was an outgoing, cheerful person.

Contd...

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
• First job • Present job • Likeness toward work • Work performance • Work stress	• As a clerk in a private firm • Continuing in the same job—Hatred toward boss • Not so good—Present	Client work environment is stressful and causing distress to client mentally as well as his work performance.

- **Relationship history (marriage/sexual contacts):** It is very important aspect of psychiatric nursing history. A person who is successful in interpersonal relations is likely to have a good mental health and less of psychological problems. Therefore, a student nurse must collect relationship history carefully.

A Sample Chart

Sample questions by student nurse	Client's responses	Student nurse inference of client's history
• Pre-marital affairs • Success of relations • Any physical contacts • Marriage • Willingly or by force • Affection with partner • Comfort with partner • Sharing and support with partner • Sexual intimacy	• Yes or No • Success/failure • Yes or No • Single/married • Willingly • Under societal pressure • Present/absent/lost with time • Present/absent • Present/absent • Present/absent/lost with time	• A successful sharing relation is good for mental health. • Failure in love, imposed marital relations can cause psychological problems. • A good intimate relation is helpful in encouraging sharing if the feeling is mutual.

- **Premorbid history:** The history of the patient before illness is included in premorbid history, i.e., history before occurrence of mental illness.

Psychiatric Nursing History Format

General identification data:

- Name of client
- Age
- Gender
- Educational status
- Occupation and working status
- Religion of client
- Cultural background
- Living conditions
- Date and time of history collection
- Location of history collection
- Client's willingness to share information

Contd...

Diagnosis of client

Presenting complaints in client's verbatim

- What brings you here in a psychiatric hospital?
- What bothers/disturbs you the most?

History of presenting illness

- What are the symptoms of mental illness?
- When did symptoms first appear? (onset of illness)
- What initiated distress in you? (precipitating factors)
- Previous treatment

Past psychiatric illness

- Episodes of psychiatric illness
- Did medication bring you any relief?

Past medical illness

- Do you have any medical illness?
- When was it diagnosed?
- Are you on any medication? Name with dosages.

History of substance use

- Do you have any addiction? Alcohol/opium/cannabis, etc.
- Dosage
- Any over the counter medication taken?

Family history of psychiatric illness

- Family tree
- Is any other family member has/had any other or similar kind of psychiatric illness?

Lifespan history

1. **Birth history**
   - Birth order = _____
   - Wanted/unwanted = _____
   - Any birth injury = _____
   - Cry after birth = Immediate/delayed, present/absent
   - Any perinatal infection or complications, if any=_____
2. **Breastfeeding/bottle feeding**
3. **Caretaker (affectionate/strict/over-protective)**
   - Who was the caretaker of child at home?
4. **Toilet training (strict/liberal/rewarding)**
5. **School history/performance**
   - What was child's reaction toward school? (separation anxiety/happy/temper tantrums)
   - How was school performance? (Brilliant/poor/average)
6. **Peer group history**
   - How many friends do you have/had? (None/many and close/few and close/many and superficial/few and superficial)
7. **Play history**
   - Do/did you play? (yes/no)
   - What do you play? (indoor games/outdoor games)

Contd...

8. **Pubertal history**
   - Age at menarche
   - Reaction towards pubertal changes
   - Heterosexual relations/Interaction with opposite gender
9. **Adulthood history**
   - Addiction, if any
   - College history
     - Did you go to college?
     - How did you like it?
     - How well you performed in academics and co-curricular activities?
   - Work history
     - First job
     - Present job
     - Likeness toward work
     - Work performance
     - Work stress
   - Relationship history (marriage/sexual contacts)
     - Pre-marital affairs (yes/no)
     - Success of relations (success/failure)
     - Any physical contacts (yes/no)
     - Marriage (single/married)
     - Willingness/forceful relations
     - Affection with partner (present/absent/lost with time)
     - Comfort with partner (present/absent)
     - Sharing and support with partner (present/absent)
     - Sexual intimacy(present/absent/lost with time)

MENTAL STATUS EXAMINATION

Mental status examination is an assessment technique of gathering data related to normal and abnormal (altered) mental functions of a person.

It is total of the observations and findings made by a student nurse during an interview focused on assessment of mental health.

Mental status examination begins with the entrance of the client in the interview room and ends when client leaves. A student nurse must observe carefully with sight and mind to make clear and accurate findings of the mental status examination.

Components of Mental Status Examination

- General appearance and behavior
- Mood and affect
- Perception
- Thought
- Cognition
  - Orientation
  - Attention and concentration
  - Memory
  - Abstract reasoning
  - Intelligence
- Judgment
- Insight

General Appearance and Behavior

A student nurse must observe a mentally ill client keenly to make a valid assessment about general appearance and behavior. It starts when a client enters in an interview room.

Steps of assessment	What to observe/ask?	How to record?
Step 1: Observe patient while he/she is coming to you.	Gait	• Normal/staggered (like an alcoholic)
Step 2: Make client sit and observe his posture.	Posture	• Open/closed/guarded
Step 3: Observe overall impression of client's body.	Body type	• Healthy/sick look/older than age/younger than age
Step 4: Observe client's clothing.	Clothing	• According to season and situation. • Examples: ▪ Schizophrenics will wear clothing inappropriate to season. (wearing woolen in summer) ▪ Manic clients do wear extra make-up, jewelry.
Step 5: Observe client's grooming.	Grooming	• Hair is combed, well-dressed, clothes are clean and proper. • Hair is not combed (dirty), clothes are not put on or are dirty. • Footwear are proper (right shoe in right foot, left shoe in left foot) or not.
Step 6: Initiate a simple conversation with client, like how are you? Did you eat breakfast and so on? While conversation, observe client's facial expression and speech.	Facial expression Speech	• Happy/sad/anxious/flat • Quantity: talkative/mute/poverty • Rate: rapid/slow • Volume: loud/low • Quality: spontaneous/emotional • Pressured/slurring/whisper • Monotonous/echolalia • Reaction time: immediate/delayed
Step 7: When client is sitting with you and you are communicating with one another, observe client's activity level.	Psychomotor activity	• Can't sit still • Mannerisms • Tics • Stereotype movement • Over-activity • Under-activity (slowness) • Echopraxia • Purposeless activity
Step 8: Acknowledge client's attitude toward examiner (Student nurse) while talking with client.	Attitude toward examiner	• Cooperative/friendly/disinterested/aggressive/very open/sexual/a feel of enjoyment

Mood and Affect

Mood is the internal feeling or emotion of a person.
Affect is the outward expression of mood, e.g., facial expression.

Steps of assessment	Client's responses	What to observe?	How to record?
Nurse: How's your mood today?	• I am feeling happy today. • I am feeling sad today. • I am very anxious today.	• Observe facial expression and body language of client. • Note whether client's facial expression match with their verbal expression.	• If client says I am happy and facial expressions are also smiling. • Record: Mood and affect are appropriate. • If client says I am sad and facial expressions are also sad. • Record: Mood and affect are appropriate. • If client says I am happy and facial expressions are sad OR If client says I am sad and facial expressions are smiling or laughing. • Record: Mood and affect are inappropriate.

Perception

Perception is the process of understanding something and making a conclusion about it. In other words, perception is the way in which an individual perceives his environment.

Every individual has his own way of perceiving the environment.

In perception, a student nurse will assess illusions, hallucinations, depersonalization and derealization.

Illusion is a wrong perception in the presence of a stimuli. For example, a rope may be perceived as a snake.
Hallucination is a wrong perception in the absence of a stimuli.
Types of hallucinations:

- **Auditory hallucinations:** Person will hear voices which others are not hearing.
- **Visual hallucinations:** Person will see images/persons which others can't see.
- **Tactile hallucinations:** Person will feel contact with something which is not present or is not visible to eyes. For example, person may say that some insects are crawling onto my skin.
- **Olfactory hallucinations:** Person will smell an odor whose source is not available and the smell is not actually present there. For example, person may say that I smell roses when actually there are no roses nearby.
- **Gustatory (taste) hallucinations:** Person will wrongly perceive a taste with/without food or other stimuli. For example, a person might complain that the food served to him is rotten when actually it is freshly prepared and tasty. Another example is that a person might complain that I have taste of rotten veggies in my mouth all the time.

Depersonalization is a wrong perception in which a person feels detached from oneself. Person may proclaim that he has been changed or he is in a dream.

Derealization is a wrong perception in which a person feels that his world has been changed or is not real.

What to ask?	Client's responses	How to record?
Auditory hallucinations Q. Do you hear voices which others don't hear?	• No • Yes, I do hear voices of people which others can't hear.	Auditory hallucinations are absent/present.
Visual hallucinations Q. Do you see images/persons/things which others can't see?	• No • Yes, I can see strange persons and others can't see them, only I.	Visual hallucinations are absent/present.
Tactile hallucinations Q. Do you experience any different sensation like something crawling or touching you?	• No • Yes, insects are crawling on my face and distress me a lot.	Tactile hallucinations are absent/present.
Gustatory hallucinations Q. Do you taste something differently?	• No • Yes, I taste rotten vegetables all the time.	Gustatory hallucinations are absent/present.
Olfactory hallucinations Q. Do you smell even in the absence of its source?	• No • Yes, I smell cigarette even if no one is smoking.	Olfactory hallucinations are absent/present.
Depersonalization Q. Have you ever felt indifferent like you or your body has been changed?	• No • Yes, I do feel that my body has been changed; I am no more the same person.	Depersonalization is absent/present.
Derealization Q. Have you ever felt that this world has been changed or is not same?	• No • Yes, this world has been changed. It is no longer a real world. All things are new and fake.	Derealization is absent/present.

Thought

Thought is the process of thinking.

A mentally sick person may have altered thinking patterns which may appear as a disorder of thought. A student nurse must evaluate the process as well as content of thought.

Thought Process

Thought process consists of formation and progression of a thought in mind. The abnormal findings of thought process are as follows:

Circumstantiality	The client will give many unnecessary details before coming to the answer of the question being asked.
Tangentiality	The client will give many unnecessary details but will not answer to the question being asked.
Flight of ideas	The client will rapidly move from one idea to another without completion of one particular detail.

Contd...

Neologism	The client will invent new words to communicate. These words may not have a dictionary meaning at all.
Perseveration	The client will stick to one idea and will not to be able to shift to other topics.
Clang association	The client will join the thoughts through a rhyme instead of their meanings.
Derailment (loosening of associations)	There will not be a logical connection between ideas as ideas are loosely connected and don't make a sense.
Thought block	A sudden cessation of thought in the mind. The client will not be able to initiate the conversation after thought block.
Word salad	Like a salad, client mixes so many related words to form a sentence but couldn't make a sense.
Incoherence	When there is no association between two thoughts and it is not understandable.

- **Assessment of thought process:** The student nurse can generally initiate a conversation with client and observe the pattern of thoughts in client's conversation to make a conclusion about thought process.
- **Thought content:** It consists of thoughts of the client related to specific questions or the thoughts which occur in the mind of the client naturally without a stimulus.

For assessment of thought content, a student nurse may ask following questions related to delusions.
Delusion: A delusion may be defined as a false, fixed belief which cannot be justified with logical explanations and is not in accordance with one's cultural and educational background.

What to ask?	Client's responses	How to record?
Delusion of grandeur • Do you believe that you have super powers? • Do you believe you do possess beauty, wealth or talent more than others?	• No • Yes, I do have super powers. • No • Yes, I am very rich, so beautiful and extremely talented that is incomparable with others.	Delusion of grandeur is absent/present.
Delusion of persecution • Do you believe that other people want to harm/kill you?	• No • Yes, people want to kill me. They are after me to harm me.	Delusion of persecution is absent/present.
Delusion of control Do you believe that you are being controlled?	• No • Yes, I have a chip in my brain which is controlling me. • Yes, I am being controlled by powers of _____.	Delusion of control is absent/present.
Obsessional thoughts Are there any repeated thoughts in your mind which you can't get out even with effort?	• No • Yes, I have repeated thoughts of _____ which disturb me a lot.	• Obsessional thoughts are absent/present.
Idea of reference Do you think that everyone is talking about you?	• No • Yes, everyone is talking about me, wherever I go.	• Idea of reference is absent/present.

Contd...

What to ask?	Client's responses	How to record?
Nihilistic delusions Do you think this world has come to an end?	• No • Yes, this world is soon coming to an end.	• Nihilistic delusions are absent/present.
Suicidal ideation • Have you ever thought about killing yourself? • Did you ever hurt yourself?	• No • Yes, I do have suicidal ideation. I think about killing myself, because this life of mine is not worth living.	• Suicidal Ideation is absent/present.

Cognition

Cognition is the sum total of all mental functions of the brain such as thought, perception, abstract thinking, intelligence, attention through which an individual understands and acquires knowledge.

In mental status examination, assessment of cognition includes assessing following mental functions of mind.

- **Orientation:** Orientation of a person should be toward time, place and person.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
• **Orientation to person** ▪ What is your name? ▪ Who am I? ▪ Who is she? ▪ Who is he?	• Mr X • A trainee • Sister In charge • Mr Y	• Client is oriented/not oriented to time, place and person
• **Orientation to time** ▪ What is time now? ▪ What time of day it is?	• ___am/pm • Morning/afternoon/evening/night	
Orientation to place • Where are you right now? • In which city it is?	• In hospital. • In _____	

- **Attention and concentration:** Ask client to count backward from 10 or 100. This test will help to assess attention.

  Serial seven subtraction test for assessment of concentration:
  - Ask client to subtract 7 from 100 for seven times.
  - Inference: Client's attention and concentration is good/poor/average.
- **Memory:** It is the mental function of the brain through which it stores, processes and retains the information.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
Immediate: Repeat after me 3, 6, 8, 9, 2, 1	• 3, 6, 8, 9, 2, 1 • 6, 9 • 1, 2, 8, 6 • No response	Client's immediate memory is good/ poor/average.
Recent (last 24–72 hours) • I will say three things to you. After some time, repeat them. • A plain paper, ginger tea, red flower. • What did you eat for breakfast?	• No response • Ginger tea, red flower • A plain paper, ginger tea, red flower. • Garlic bread with one cup of tea	Client's recent memory is good/ poor/average.
Long-term (remote memory) • When did you get married? • Tell me name of your class teacher in class X.	• No response • Client did answer correctly.	Client's remote memory is good/ poor/average.

Note: Nurse should confirm answers from other sources too.

- **Abstract reasoning:** Abstract reasoning is that intelligence of an individual which measures one's ability to reason out and give logical explanation of concept or phenomena.
  A student nurse may ask client to find out similarities or dissimilarities between two concepts or giving meanings of simple proverbs.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
Q. What do you understand by proverb? A friend in need is a friend indeed.	• No response • I don't understand. • True friend is that friend who is available in your times of need.	Abstract thinking is good/average/poor.
Q. What is the similarity between apple and orange?	• Both are round. Both are fruits.	
Q. How does apple and orange differ?	• Apple is solid fruit. Orange can be squeezed.	

- **Intelligence:** Intelligence may be defined as one's ability to comprehend, acquire and retain new and old information.
  It can also refer to as one's intellectual ability or brilliance.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
• Who is the prime minister of India? • Which city is capital of India?	• Mr Narender Modi • New Delhi • No response	Client's intelligence is fine/not good.

Judgment

It refers to person's ability to make correct decisions and acting upon them. It is of three types. A student nurse may evaluate client's judgment by asking following standardized judgment questions.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
Test judgment: What will you do if you find a letter on a road on which there is address and it is stamped?	• I will ignore. (sign of depression or schizophrenia) • I will open it and read it and will tear it into pieces. (sign of suspicious behavior) • I will post it. (correct judgment) • I myself will take it to the given address. (sign of mania)	Client's test judgment is correct/incorrect and manifest thoughts of Depression/mania/suspicion/ schizophrenia.
Personal judgment: What will you do after being discharged from hospital?	• I will start with my job and earn OR any other constructive work. • I will beat my brother who got me admitted in hospital OR any other destructive thought.	• Client's personal judgment is correct. • Client's personal judgment is incorrect.
Social judgment: What will you do if you find a child who is crying?	• I will try to make him quiet. • I will ask him/her about his/her mother or significant others. • I will make magic and child will laugh.	• Client's social judgment is correct. • Client's social judgment is incorrect.

Insight

Insight refers to client's awareness about his/her mental illness. A student nurse may ask following questions to assess insight of client.

A Sample Chart

Sample questions by student nurse	Client's responses	How to record
Do you think you are sick?	• No	Insight is absent. (Insight grade-1)
Is your illness physical or mental?	• Yes • I don't know • Physical • Mental.	Insight is present. (Insight grade varies here from 2 to 6)
What is the cause for your mental sickness?	• External factors • Psychosocial factors	

Grades of insight

1. Grade 1 = Complete denial of illness
2. Grade 2 = Ambivalent feelings about having illness; Sometimes yes and other times no.
3. Grade 3 = When patient blames external factors for having mental illness, e.g., my brother has brought me here in hospital because I am having headache and loose motions.
4. Grade 4 = When patient blames psychosocial factors for having mental illness, e.g., I am mentally sick because my wife fights with me. I am mentally sick because my family do not love me.
   OR Awareness that illness is caused by something unknown.
5. Grade 5 = Intellectual Insight: Awareness that there is mental illness without applying this knowledge to future experiences.
6. Grade 6 = Emotional Insight: Emotional awareness into the feelings and illness and ability to modify behavior accordingly.

Mental Status Examination Format

1. **General appearance and behavior:**
   - Gait
   - Posture
   - Body type
   - Clothing
   - Grooming
   - Facial expression
   - Speech
   - Psychomotor Activity
   - Attitude toward examiner
2. **Mood and affect:**
3. **Perception:**
   Auditory hallucinations
   Q. Do you hear voices which others don't hear?
   Visual hallucinations
   Q. Do you see images/persons/things which others can't see?
   Tactile hallucinations
   Q. Do you experience any different sensation like something crawling or touching you?

Contd...

Gustatory hallucinations

Q. Do you taste something differently?

Olfactory hallucinations

Q. Do you smell even in the absence of its source?

Depersonalization

Q. Have you ever felt indifferent like you or your body has been changed?

Derealization

Q. Have you ever felt that this world has been changed or is not same?

4. **Thought:**
   - Circumstantiality
   - Tangentiality
   - Flight of ideas
   - Neologism
   - Perseveration
   - Clang association
   - Derailment (loosening of associations)
   - Thought block
   - Incoherence
   - Word salad

Delusion of grandeur:

- Do you believe that you have super powers?
- Do you believe you do possess beauty, wealth or talent more than others?

Delusion of persecution:

- Do you believe that other people want to harm/kill you?

Delusion of control:

Do you believe that you are being controlled?

Obsessional thoughts:

Are there any repeated thoughts in your mind which you can't get out even with effort?

Idea of reference:

Do you think that everyone is talking about you?

Nihilistic delusions:

Do you think this world has come to an end?

Suicidal ideation:

- Have you ever thought about killing yourself?
- Did you ever hurt yourself?

5. **Cognition:**
   - **Orientation**
     - Orientation to Person

       What is your name?

       Who am I?

       Who is she?

       Who is he?
     - Orientation to time

       What is time now?

       What time of day it is?

Contd...

- Orientation to place
  Where are you right now?
  In which city you are residing?

- **Attention and concentration:**
  Serial Seven Subtraction Test for Assessment of Concentration
- **Memory:**
  Immediate:
  Repeat after me. 3, 6, 8, 9, 2, 1
  Recent (last 24–72 hours)
  - I will say three things to you. After some time, repeat them.

  A plain paper, ginger tea, red flower.
  - What did you eat for breakfast?

  Long-term (remote memory)
  - When did you get married?
  - Tell me name of your class teacher in class X.
- **Abstract reasoning:**
  Q. What do you understand by proverb?
  For example: A friend in need is a friend indeed.
  Q. What is similarity between apple and orange?
  Q. How does apple and orange differ?
- **Intelligence:**
  - Who is the prime minister of India?
  - Which city is capital of India?

6. **Judgment:**
   - Test Judgment
   - What will you do if you find a letter on a road on which there is address and it is stamped?
   - Personal Judgment
   - What will you do after being discharged from hospital?
7. **Insight:**
   - Do you think you are sick?
   - Is your illness physical or mental?

Mini-mental Status Examination

The Mini Mental Status Examination (MMSE) is a 30-point questionnaire which is used in clinical settings to measure cognitive impairment.

It is a screening test for dementia and is able to assess severity and progression of cognitive impairment.

MMSE can be done in 5–10 minutes and it will evaluate registration, attention and calculation, recall, language and ability to follow simple commands and orientation.

Category	Possible points	Description
Orientation to time	5	From broadest to most narrow.
Orientation to place	5	From broadest to most narrow.
Registration	3	Repeating named prompts

Contd...

Category	Possible points	Description
Attention and Calculation	5	Serial seven subtraction test OR Spelling word backwards.
Recall	3	Registration recall
Language	2	Naming a pencil and a watch
Repetition	1	Speaking back a phrase
Complex commands	6	Varies, can involve drawing figure shown

Interpretations of MMSE

- Total score = 30
- A score of 24 or more = Normal cognition
- A score of 19–23 = Mild cognitive impairment
- A score of 10–18 = Moderate cognitive impairment
- A score of 9 or less = Severe cognitive impairment

INTERVIEW TECHNIQUE

Interviewing technique is also known as process recording. Interviewing signifying collecting client's life stories and experiences in relation to the cause and presenting mental illness.

- It is the basic technique of collecting significant information related to client's past life history which has shaped presenting mental sickness.
- It is an important evaluation made by a student nurse, which is helpful to make nursing diagnoses and accordingly plan the care.
- Interviewing the client can help establish a strong nurse patient relationship.

Location or setting in which interview can take place:

- Psychiatric inpatient units
- Outpatient department
- Psychiatric nursing homes
- Psychiatric rehabilitation unit

Seating arrangement: The interviewer (student nurse) and client need to sit face to face at the same level, i.e., preferably chairs of the same height.

Length of interview: It depends on the setting in which interview is going to take place and objectives of the interview. On an average, 45–90 minutes are mandatory for a therapeutic interview. For an initial interview, 20–30 minutes are required and may be planned accordingly in consecutive sessions.

Techniques of Interview Technique

Interview is not a general conversation between two persons. It must have following techniques to be followed to have a therapeutic interview.

- **Introduction:** The student nurse and client need to introduce themselves to each other before initiating the interview.

- **Informed consent:** The student nurse should explain the purpose of the interview and encourage the client to share the topics about which he wants to be interviewed. For this purpose, an informed consent should be obtained from client.
- **Confidentiality:** The student nurse should maintain confidentiality of the shared information. It shouldn't be shared with any other person unless it is mandatory to have a therapeutic alliance.
- **Privacy:** The location of interview needs privacy to encourage true expression of feelings and emotions. Therefore, it should be done in a private room. If it is not possible, make sure, client's talk is not being heard by others.
- **Empathy:** Empathy can be defined as considering oneself in another person's situation and understand how it feels. A student nurse must be empathetic to client's expression of emotions. This empathy must be conveyed via non-verbal expressions such as nodding, leaning forward, silence, etc.
- **Nurse-patient relationship:** NPR is the most essential requirement for an efficient interview. If NPR is good, client will be more comfortable to share his personal and private details. If client feels that student nurse really wants to help, he/she will express more of information and feelings with a strange person. These feelings may be very personal and private. Therefore, student nurse should be of considerate help.
- **Respectful environment:** Client must feel secured and respected to ensure a therapeutic interview. Client's problems may already be related to humiliation, criticism and disrespect by others. Therefore, if student nurse respects client's feelings, he/she will feel more secure and safe to share information.
- **Patient centered approach:** The interview must be focused on client to ensure professionalism. No personal information should be shared by student nurse unless it is of therapeutic in nature. It is also helpful to make client centered nursing care plans.
- **Open-ended questions:** Student nurse needs to ask only open-ended questions in interview as they allow more expression of thoughts. Instead of asking, "Are you still in pain," student nurse should ask, "Please tell me about your pain now." As patient starts sharing information, student nurse may ask more close-ended questions to maintain the continuity of interview and achieving objectives of interview.

Interview Technique Format

General identification data:
Name of client
Age
Gender
Educational status
Occupation and working status
Date and time of interview
Location of interview
Client's willingness to share information

Goals of process recording. It can be general or specific.
For example, to take school history (A specific goal)
To trace out all psychosocial factors in relation with causation of disease. (A general goal)

Diagnosis of client:

Participant	Conversation	Therapeutic technique used	Inference
Nurse			
Client			
General conclusion of interview _____			

ASSESS YOURSELF

Long/Short Answer Questions

1. Write a short note on interview technique.
2. Define mental health.
3. Define following terms:
   a. Hallucination
   b. Echolalia
   c. Tangentiality
   d. Perseveration
   e. Obsession
   f. Incoherence
   g. Delusion of grandeur
   h. Insight
   i. Illusion
   j. Echopraxia
   k. Affect
   l. Flight of ideas
4. Write a short note on types of delusions.
5. Describe role of a nurse in observation, reporting and recording of mentally sick.

Multiple Choice Questions

1. Imitation of words of examiner is known as:
   a. Mannerism
   b. Echopraxia
   c. Echolalia
   d. Tics

2. A person perceives rope as a snake, what kind of perception it is?
   a. Visual hallucination
   b. Illusion
   c. Depersonalization
   d. Derealization

3. A person gives many unnecessary details and finally reaches its goal and answers question. This is known as:
   a. Tangentiality
   b. Circumstantiality
   c. Derailment
   d. Perseveration

4. A student nurse asked to a patient, "What will you do if you find a letter on a road on which there is address and it is stamped? What she has to evaluate?"
   a. Test judgment
   b. Abstract thinking
   c. Insight
   d. Personal judgment

5. When a client complains that everybody around is talking about him. What does it signify?
   a. Delusion of grandeur
   b. Idea of reference
   c. Delusion of persecution
   d. Delusion of control

6. Insight is:

a. Curiosity about mental illness
b. Anxiety about mental illness
c. Awareness about mental illness
d. Denial of mental illness

7. If a client feels indifferent or like his/her body has been changed, a nurse will make a conclusion that client is having:

a. Delusion
b. Derailment
c. Depersonalization
d. Derealization

8. A client stated that this world will soon come to an end. What it is signifying?

a. Suicidal Ideation
b. Nihilistic Delusions
c. Flight of ideas
d. Obsessional thoughts

9. A client always gives answers in a rhythmic manner. What it is called as?

a. Neologism
b. Thought block
c. World salad
d. Clang association

10. Which of the following is not a component of psychiatric nursing history?

a. Family history
b. Medical history
c. Thought process
d. Presenting complaints

11. To assess abstract thinking of client, a student nurse should ask about which of the following?

a. Educational qualification
b. Mathematical calculation
c. Daily routine
d. Proverb

12. While answering a question, a client suddenly stops and is not able to initiate the conversation again, this is known as:

a. Disinterest
b. Anger
c. Thought block
d. Loosening of associations

13. Mental function of the brain which collects, processes and retains the information is known as:

a. Thought
b. Memory
c. Abstract reasoning
d. Intelligence

14. The outward expression of emotions is known as:

a. Mood
b. Effect
c. Affect
d. Thought

15. For an initial interview, length of the session should be:

a. 1 hour
b. 10–15 minutes
c. 20–30 minutes
d. 45–90 minutes

ANSWERS KEY

1. c **2.** b **3.** b **4.** a **5.** b **6.** c **7.** c **8.** b **9.** d
10. c **11.** d **12.** c **13.** b **14.** c **15.** c

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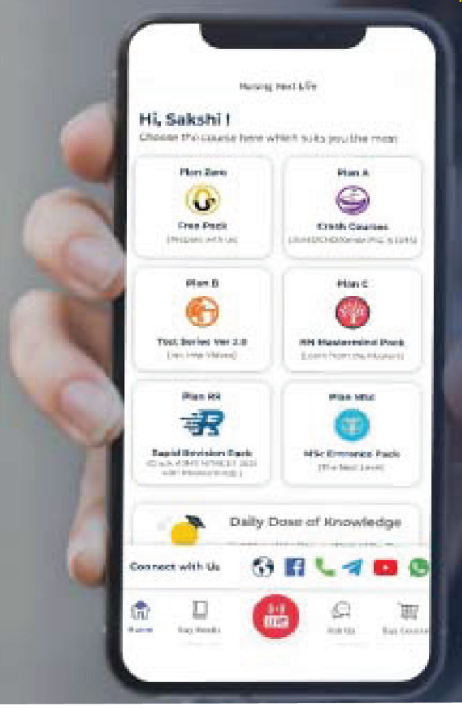

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Unit

4

THERAPEUTIC NURSE-PATIENT RELATIONSHIP

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Describe therapeutic nurse-patient relationship, its phases and therapeutic and non-therapeutic communication techniques.

UNIT OUTLINE

- Definitions
- Components
- Phases
- Importance of Therapeutic Nurse-patient Relationship
- Communication

KEY POINTS

- A therapeutic nurse-patient relationship is a mutual sharing experience in which nurse uses personal aptitudes and skills to bring correct behavior and insight in patient.
- It is mandatory for a psychiatric nurse to have maturity in conduct and in mind to have a therapeutic nurse-patient relationship.
- A psychiatric nurse must demonstrate respect for dignity and human rights of mentally sick patients.
- Therapeutic nurse-patient relationship plays an important functional tool of mental health care.
- A psychiatric nurse's own misconceptions can hinder the progress of a therapeutic nurse-patient relationship.
- Communication is the exchange and flow of information and ideas from one person to another; it involves a sender transmitting an idea, information, or feeling to a receiver.

DEFINITIONS

- "When we treat man as he is, we make him worse than he is. When we treat him as if he already were what he potentially could be, we make him what he could be." —**Johann Wolfgang von Goethe**
- A therapeutic nurse-patient relationship is a helping relationship for a corrective emotional experience of a patient with a basis of mutual learning experience.
- A therapeutic nurse-patient relationship is a mutual sharing experience in which a nurse uses personal aptitudes and skills to bring correct behavior and insight in patient.
- A therapeutic nurse-patient relationship is sum total of emotional experiences in which nurses take the lead to have a supportive interaction which is aimed to bring quality of life and well-being for a patient.

COMPONENTS

To have an effective nurse-patient relationship, some of the important requisites which form the components of a therapeutic NPR are mandatory. These components are briefly discussed here.

- **Altruism:** It is an ego defense mechanism in which an individual exhibits the character of helping and supporting other humans who may or may not be suffering with the same psychological stressors. In this way, a person experiences inner mental peace and contentment. It is a mature defense mechanism. It is mandatory for a psychiatric nurse to have maturity in conduct and in mind to have a therapeutic nurse-patient relationship. A nurse must be willing to help others to be an effective helper.
- **Ethics:** It refers to the moral principles of an individual which constitutes his/her conduct in a given situation. Ethics form the conscience of an individual. A psychiatric nurse must have strong ethical principles for professionalism and health care society. Following ethical principles need to be shared by a psychiatric nurse.

Ethical principles	Description
Fidelity	A psychiatric nurse must keep her promises with a mentally sick patient as well as promise (Nurses pledge) toward nursing (serving) profession.
Autonomy	Psychiatric health care facilities keep psychiatric nurses accountable and responsible for their decisions. Decisions are a routine in psychiatric set-up for nurses. Therefore, a psychiatric nurse must have an ethical principle of autonomy, i.e., an ability to take independent decisions.
Beneficence	Beneficence means to benefit others. A psychiatric nurse must be willing to benefit mentally sick patients by providing quality care. A nurse's every action should be of beneficence.
Non-maleficence	When a nurse practices beneficence, she must take into consideration non-maleficence, i.e., doing no harm or least harm while providing benefits.
Equity	It refers to fairness in all situations. A psychiatric nurse must provide care without discrimination on the basis of color, caste, race, ethnicity, country, etc.

- **Self-awareness:** The window to outside is a window to inside. Campbell (1980) has acknowledged a holistic nursing model of self-awareness which consists of four components.
  - **Psychological component:** It consists of an individual's emotions, motivations, self-concept and personality. When an individual (nurse) knows one's own feelings and thoughts and is aware of their influence on others; he/she will be able to practice loyalty, love and care.
  - **Physical component:** It is an individual's awareness of one's body image, potentials and body physiology. Awareness of the physical component resolves psychological conflicts of an individual.
  - **Environmental component:** Environmental component of self-awareness talks about socio-cultural environment. Acknowledgement of relationships between humans, society and nature is helping to develop morals, ethics and creativity.
  - **Philosophical component:** An individual is having no meaning and purpose for his life unless he/she resolves the quest of his philosophy. It includes, "Why I am on this earth"? "Why I need to relate to others"? "Who I am to society?" "What is my contribution to life and death?" The answers to these questions do form the philosophy of an individual which is a mandatory component of self-awareness.
  - This model can be used to increase self-awareness which can further enhance growth of patients.
- **Honesty:** A psychiatric nurse must be honest and deal with mentally handicapped persons with a transparency. He/she should never mislead or deceive the mentally sick people as they are sometimes not able to take independent decisions.
- **Integrity:** It means to do right even if no one is an overseer. A psychiatric nurse must be upright and have courage to fight for one's beliefs and practice righteousness.
- **Loyalty:** A psychiatric nurse is worthy of trust. He/she should demonstrate loyalty to patients, colleagues and institution. A psychiatric nurse must maintain confidentiality, i.e., not sharing patient's information with others unless it is consented or required by law.
- **Respect and trustworthiness:** A psychiatric nurse must demonstrate respect for dignity and human rights of mentally sick patients. A psychiatric nurse should be impartial in his/her interventions. A psychiatric nurse needs to be a dependable and trustworthy health care professional.

- **Accountability:** A psychiatric nurse is accountable for his/her actions taken for mentally sick patients, community and institutions.
- **Sympathy:** It refers to the care and concern for the mentally sick patients. It is feeling of pity for the condition of the mentally sick.
- **Empathy:** Empathy implies realizing the emotions and concerns of mentally sick patients by placing oneself in his/her condition. Empathy is more efficient tool to comprehend mentally sick's thoughts and emotions.

PHASES

There are four phases of a therapeutic nurse-patient relationship which are applied to all clinical conditions. These phases are discussed here in brief.

1. **Preinteraction phase:** As the name suggests, preinteraction phase begins before actual encounter between a psychiatric nurse and patient.
   Tasks of preinteraction phase:
   - **Self-exploration:** The psychiatric nurse's first task in pre-interaction phase is self-exploration in which he/she explores one's fears, prejudices, anxieties and misconceptions. A psychiatric nurse's own misconceptions can hinder the progress of a therapeutic nurse-patient relationship. So, he/she must explore what all misconceptions are causing fears and anxieties in him/her. He/she must learn about facts and corrects the conduct.

     In the beginning, a student psychiatric nurse may feel inefficient, inadequate to deal with the patient. He/she may be afraid and nervous about mentally sick patient. He/she may not have adequate knowledge and experience to deal with mentally sick patients.

     Some of the mentally sick patients because of their symptoms of mental illness may not talk with new student psychiatric nurses. They may reject them altogether. This can further increase the anxiety of student psychiatric nurse.

     To deal with all these fears, prejudices and misconceptions, self-exploration is mandatory. This can be done through adequate knowledge and by working under supervision. A student psychiatric nurse must work on his/her own self-esteem and self-concept which needs to be strong enough to shake with little rejection and avoidance. A student psychiatric nurse must never forget his/her strengths and potentials and her previous clinical experience which may or may not be with mentally sick clients.
   - **Data collection:** The other important task of pre-interaction phase is collection of patient's information through other sources except patient himself. The psychiatric nurse may read the clinical file of the patient and can get information regarding diagnosis, clinical course of disorder, medications and patient's current mental status.
   - **Planning for the first encounter/ interaction:** This task is a planning task. A student psychiatric nurse plans his/her first interaction with mentally sick patient. He/she decides the venue, duration and nursing care in first interaction. This planning may exhibit under supervision of a clinical instructor or nursing staff working in the psychiatric health care area.
2. **Introductory phase or orientation phase:** This phase is the actual interaction between a psychiatric nurse and a mentally sick patient. In orientation phase, patient and psychiatric nurse get to know one another.

Tasks of interaction phase:

- **Build rapport**, i.e., a sense of mutual respect and trust between two people as a result of share of emotions and thoughts.
- **Establish a contract** between a psychiatric nurse and mentally sick which suggests the expectations and obligations of both parties. A contract set limits over therapeutic nurse-patient relationship.
- **Data collection:** A psychiatric student nurse now gathers data from mentally sick patient to verify it with clinical record and reliable referent (relative/guardian).
- **Make nursing diagnoses:** On the basis of clinical signs and symptoms of mentally sick, a student psychiatric nurse makes nursing diagnoses with paper and pen and record it.
- **Make nursing care plan till planning phase:** A psychiatric nurse develops planning of nursing care and formulates the care he/she is going to provide to psychiatric ill.
- **Interaction:** Here, a psychiatric nurse and a mentally sick patient actually meet and share feelings and thoughts with one another. This interaction may be superficial in the beginning but as it progresses, it relieves the anxiety of both parties.

3. **Working phase or exploitation phase:** This is the action/active phase of therapeutic nurse-patient relationship. An actual action and work is done here.

   Tasks of working phase

   - **Maintaining trust and rapport:** A psychiatric nurse keeps his/her promises of provision of nursing care which in turn helps in maintaining trust and rapport. He/she fulfils her obligations toward nursing profession and mentally sick patient.
   - **Insight building:** A psychiatric nurse works with client to help mentally sick to gain insight. The psychiatric nurse helps understand the course of mental illness, treatment modalities and etiology of mental sickness. In this way, a client touch with reality is developed.
   - **Problem solving:** A psychiatric nurse sits and works with patient and encourages the expression of emotions, thoughts and problems of the mentally sick. They both work out every problem and try to find out the solutions. Every solution is tested and the best one is implemented to solve the problem.
   - **Overcoming resistance (transference and countertransference):** Transference occurs when a mentally sick unconsciously identifies psychiatric nurse as any person in patient's past. Countertransference is when a psychiatric nurse unconsciously identifies mentally sick as a significant person in his/her life. Both ways, (Countertransference/transference) it will cause a barrier in therapeutic communication.

4. **Termination phase or resolution phase:** Termination of relationship is difficult and troublesome for both parties. Sometimes, due to dependency and sharing between a psychiatric nurse and a mentally sick patient, termination is painful.

   Termination phase begins with admission of client and ends with discharge. A patient is told on day one of hospitalization that relationship is not lasting, will only last till patient is at hospital.

   Tasks of termination phase:

   - Summarizing the work and problem solving approaches learned during working phase.
   - Discussing follow-up and rehabilitation plans
   - Encouraging expression of emotions and thoughts about termination of nurse- patient relationship.

IMPORTANCE OF THERAPEUTIC NURSE-PATIENT RELATIONSHIP

Therapeutic nurse-patient relationship plays an important functional tool of mental health care. Therapeutic NPR brings benefits to both parties. Importance of therapeutic nurse-patient relation can be understood under following headings:

Sl. no	Importance of a therapeutic NPR for a psychiatric nurse	Importance of a therapeutic NPR for a mentally sick
1.	A therapeutic NPR increases a genuine self-respect for oneself.	Patient is being accepted as he/she is. This helps in developing trust in health care professional. Patient is allowed to express his/her thoughts and emotions in a non-judgmental way.
2.	A psychiatric nurse realizes one's own potentials and weakness which in turn increases confidence, self-esteem and professional growth.	Patient realizes his/her own potentials and weaknesses and learns to adapt with the psychological environment which resolves conflicts of patient.
3.	A therapeutic NPR helps in realizing one's self-concept.	A mentally sick patient develops his/her self-concept after realizing oneself.
4.	A therapeutic NPR helps in realizing empathy as a character of psychiatric nurse.	A mentally sick patient appreciates empathetic approach and learns to understand other person's situations. This results in patient's successful return to community and settlement in society.
5.	A therapeutic NPR encourages socialization skills.	A mentally sick patient learns to express emotions and thoughts with a free mind and appreciates effects of catharsis (emotional discharge) on mental health.
6.	A psychiatric nurse learns effective communication skills.	A mentally sick patient learns limit setting on behavior which do not bring mental health.
7.	A psychiatric nurse learns to accept differences of cultures and society.	A mentally sick patient learns to appreciate the presence of a psychiatric nurse in need.
8.	A psychiatric nurse get an insight of own emotions and their control in a therapeutic way.	A mentally sick patient develops an insight of disease condition, its natural course and symptomatology.
9.	A psychiatric nurse develops problem-solving skills.	A mentally sick patient develops problem-solving skills.
10.	A therapeutic NPR brings positive behavior modification.	A mentally sick patient brings positive behavior modification.

COMMUNICATION

Definition and Meaning

- Communication is the means of expression.
- Communication is the way of interacting with oneself and others.
- Communication is a medium of expressing thoughts, emotions and ideas with others.
- Communication is to exchange and impart the information between two or more people.

According to Oxford Dictionary, "communication is imparting or exchanging of information by speaking, writing, or using some other medium."

"Communication is the exchange and flow of information and ideas from one person to another; it involves a sender transmitting an idea, information, or feeling to a receiver." **—US Army**

"A communication takes place when an individual or a sender displays, transmits or otherwise directs a set of symbols to another individual or a receiver, with the aim of changing something, either something the receiver is doing (or not doing) or changing his or her world view. This set of symbols is typically described as a message." **—William Rice-Johnson**

Elements/Essentials/Components of Communication

Communication is an ongoing, dynamic process. Communication process is made up of following components and together, they form communication process. Its basic elements are described below.

Referent

Referent is the motivator which urges an individual to initiate the communication. The basic principle of communication in psychiatric health care area is 'talk with a purpose'. This purpose establishes the motivation for communication. For example, an Alzheimer's patient who is not able to tie knot of his/her pajama, will initiate talk with a nurse for help. This need which motivates the talk is referent element of the communication.

Sender and Receiver

The person who delivers the message is known as Sender and the one who receives the message is known as Receiver. The sender expresses his/her thoughts and ideas in an understandable form and sends it to the receiver through a medium.

The sender's message acts as a referent (motivator) for the receiver who then translates the message and responds accordingly.

Messages

Content of communication is the message element. The message can be in verbal, non-verbal or symbolic form. How effectively a message is communicated will decide the effectiveness of communication. Two psychiatric nurses may be talking on the same topic with patient, but the message which is communicated effectively will have a lasting impact on patient. Effective message will bring effective responses as they will be interpreted right.

Channels

Channels are the means of conveying the messages through verbal, non-verbal or symbols.

- The message may be visual through facial expression.
- Hearing of a message through ear is a kind of auditory message.
- Therapeutic touch is a kind of tactile message.

The greater the number of used channels, more effective the communication will be.

Feedback

Feedback is the returned message. Right feedback is an indication of correct comprehension of the message. In a therapeutic nurse-patient relationship, feedback by a patient decides efficiency of a psychiatric nurse. Therefore, a psychiatric nurse assumes the responsibility of an effective communication.

Interpersonal Variables

The factors other than sender and receiver, which influence the communication are known as interpersonal variables that exist within the receiver and sender. Following are the interpersonal variables that influence the communication:

- Perception
- Educational status
- Socio-cultural background
- Developmental level (age/maturity)
- Ethics
- Emotional tone
- Gender
- Physical health
- Pain
- Anxiety

Environment

The setting in which sender and receiver interact is the environment of communication. Following are the factors in environment which influences efficiency of communication.

- Noise
- Temperature
- Comfort
- Safety
- Privacy
- Personal space
- Discomfort
- Confusion
- Distractions
- Mental tension

The more conducive the environment in which communication takes place, more effective communication will happen.

Elements of Professional Communication

- **Uniform of the nurse:** A nurse's uniform communicates that she has dressed for professional help. It also demonstrates that he/she is clinically skilled. Uniform also communicates trustworthiness and a professional appearance.
- **Call by name:** In interaction phase, nurse and patient both introduce oneself to each other. No other way such as auntie, uncle, sir, madam is used in professional set-up. Instead, nurse calls patient by his/her name.

- **Eye-contact:** Maintaining eye contact demonstrates willingness and participation in the communication. When a nurse maintains eye contact while communicating with patients, it gives recognition to patients and helps in improving their self-esteem.
- **Privacy and confidentiality:** Confidentiality is a professional conduct, i.e., a nurse is obliged to maintain it and he/she will not share patient's information with others unless it is consented or required by law. Patient's feelings are respected and protected when a psychiatric nurse keeps privacy while providing care.
- **Courtesy:** Courtesy is practiced by a nurse by saying, hello, good-bye and introducing self, knocking the door before entering, saying please and thank you and apologizing for a mistake.
- **Assertiveness:** It means protecting or defending one's own rights without violating the rights of another person. When a psychiatric nurse is clear, open and honest in his/her communication, he/she will be more respected. Assertiveness also helps us to take prompt decisions. It is helpful in avoiding unnecessary aggression. Assertive talk starts with 'I' statements such as I think, I want, I feel.
- **Trustworthiness:** Trust in a psychiatric nurse by his/her client is the backbone of professional endeavor. A psychiatric nurse fosters trust in his/her patients by maintaining consistency, routines, honesty and responsibility for work.
- **Autonomy and responsibility:** A psychiatric nurse must be autonomous, i.e., takes independent decisions and also holds the responsibility for his/her decisions.

Types of Communication

A therapeutic nurse-patient relationship is successful only with an effective communication. A psychiatric nurse and a mentally sick communicate in many ways through verbal (use of spoken words) and non-verbal (facial expression, body language, gestures, gait, etc.). On the basis of different channels used, communication can be of following kinds:

- Verbal communication
- Non-verbal communication
- Symbolic communication
- Meta-communication

Verbal Communication

Verbal communication is the use of written and spoken words by using a vehicle of language for communication. In verbal communication, message is being conveyed verbally by words of mouth or in writing with a paper and pen.

Acronym for verbal communication is: KISS (Keep it short and simple). A verbal message is said to be successfully communicated if it is understood in the same context in which it was said. A person who is verbally communicating has his own values, ethics, attitudes and aptitudes when he/she is conveying a message and these all factors do influence the effectiveness of verbal communication.

Verbal communication is of two types:

1. **Oral communication:** Oral communication includes face to face conversation, telephonic conversation, video conversation and radio conversation. Oral communication is influenced by audibility, volume and clarity of message.
2. **Written communication:** Written communication is the use of written words, signs and symbols for conveying a message. Written messages can be conveyed through letter, emails, records, reports, pictorial presentations, etc. Written communication is influenced by knowledge of language, its vocabulary and grammar.

Non-verbal Communication

Non-verbal communication is the communication which occurs without use of spoken words. Non-verbal communication happens with the use of facial expressions, gesture, posture, tone of voice and body language. Actions speak louder than words. Non-verbal communication is more effectively communicated without manipulation. A message is said to be accurate and honest if verbal and non-verbal communication both are conveying the same meaning and comprehension.

Symbolic Communication

Communication via use of symbols is known as symbolic communication. The forms of symbolic communication are Arts, Music, Dreams, Drawings, Metaphorical language and Play. Symptomatology of mental illness is also a kind of symbolic communication which if understood by a psychiatric nurse, can do wonders for mentally sick patients.

Meta-communication

It is a communication to understand a deeper message which was uncovered in the beginning. For example, a mentally sick may state that he is not afraid of anything in the world but expectations. Now a Meta-communication by a psychiatric nurse will be, "I can understand that you were hurt for expecting from people."

Factors Affecting Communication

Communication is influenced by many factors. Following is a list of the factors which are affecting the communication directly or indirectly:

Age

- Age is one of the most influential factors in communication.
- Verbal communication is meant for adults and non-verbal communication is the accent of infants and toddlers who lack knowledge of language, spoken words and sometimes, vocabulary.
- An individual learns mother tongue as his/her first language in which he/she will be more comfortable in talking.
- As age progresses, an individual learns more in language as well as communication skills, which will influence his/her communication pattern accordingly.
- Every developmental stage has different level of communication and as one progresses in age; his/her communication gets maturity.

Gender

- Gender is another important factor which influences communication.
- Males and females communicate differently. Males are less expressive in comparison with females. Males make use of more non-verbal communication and females are more vocal.
- Females are shy in expressing directly. On the contrary, a male's speech is direct.
- Females are soft spoken and males are more audible.
- Men and women not only differ in communication rather they interpret the same communication differently.

Societal/Cultural/Educational Background

- Culture and education also influence communication process.
- An individual's body language, eye-contact and touch are greatly influenced by society, culture and educational status.
- A literate and illiterate person differ greatly in vocabulary while conversations.
- An educated person will communicate very efficiently in writing and reading.
- Today, communication happens through internet emails, YouTube, WhatsApp and other internet based communication resources. Our society and culture has been greatly influenced by internet which in return influences communication pattern greatly.

Personal Space

- Personal space is the space around an individual in which entry of another person is not allowed or is allowed only with consent.
- Intimate zone: 1.5 feet
- Personal zone: 1.5–4 feet
- Social zone: 4–12 feet
- Public: 12–15 feet
- This is a rough measurement of space around an individual. An individual is more comfortable in his/her personal zone and feels uncomfortable if his/her personal space is disturbed.

Environment

- Conducive environment encourages effective communication.
- A noisy, hot environment can irritate an individual's mind and hinder the progress of communication.
- Distractions in the environment also block the communication process.

Attitude

- An attitude is the sum of beliefs, opinions and emotions of an individual toward an event, situation or a person.
- Attitudes of care and affection by a psychiatric nurse will facilitate the communication between a psychiatric nurse and mentally sick patient.
- Lack of interest in the talk of patient will hinder the therapeutic communication.

Perception

- Personality is the sum total of all the innate and acquired dispositions of an individual which shape the perception of an individual.
- Each stimulus is perceived differently by every individual because of his unique personality.
- A psychiatric nurse must be aware of personality of an individual to learn about his perceptions which will be helpful in progression of the communication.

Appropriateness

- A right answer to a question decides the appropriateness of the conversation.
- When to command, when to praise, when to be silent, when to talk; all of these questions exhibit the appropriateness of conversation.

Timing

- A good timing of conversation facilitates the therapeutic communication.
- An answer given at the right time can do miracles for the mentally sick patients.
- Unnecessary talk and vain conversations hinder the communication process.

Roles & Relationships

- A teacher talks the language of a teacher and a student will speak accordingly.
- Roles and responsibilities of an individual differ, so their conversation will be different accordingly.
- A psychiatric nurse is more responsible in a therapeutic NPR rather a mentally sick patient.
- Content of the conversation is shaped by roles and responsibilities of the individual.

Therapeutic Communication

A communication is said to be therapeutic when it is fostering comprehension of emotions and thoughts to bring healing.

Words are powerful tools. With encouraging words, a positive result in recipient will come. On the contrary, if words are to belittle others, a negative result will come.

The Bible reads, "like there are golden apples in silver buckets, like the words said at the perfect time."

Therefore, a therapeutic communication is a healing conversation between psychiatric nurses and mentally sick. Therapeutic communication must be non-judgmental and to promote trust in both parties.

Therapeutic communication is a need based conversation and no vain talking. Therapeutic communication is decent and sober talk.

Communication Skills (Therapeutic Communication Techniques)

There is a must need for a psychiatric nurse to learn therapeutic communication techniques so as to bring healing in his/her words. The following is a list of therapeutic communication techniques with explanation and examples:

Sl. no.	Therapeutic communication techniques	Description with example
1.	**Silence**	Not every question is having a verbal answer. Sometimes, silence is the best answer. Silence allows mentally sick to recollect and reflect his/her thoughts and emotions.
2.	**Observation**	A psychiatric nurse needs to verbalize what is being observed by him/her. For example: You are looking tense. I am sensing your discomfort.

Contd...

Sl. no.	Therapeutic communication techniques	Description with example
3.	**Restating**	Repeating the sentence of the mentally sick is called restating. Restating the thought of mentally sick allows free expression and a sense of being understood. For example: A mentally sick say, "My mind wanders." A psychiatric nurse may restate the words, "Your mind is wandering."
4.	**Reflecting**	Emotions and thoughts of the mentally sick are reflected back onto him to make him understand his emotions and thought to bring acceptance. For example: A mentally sick says, "I don't understand what is to be done for my drinking habits?" A psychiatric nurse may reflect it by stating, "What do you think you should do?"
5.	**Focusing**	When a mentally sick talks about one idea repeatedly. It is a signal for a psychiatric nurse that he/she is bothered by that idea in his/her mind. Here, a psychiatric nurse can use focusing and bring patient's focus on that particular idea. For example: I think we need to talk more about your marital affairs.
6.	**Comparison**	A psychiatric nurse may encourage mentally sick to compare his/her life events; Happy and sad events altogether. For example: When this crisis comes, "It is the usual behavior exhibited by you to overcome it, is not it?"
7.	**Description**	The mentally sick experiencing hallucinations can be asked to describe his perceptions. For example: Do you hear those voices now?
8.	**Acceptance**	"Accepting the patient as he is" is the first principle of psychiatric nursing. This is a wonderful therapeutic communication technique which is very effective in all the situations. For example: Eye contact nodding, etc.
9.	**Recognition**	A psychiatric nurse acknowledges the thoughts and emotions of the mentally sick. For example: I noticed that you did well in gardening today.
10.	**Broad opening**	A psychiatric nurse should ask the client to initiate the conversation and bring the most needed thought to be discussed on the surface. For example: What would you like to talk about today?
11.	**Time and sequence**	A psychiatric nurse must learn and practice time and sequence to find out occurrence of events in relation with it. For example: When was the beginning of the panic attack?

Contd...

Sl. no.	Therapeutic communication techniques	Description with example
12.	**Exploring**	A psychiatric nurse may go deeper into the conversation about a particular topic which he/she finds fit for exploration. For example: Please explain it in detail so we can discuss it more clearly.
13.	**Reality presentation**	When a mentally sick is experiencing misperception, i.e., illusions or hallucinations, then a psychiatric nurse must present reality instead of being a part of it. For example: I know the voices are real to you but I don't hear them.
14.	**Clarification and validation**	When a psychiatric nurse is not able to comprehend the message of a patient, then he/she must clarify it and validate to avoid miscommunication. For example: I am not getting you, can you explain it again?
15.	**Self-offering**	A psychiatric nurse must exhibit unconditional care and affection. This self-offering attitude increases confidence in psychiatric nurse and allows progress of therapeutic communication.

Barriers of Communication (Therapeutic Impasse/Non-therapeutic Communication Techniques)

Many of the non-therapeutic communication techniques are said to be barriers in therapeutic communication. Following are the non-therapeutic communication techniques which hinder the therapeutic communication between a psychiatric nurse and a mentally sick patient.

Sl. no.	Barrier/non-therapeutic communication technique	Description
1.	**Transference**	Transference occurs when a mentally sick unconsciously identifies psychiatric nurse as any person in patient's past. For example, treating psychiatric nurse as a sister, wife, girlfriend, etc. This is a block in therapeutic communication.
2.	**Countertransference**	Countertransference is when a psychiatric nurse unconsciously identifies mentally sick as a significant person in his/her life. Both ways, (Countertransference/transference) it will cause a barrier in therapeutic communication.
3.	**Advising**	Advices are seldom welcome when they are needed the most. A mentally sick patient is not in a condition to be advised for, "What is to be done? How is to be done? For example: Instead of advising, a psychiatric nurse says, "What is your suggestion for this matter?"

Contd...

Sl. no.	Barrier/non-therapeutic communication technique	Description
4.	**Reassuring**	When we underestimate the significance of the problem and say, "There is no need to worry? Why are you bothering so much, this is not that big issue?" This kind of reassurance is a hindrance for therapeutic communication.
5.	**Belittling emotions expressed**	When a nurse lacks empathy and does not understand the degree of problem and promptly gives a judgmental answer, "This is very common. Everybody feels that way some or the other time during lifetime."
6.	**Asking why of the behavior**	When a psychiatric nurse demands explanation for every thought and behavior of the mentally sick, it results in non-therapeutic communication. For example: Why are you doing that? Why do you feel that way?
7.	**Agreeing/disagreeing**	When a psychiatric nurse labels the behavior as good or bad/right or wrong, it acts as a barrier in communication. A psychiatric nurse must be non-judgmental in his/her approach.
8.	**Defending**	When a mentally sick is criticizing any person, event or situation; psychiatric nurse should not defend the opposite side. A mentally sick may assume psychiatric nurse as an opposition. For example: In our hospital, every psychiatric nurse is an efficient professional; there is not any chance of mistake.
9.	**Approval/disapproval**	When a psychiatric nurse approves or disapproves a patient's behavior; it brings an idea to the mentally sick that all of his actions must assure nurses' agreement. This gives nurse a right to be judgmental which a non-therapeutic technique is. For example: I will be glad if you can……..
10.	**Probing**	When a mentally sick do not have trust in a psychiatric nurse, he/she may not be willing to answer the questions being asked by psychiatric nurse. In this case, asking the client time and again continuously can hinder the therapeutic communication. Persistently asking the same question, i.e., probing can irritate a mentally sick's mind.
11.	**Acknowledging supernatural powers**	When a psychiatric nurse holds responsibility of thoughts and emotions onto supernatural powers. For example: This is the will of God, I am no one in front of universe. This will bring a mentally sick's mind to projecting and blaming his/her thoughts onto external powers which are not healthy defense mechanisms.
12.	**Rejection**	When a psychiatric nurse rejects mentally sick and does not pay heed to his/her thoughts and emotions, it hinders the communication from patient's side.

Contd...

Sl. no.	Barrier/non-therapeutic communication technique	Description
13.	**Change the topic**	When a mentally sick has initiated the conversation on a specific topic; instead of listening to him/her, if a psychiatric nurse will change the topic accordingly; then it will bring a barrier in therapeutic communication.
14.	**Denial**	A psychiatric nurse must never deny the existence of a problem. Denial will block the therapeutic communication process.

ASSESS YOURSELF

Long/Short Answer Questions

1. a. Define nurse-patient relationship.
b. List down the phases of NPR.
c. Explain any one phase of NPR.

2. a. What is communication?
b. List down five essentials/components of communication process.
c. Mention five communication skills.

Multiple Choice Questions

1. Which among the following is not a non-verbal communication?
a. A written statement
b. Facial expression
c. Posture
d. Eye-contact

2. Which of the following is not a therapeutic communication technique?
a. Exploration
b. Silence
c. Probing
d. Restating

3. Which of the following is not a non-therapeutic communication technique?
a. Changing the topic
b. Probing
c. Reflecting
d. Defending

4. Which among the following is influencing the communication?
a. Age and socio-cultural background
b. Developmental stage
c. Education and vocabulary
d. All of these

5. Which of the following is not an element of professional communication?
a. Courtesy
b. Discomfort
c. Assertiveness
d. Autonomy

6. Which of the following is not an element of communication?
a. Referent
b. Personal space
c. Message
d. Feedback

7. When you are not sure about right answer, what should be your approach while conversation with a patient?

a. Restating
b. Reflecting
c. Broad-opening
d. Silence

8. When a psychiatric nurse allows patient to initiate the talk, he/she is using which of the following therapeutic technique?

a. Broad opening
b. Advising
c. Reassurance
d. Self-offering

9. "Everybody feels that way some or the other time during lifetime." This demonstrates:

a. Self-offering
b. Reassurance
c. Belittling the emotions expressed
d. Approval

10. When a mentally sick unconsciously identifies psychiatric nurse as any person in patient's past. This concept is known as:

a. Countertransference
b. Identification
c. Transference
d. Validation

11. "Please explain it in detail so we can discuss it more clearly." A psychiatric nurse demonstrates:

a. Probing
b. Exploration
c. Clarification
d. Reassurance

12. Sum of beliefs, opinions and emotions of an individual toward an event, situation or a person is known as:

a. Personality
b. Attitude
c. Affection
d. Spirituality

13. A psychiatric nurse blames supernatural powers for the occurrence of an event is a kind of:

a. Therapeutic communication
b. Non-therapeutic communication
c. Belittling the emotions expressed
d. Agreeing to supernatural power

ANSWERS KEY

1. a **2.** c **3.** c **4.** d **5.** b **6.** b **7.** d **8.** a **9.** c
10. c **11.** d **12.** b **13.** d

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Unit

5

MENTAL DISORDERS AND NURSING INTERVENTIONS

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Describe the etiological factors of various mental disorders.
- Explain the psychopathology of various mental disorders.
- Know about various mental disorders and their treatment modalities.

UNIT OUTLINE

Introduction to Mental Disorders and Nursing Interventions

- Definitions
- Psycho-pathophysiology of Human Behavior
- Cell of Nervous System
- Etiological Theories (Genetics, Biochemical, Psychological)
- Psychosexual Stages of Development
- Classification of Mental Disorders
- Mental Disorders

5A: Personality and Types of Personality Related to Psychiatric Disorders

- Personality
- Personality Disorder
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder/ Passive-Dependent Personality
- Obsessive Compulsive Personality Disorder

5B: Neurocognitive Disorders (Organic Mental Disorders): Delirium, Dementia

- Delirium
- Dementia

5C: Schizophrenia Spectrum Disorders

- What is Psychosis
- Schizophrenic Disorders/Schizophrenia
- Course of Schizophrenia
- Types of Schizophrenia
- Prevalence
- Epidemiology
- Etiology
- Endocrine Disorders
- Immune System
- Brain Structural and Functional Abnormalities
- Signs and Symptoms
- Premorbid History of Schizoid or Schizotypal Personality Disorder
- Disorders of Perception Such as Illusions and Hallucinations
- Disorders of Thought
- Treatment for Registant Patients
- Psychological Management

5D: Other Schizophrenic Disorders

- Schizoeffective Disorder
- Schizophreniform Disorder
- Delusional Disorder
- Shared Psychotic Disorder
- Brief Psychotic Disorder

5E: Mood (Effective) Disorders: Mania, Depression and Bipolar Effective Disorder (BPAD)

- Mood Disorders
- Depression/Major Depressive Disorder/ Unipolar Depression
- Mania
- Bipolar Effective Disorder
- Bipolar Disorder

5F: Neurotic Disorders

- Introduction
- Phobia
- Anxiety Disorders
- Depressive Neurosis
- Conversion Disorder
- Dissociative Reaction
- Depersonalization/Derealization Disorder
- Dissociative Identity Disorder
- Psychosomatic Disorder/Somatic Symptom Disorder/Hypochondriasis
- Illness Anxiety Disorder
- Nursing Care Plans

5G: Obsessive Compulsive Disorder (OCD)

- Definition
- Prevalence
- Etiology
- DSM-5 Diagnostic Criteria for OCD
- Prognosis
- Medical Management

5H: Trauma and Stress-related Disorders

- Introduction
- Definitions
- Prevalence
- Etiology
- Post-traumatic Stress Disorder
- Prognosis
- Medical Treatment

5I: Substance Use and De-Addiction: Alcohol, Tobacco and Other Psychoactive Substance

- Terminologies Related to Substance Use
- Types of Substance Use
- Prevalence
- Etiology
- Comorbidity
- Classification of Substance Use Disorders
- Alcohol Use Disorders
- Caffeine-related Disorders
- Cannabis Use Disorders

5J: Sleep Disorders

- Characteristics of Sleep
- Stages of Sleep
- Physiology of Sleep
- Regulation of Sleep
- Functions of Sleep

Contd...

- Normal Sleep Requirements
- Classification of Sleep Disorders

5K: Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa

5L: Sexual Disorders

- Introduction
- Terminology Related to Sexuality
- Components of Sexual History
- What are Sexual Dysfunctions?
- Male Hypoactive Sexual Desire Behavior
- Female Sexual Interest/Arousal Disorder
- Male Erectile Disorder
- Female Orgasmic Disorder
- Delayed Ejaculation
- Premature Ejaculation
- Sexual Pain Disorders

5M: Child and Adolescent Psychiatry Disorders

- Introduction
- Intellectual Disability
- Communication Disorders
- Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder
- Specific Learning Disorder

KEY POINTS

- Psychological disturbances can cause physiological disorders and in the same way, physiological disturbances can cause psychological disorders.
- Cell is the basic structural and functional unit of the human body. Neuron is the cell of nervous system, i.e., basic structural and functional unit of nervous system.
- Each section of brain is having cerebrospinal fluid filled cavities known as ventricles.
- Dissociative amnesia is characterized by an inability to recall painful memories of traumatic or stressful life events.
- Catatonia is characterized by Waxy flexibility, Mutism and Negativism.
- A mild form of depression is known as Dysthymia.
- An unusual habit of pulling hairs is known as Trichotillomania.
- Somatic delusions are false, fixed belief that one is having disease or his/her body is abnormal or changed.
- Antisocial personality disorder is characterized by not be at peace with societal norms and regulations.
- Borderline personality disorder is characterized by impulsive behavior with self-mutilation and boredom.
- Addictions causing dependence, intoxication, etc. is the basis for substance use disorders.
- Child does a lot of fighting and bullying in conduct disorder.
- Child is having authority rivalry, doesn't like to be controlled is a symptom of oppositional defiant disorder.
- A child likes to ignite fires is a manifestation of pyromania.
- Sleep attacks during day time is known as narcolepsy.
- Abnormal behaviors during sleep, e.g., sleepwalking, speaking while speaking is known as Parasomnia.
- Binge eating may or may not be followed with vomiting is a clinical manifestation of Bulimia nervosa.
- Pseudocyesis is when, a woman has false belief that she is pregnant.
- Factitious disorder is purposely assuming sick role to have benefits of being sick.
- A childhood disorder/adolescent disorder in which person feels fearful to talk with strangers is known as dis-inhibited social engagement disorder.
- Person has repeated a thought that his/her partner is not faithful is a manifestation of obsessional jealousy.
- Depression which occurs at a specific time of year is known as seasonal effective disorder.
- Melancholia is characterized by suicidal ideation and hopelessness.
- Depressive episode of 4–14 days is short duration depressive episode.

INTRODUCTION TO MENTAL DISORDERS AND NURSING INTERVENTIONS

DEFINITIONS

Mental Health (Psychiatric) Nursing is a specialized professional field appointed for practice expertise in the field of mental health for care of individuals, families and community through application of nursing principles and practices.

Physiology is the study of normal functioning of the human body and mind in total. It means physiology deals with functions of human mind and body.

Psychology is the study of human mind and behavior which forms mental characteristics or attitudes of a person. It means psychology of a person is the sum of human mind and behavior which includes mental characteristics and attitudes of a person.

Pathology is the study of disorders. Anything which is not in order is said to be disordered. Therefore, if human body is not in order in terms of its structure or function is said to be disordered.

Psycho-pathophysiology is the relationship between three sciences, i.e., Psychology, pathology and physiology.

The three Sciences are affecting one another and pathology in between (psycho-pathophysiology) signifies that disorders of the human mind and body can be caused by two factors:

1. Psychological disturbances
2. Physiological disturbances

We can conclude that psychological disturbances can cause physiological disorders and in the same way, physiological disturbances can cause psychological disorders.

PSYCHO-PATHOPHYSIOLOGY OF HUMAN BEHAVIOR

The principal organ system responsible for human behavior is Nervous system. Brain is the master organ of human body. The structure of the brain is responsible for every function of the body and even the brain itself. The functional brain is known as mind.

Nervous system is divided into two main divisions:

1. Central nervous system (brain + cranial nerves + spinal cord + spinal nerves)
2. Peripheral nervous system (somatic division + autonomic nervous system)
   - Autonomic nervous system (sympathetic nervous system + parasympathetic nervous system)

Central Nervous System (Brain + Cranial Nerves + Spinal Cord + Spinal Nerves)

The central nervous system is protected by skull (for brain) and vertebral column (for spinal cord).

The Brain (Anatomy and Physiology)

Cerebrum is the largest part of the human brain, which is divided into two hemispheres (superior view). The underneath part of cerebrum is brain stem in front and cerebellum at behind (inferior view) (Fig. 1).
The outermost layer of brain is known as cerebral cortex.

Cerebral cortex consists of four lobes:

1. The frontal lobe
2. The parietal lobe
3. The temporal lobe
4. The occipital lobe

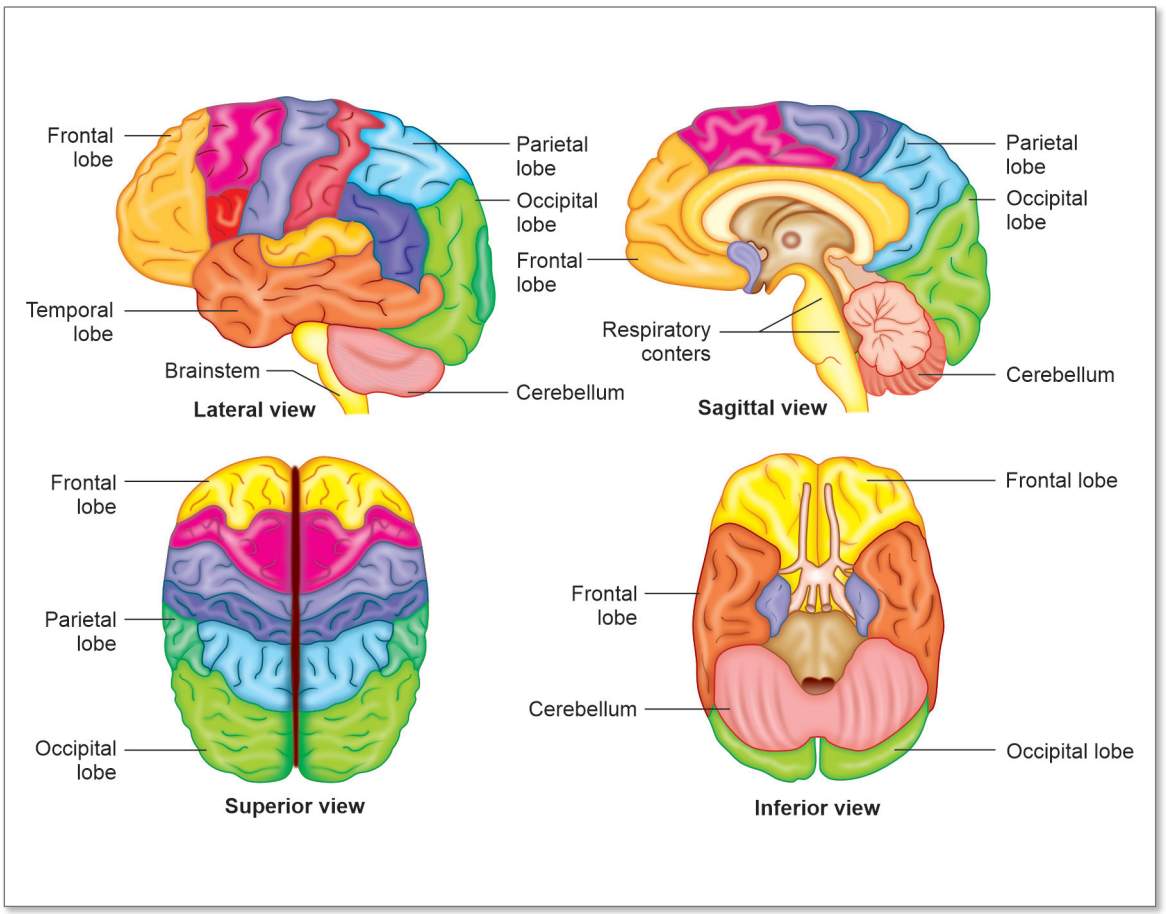


Fig. 1: Human brain anatomy and physiology

Human brain is having three sections:

1. Forebrain (front section) (cerebrum and underlying structures)
2. Midbrain (middle section) (brainstem consists of medulla oblongata, pons)
3. Hindbrain (back section) (cerebellum)

Each section of brain is having cerebrospinal fluid filled cavities known as ventricles.

Cerebral cortex is having different areas which are responsible for different functions of brain. These are given as follows:

Brain area	Function
Cerebral cortex in total	Complex thought
Occipital lobe	Visual processing
Temporal lobe (hippocampus + amygdala)	Sound and language (memory + emotion)
Parietal lobe	Spatial orientation

Functions of Parts of Brain

Brain part	Function
Brain stem	• Communicating the information between brain and the body. • Supplying cranial nerves of face and head. • Controls heart • Sustain consciousness
Between cerebrum and brainstem, there are thalamus and hypothalamus	
Thalamus	• Communicates sensory and motor signals to cerebral cortex. • Regulates consciousness, sleep and alertness.
Hypothalamus	• A bridge between nervous system and endocrine system. • Regulates pituitary gland.
Cerebellum	• Motor control. • Coordination and balance • Cognitive functions
Left hemisphere	• Controls all muscles on the right side of the body.
Right hemisphere	• Controls all muscles on the left side of the body.

Areas of Brain and their Functions

Human brain is divided into different areas on the basis of divided portions of cerebral cortex and their functions. For example, Broca's area + Wernicke's area-Speech and language, mathematical calculation (Fig. 2).

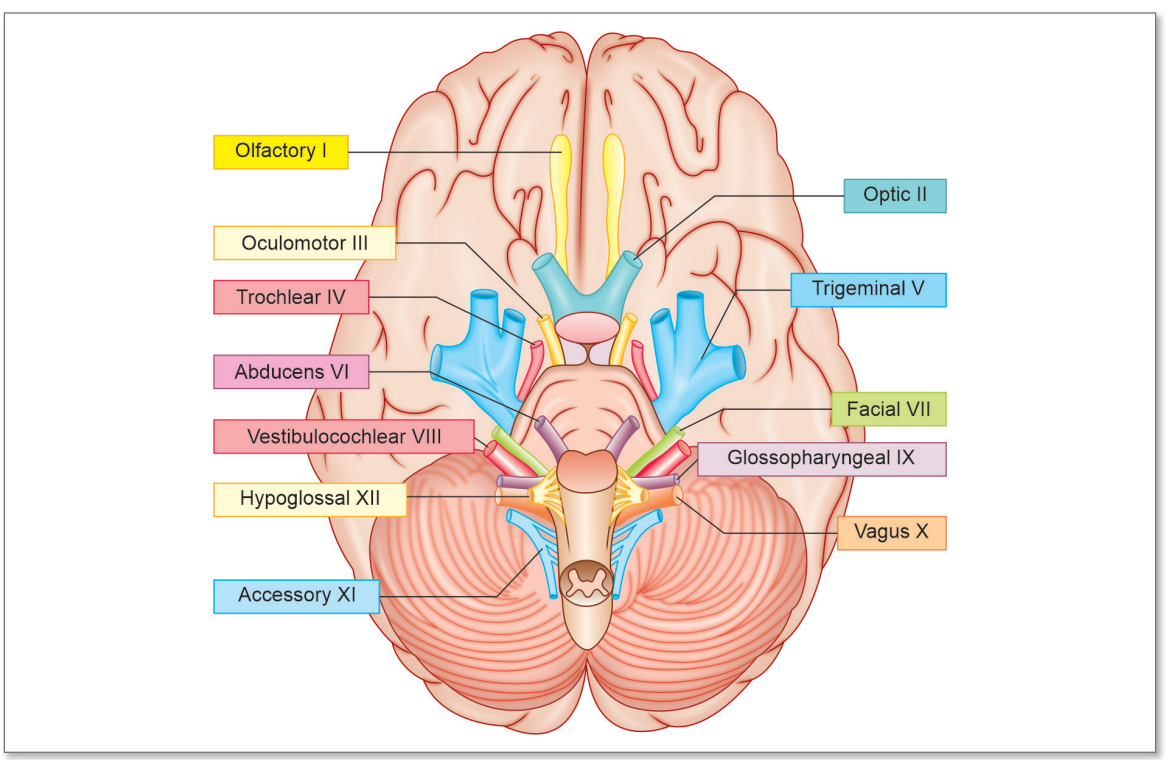


Fig. 2: Location of cranial nerves on brain

The Cranial Nerves

There are twelve pairs of cranial nerves. They are listed as follows:

- **Cranial nerve-I:** Olfactory
- **Cranial nerve-II:** Optic
- **Cranial nerve-III:** Oculomotor
- **Cranial nerve-IV:** Trochlear
- **Cranial nerve-V:** Trigeminal
- **Cranial nerve-VI:** Abducens
- **Cranial nerve-VII:** Facial
- **Cranial nerve-VIII:** Vestibulocochlear
- **Cranial nerve-IX:** Glossopharyngeal
- **Cranial nerve-X:** Vagus
- **Cranial nerve-XI:** Accessory
- **Cranial nerve-XII:** Hypoglossal

Cranial nerves I and II arise from cerebrum and cranial nerves III to XII arise from brain-stem and its specific parts.

Every cranial nerve is responsible for carrying a nerve impulse either to or from the brain. On this basis, they are having either sensory or motor neurons. Sensory neurons are those neurons which carries nerve impulse from sensory organs to brain. Motor neurons are those neurons which carries nerve impulses from brain to the sensory organs or other body parts. Mixed neurons are those which carry nerve impulses both ways, i.e., from brain to sensory organs/other body parts or to brain from sensory organs.

The type of cranial nerve is decided by the neurons, it carries.

Cranial nerves and their functions are as follows:

Cranial nerve	Name	Type	Function
I	Olfactory	Sensory	Smell
II	Optic	Sensory	Vision
III	Oculomotor	Motor	Innervates for eye muscles and pupillary sphincter
IV	Trochlear	Motor	
To innervate means to stimulate or to supply that body part.			
V	**Trigeminal** • Ophthalmic • Maxillary • Mandibular		• Innervates scalp, forehead and nose • Innervates cheeks, lower eye lid, nasal mucosa, upper lip, teeth (upper) and palate. • Innervates tongue, mandible skin, teeth (lower), and muscles of mastication.
VI	Abducens	Motor	Innervates lateral rectus
VII	Facial	Mixed	• Innervates external ear • Brings taste from tongue (anterior) and soft palate. • Innervates facial expression muscles. • Innervates lacrimal, submandibular, sublingual glands and mucous glands.

Contd...

Cranial nerve	Name	Type	Function
VIII	Vestibulocochlear	Sensory	Hearing and balance
IX	Glossopharyngeal	Mixed	• Innervates tongue, external ear and middle ear cavity. • Brings taste from tongue (posterior).
X	Vagus	Mixed	• Innervates external ear and pharynx. • Brings taste from epiglottis region of tongue. • Innervates larynx and pharynx.
XI	Spinal accessory	Motor	• Innervates shoulder muscles.
XII	Hypoglossal	Motor	• Innervates tongue muscles.

Spinal cord and spinal nerves (Fig. 3)

- Spinal cord is a cylindrical nervous tissue within the confinements of vertebral column.
- The spinal cord is the continuation of brain-stem (medulla oblongata).
- Spinal cord is having same cerebrospinal fluid which circulates in ventricles of the brain.
- The terminal part of the spinal cord is known as conus medullaris at L2 vertebral level.
- At the terminal end of spinal cord, spinal nerves bundled together and it is known as cauda equina (Fig. 4).
- As spinal cord is continuous structure, it is having divisions in accordance with vertebral column.
- Cervical, thoracic, lumbar and sacral

Peripheral Nervous System

From every division of the spinal cord, spinal nerves originate. There are 31 pairs of spinal nerves which innervate different body parts. The spinal nerves form peripheral nervous system i.e., nervous system outside the brain and spinal cord. The PNS consists of all the spinal nerves and ganglia (clusters of nerves) outside the brain and spinal cord which innervate limbs and body organs (Fig. 5).

The spinal nerves are mixed nerves which mean they contain both sensory and motor neurons.

Every spinal nerve has two roots; an anterior root (motor) and a posterior root (sensory).

Both roots join at intervertebral foramina (space/foramina between two spinal vertebrae) and then form a single spinal nerve.

Nerve roots at L2 to S5 forms a bundle of nerves which is known as cauda equina

Each division of spinal cord forms a plexus, i.e., a network of nerve fibers to supply different body parts. These plexuses are as follows:

- Cervical plexus
- Brachial plexus
- Lumbar plexus
- Sacral plexus

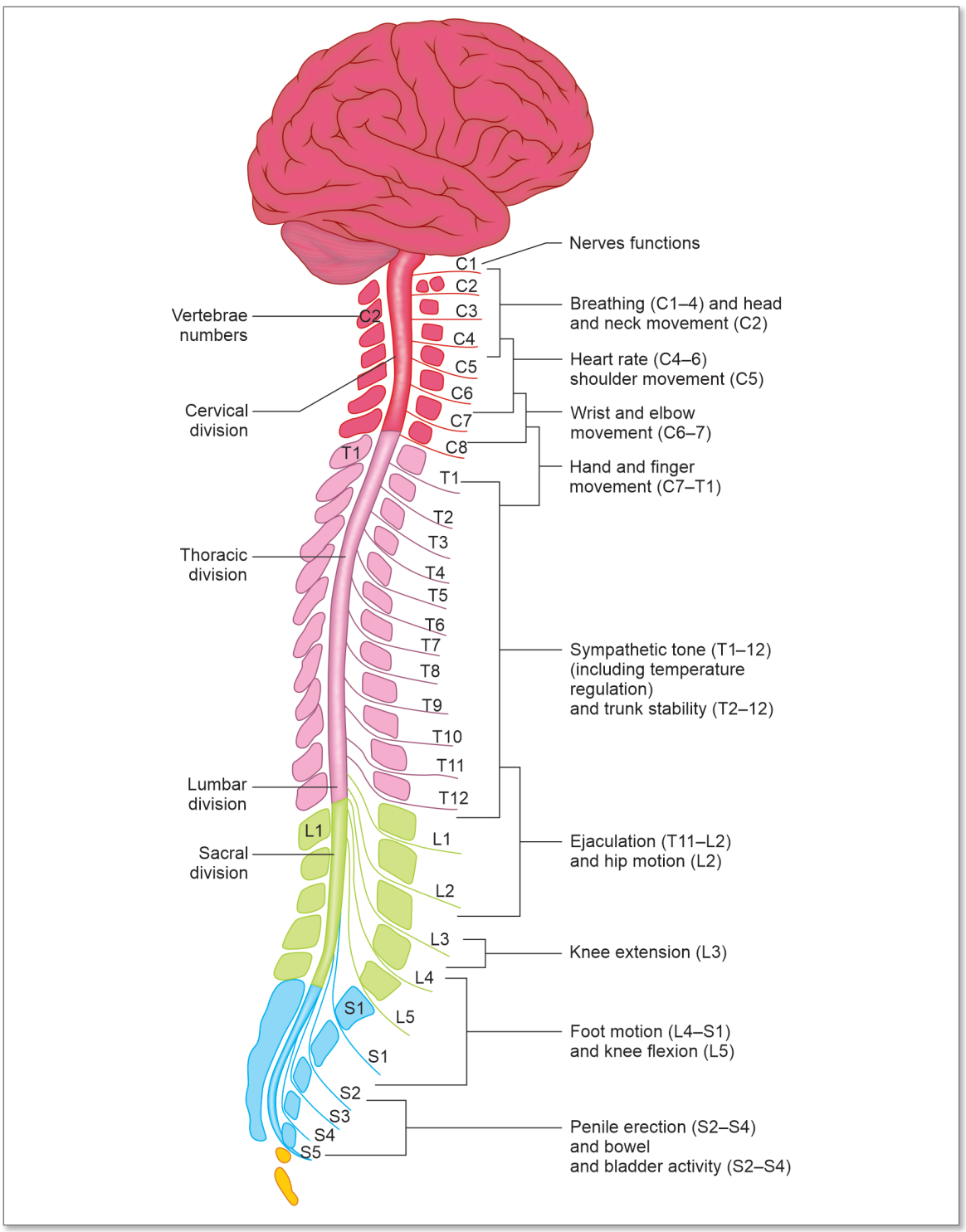


Fig. 3: Spinal cord and spinal nerves

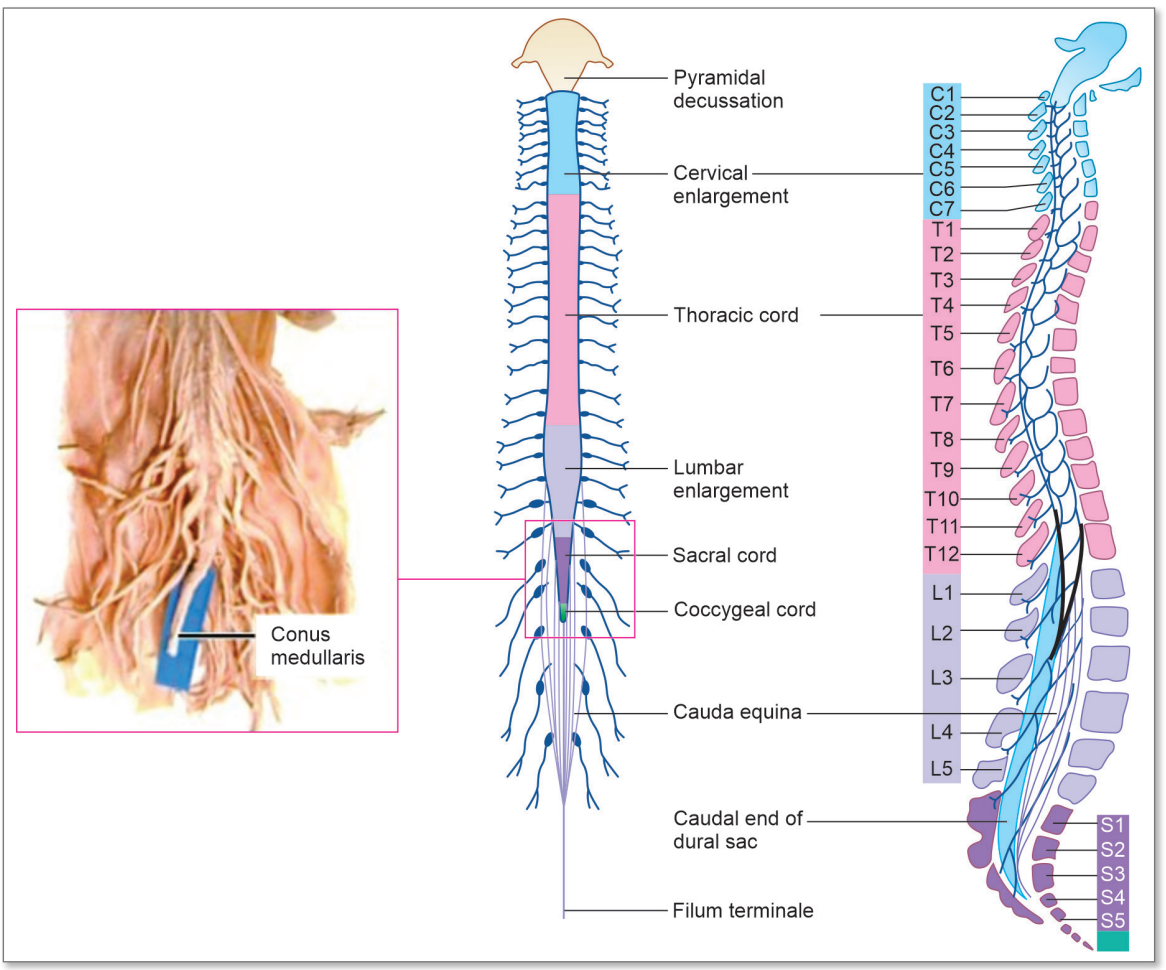


Fig. 4: External structure of spinal cord

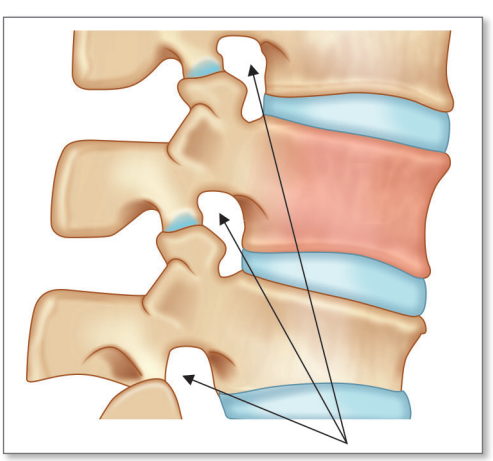


Fig. 5: Vertebral foramina

The following is a description of each plexus along with its innervations and functions.

Plexus	Innervations + functions
Cervical (C1, C2, C3, C4)	• Innervates skin and muscles of neck, shoulder muscles, back muscles and diaphragm. • Helps in keeping the diaphragm alive. • Elevates larynx for normal breathing. • Innervates to external ear and parotid gland.
Brachial (C5, C6, C7, C8, T1)	• Innervates skin and musculature of the upper limb.
Lumbar (L1, L2, L3, L4)	• Innervates skin and musculature of lower limb. • Innervates posterolateral gluteal skin in the pubic region.
Sacral (S1, S2, S3 and S4)	• Innervates and regulates skin and muscles of pelvis and lower limb.
Lumbosacral (S1, S2, S3, S4 and L4, L5)	• Innervates pelvis via greater sciatic foramen and regulates gluteal region of lower limbs.

CELL OF NERVOUS SYSTEM

Cell is the basic structural and functional unit of the human body. Neuron is the cell of nervous system, i.e., basic structural and functional unit of nervous system.

Neuron is having three parts: Cell body + Dendrites + Axon

Cell body is having the organelles as a human cell have. Dendrites are the receiving input channels of neuron. Axon is the elongated part of the neuron which transmits nerve impulse (message). Axon terminals are the ending output channels of the neuron (Figs 6 and 7).

The axon transmits nerve impulses from the body to the effectors organ or another neuron.

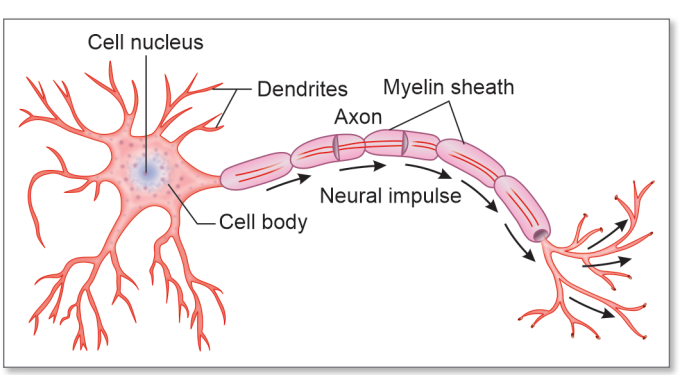


Fig. 6: Neuron

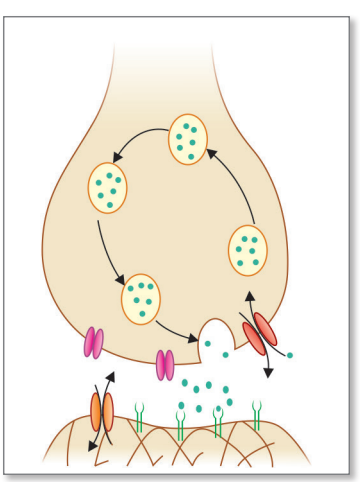


Fig. 7: Synaptic cleft

Mechanism of Action of Neuron

Human body is having nervous tissue networks all over the body. Neurons receive stimulation (message) from the external world by receptors (a region of cell or tissue that receives stimuli) which are present at its cell body and dendrites. This conducts a signal (nerve impulse/message) along the axon and reach axon terminals. Axon terminals release the nerve impulse/message in the synaptic cleft (a small space between two neurons/between one neuron and effector cell). Then another neuron or effector cell receives the nerve impulse (message). The effector may be another neuron, gland or a muscle.

ETIOLOGICAL THEORIES (GENETICS, BIOCHEMICAL, PSYCHOLOGICAL)

Etiology means the sum of causative factors.

Theory means a set of ideas and concepts interrelated together to explain, predict or describe certain phenomenon applied to a particular subject.

Etiological theories are those theories which are helpful in describing, explaining and predicting the causative factors of diseases.

In the field of psychiatry, three types of theories are referred to describing, explaining and predicting the causes of mental illnesses.

1. Genetics
2. Biochemical theories
3. Psychological theories

Genetics Theory

In psychiatry, taking family history is very important aspect of psychiatric nursing theory, because, genetics plays a major role in causation of some pairs of mental illnesses.

- Schizophrenia and bipolar disorder
- Autism and schizophrenia
- Depression and bipolar disorder
- Attention deficit hyperactivity disorder and autism

These disorders are found on the basis of research done by National Institute of Mental Health in the field of neurosciences and genetics. This has given a new conceptual framework to understand the etiology of certain mental disorders which states that certain mental disorders are corelated by genetic factors and have similar and overlapped shared symptoms. For example, schizophrenia and mania both have shared symptom of delusion of grandeur. Another example may be a switch to mania while getting treatment for major depression.

The following are the genetic factors which are responsibly explaining the role of genetics in the causation of mental illnesses:

- Psychiatric disorders tend to run in families because of genetic roots, i.e., genetic make-up of offspring is similar to forefather.
- Families also share similarities at biological level. Neurotransmitters levels in the brain may be in the same proportion in monozygotic and/or dizygotic twins.

- **GWAS, i.e., Genome-wide Association Studies have also identified following factors in relation with etiology of mental disorders:**
  - An abnormality in genetic make-up
  - Faulty cell division during fertilization process
  - Genetic markers
  - Variations in genes that regulate the flow of calcium in neurons such as CACNA1C and CACNB2
  - CACNA1C affects brain areas involved in emotion, thinking, attention and memory. Disruption in these areas can cause bipolar disorder, schizophrenia and major depression.
  - CACNB2 affects calcium channel gene.
  - Chromosomes 3 and 10 are found to be linked with causation of mental disorders.

Therefore, genetic factors and their link with etiology of mental disorders can help in diagnosing and treating the mental illnesses in a better way.

Biochemical Theory

Any abnormality in nervous system (structural or functional) can cause mental illness. Mental illness caused by structural and functional abnormalities of nervous system is known as "**Organic Mental Disorder**".
To understand, biochemical theories in causation of mental illnesses, one must learn the concept and functioning of two biochemicals.

1. Neurotransmitters
2. Hormones

Neurotransmitter

It is a chemical mediator in the brain which is responsible for transmission of nerve impulses, i.e., sensory and motor messages to and from the brain.

Neurotransmitters convey the messages from sensory organs to brain and from brain to the sensory organs for motor responses. Neurotransmitters accomplish this task by generating a nerve impulse along the neurons.

Types of Neurotransmitters in the Brain

- Adrenaline (flight or fight transmitter)
- Nor-adrenaline (concentration neurotransmitter)
- Dopamine (pleasure neurotransmitter)
- Serotonin (mood neurotransmitter)
- GABA, i.e., gamma-aminobutyric acid (calming neurotransmitter)
- Acetylcholine (learning neurotransmitter)
- Glutamate (memory neurotransmitter)
- Endorphins (euphoria neurotransmitter)

Every neurotransmitter is responsible for generating a specific nerve impulse. For example, to generate a mood nerve impulse, serotonin will be functional; to generate a learning nerve impulse, acetylcholine will be neurotransmitter which will be released in the brain to transmit a nerve impulse.

Any abnormality (upsurge or down surge) in the concentration of these neurotransmitters can cause mental disorders (Fig. 8). The relationship between neurotransmitter and mental illness can be illustrated as follows:

Neurotransmitter	Mental disorder
Dopamine	Schizophrenia, psychosis, delusional disorder
Serotonin	Mood disorders (an increased level of serotonin may cause mania and a decreased level of serotonin may cause depression)
Adrenaline	Stress and stress related disorders
Noradrenaline	Attention deficit hyperactivity disorder
GABA	Panic disorder, anxiety disorders, phobia
Acetylcholine	Dementia
Glutamate	Memory disorders
Endorphins	Mood abnormalities

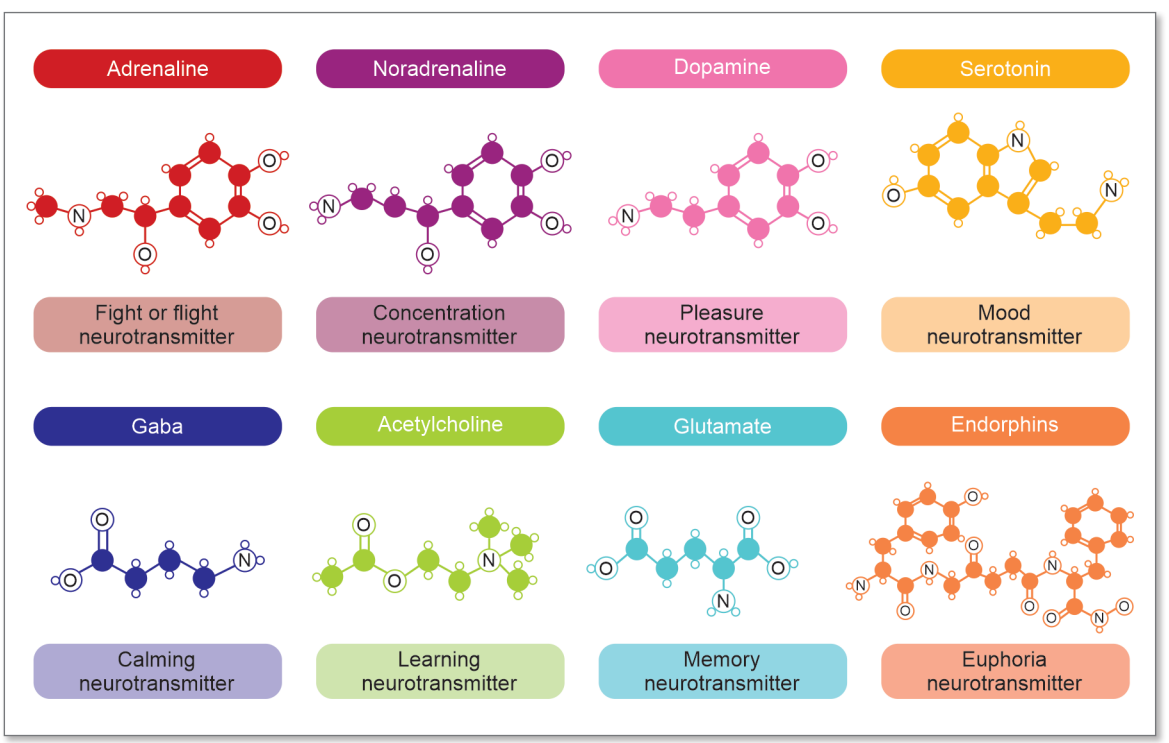


Fig. 8: Neurotransmitters with function and chemical structure

Hormone

It is a chemical messenger released by a specific gland of the body in response to any change in the biochemical environment of the body. Hormones are responsible to act on different aspects of bodily functions and can cause a certain reaction in response to every stimulus.

In the field of psychiatry, researches evidenced that a weak immune system can cause a weak psychology and vice-versa. There are various hormones, which are responsible for etiology of certain mental disorders.

Adrenaline is both, a neurotransmitter in the brain and a hormone released by adrenal glands. Like neurotransmitters, any abnormal level of hormone can cause mental illness.

The first encounter with hormonal influence on human body and mind is at age of puberty. The last encounter will be with menopause along with its residual effects. The relationship between hormones and mental illness can be illustrated as follows:

Hormone	Mental disorder(s)
Pubertal hormonal upsurge at puberty	**Women:** Premenstrual syndrome (labile mood/mood swings, depression, anxiety, irritability) **Men:** Anger and depression with increased and fluctuating levels of testosterone.
Hormonal disturbances in pregnancy and after delivery	Postpartum depression; postpartum psychosis.
Menopause	Erratic periods, hot flashes, weight redistribution, changes in sex drive
Sex hormones (androgens) imbalance	**Men:** Increased levels of estrogens results in depression and mood swings. **Women:** Increased levels may cause mental disturbances.
Thyroid hormones	**Hyperthyroidism:** Anxiety, insomnia, mood swings, panic attacks **Hypothyroidism:** Depression, moodiness, fatigue
Adrenal hormones • Adrenaline • Cortisol	Depression, anxiety, insomnia, difficulty concentration

Psychological Theories

Erik Erikson's Psychosocial Theory/Psychosocial Theory

Every person is having his/her unique personality. The individual differences do exist with every individual on this earth. There are many dimensions which do influence the personality characteristics of an individual. These dimensions may be inherited/acquired or internal/external. For example, genetics is an inherited dimension of personality and culture is an acquired dimension.

Erik Erikson was an American psychoanalyst. He was a pioneer in psycho-historical investigation.

Erik Erikson studied the sociocultural dimension of the personality and its influence on the psychosocial development of an individual. Erik explained the concept of psychosocial development in eight stages of psychosocial conflicts. Erik exclaimed that an individual has to overcome or resolve these psychosocial conflicts successfully to grow and mature during lifespan.

Erik divided an individual lifespan in eight stages. At every stage, individual will face a crisis and he/she has to encounter the crisis and resolve it to successfully move to the next stage of psychosocial development (Fig. 9).

Erik Erikson's psychosocial theory can be understood in this manner; life is a game of eight stages or levels. Every level of the game is having a crisis to fight. If the individual wins in the fight in the given time-period, he/she can move to the next level of game successfully and the individual will be rewarded with awards (In life, awards are development and maturity). If individual loses in the game or is not able to fight crisis within given time, he/she may move to the next level, but not successfully and without rewards (in life, person lacks development and maturity).

Erik Erikson's eight stages/levels of psychosocial development are as follows:

Fig. 9: Erik Erikson's eight stages/levels of psychosocial development

Stage 1: Trust versus Mistrust

Newborn feels external environment to be harmful and threatening. The most effective way to demonstrate that world is a worth living place and human beings can be trusted by providing care and affection. The parents/care-takers/guardians are the first encountered trusted person for the baby. Another way to demonstrate trust is to provide food, shelter, sustenance to the baby.

If stage one is accomplished successfully, child will develop trust. A neglected child will develop mistrust in the world and worldly pursuits.

Stage 2: Autonomy versus Shame and Doubt

Autonomy means independence. A child attains independence through successful completion of toilet training and learning basic ways of taking care of them. In this way, he/she attains autonomy. If child fails to attain independence, shame and doubt develops.

Stage 3: Initiative versus Guilt

Stage three accomplishes task of schooling and more extensive way to take care like dressing, combing, and bathing, etc. on their own. If achieved mastery over work assignments in school and home, initiative develops. A failure of the stage will result in guilt.

Stage 4: Industry versus Inferiority

At this stage, child learns logical reasoning and self-awareness through task completion in school and home. He/she become competitive and starts comparison between achievements. If child accomplishes tasks and succeed, he/she will have industry feeling, otherwise in case of consistent failure in competition, child will develop inferiority complex.

Stage 5: Identity versus Role Confusion

The age of the individual at stage five is at the time of puberty. An individual attains sexual identity and starts appreciating his/her presence as a unique member of the same gender community. This is very crucial stage and a transition from childhood to adulthood through the stage of adolescent. At adolescent stage, an individual finds hard to understand the concept that where he/she actually belongs? Childhood or adulthood? If he/she is able to understand the bridge between childhood and adulthood, i.e., adolescent stage for maturity, they will find their identity. If the confusion persists, then there will be role confusion.

Stage 6: Intimacy versus Isolation

This is the stage of heterosexual relationships. The task is to find the right partner/companion. If the outcome of the relationship is positive, individual will have intimacy. But if the outcome is wrong and painful, individual will get idea of isolation. Usually, people are not mature enough to understand origin of lasting relationships, and because of hurried behavior, end up in wrong relationships or divorce.

Stage 7: Generativity versus Stagnation

Adults in their 40s and 50s are now more concerned with productivity. The productivity is measured in terms of work and family. If family and work grows, generativity develops. If individual fails to be productive, Stagnation occurs.

Stage 8: Ego Integrity versus Despair

People in their 60s are off from their work duties and social responsibilities. They integrate their all life stages and experiences and evaluate the results and outcomes. If result is good and individual feels satisfied with his/her life experiences, Ego-integrity is achieved. If individual feels that his/her life was not worth living and it was wastage to spend years on the earth, despair occurs.

Sigmund Freud's Psychosexual Theory

Sigmund Freud was the founder of the great psychoanalysis. He has invented a wonderful way to resolve many psychological conflicts embedded in one's childhood and appeared as a psychological burden in adulthood. Despite the criticism of theory, psychoanalysis (individual psychotherapy) is still in use and effective in treatment of mental disorders.

Freud's psychosexual theory has the basic concept that an individual throughout his life passes through different psychosexual stages which are related to erogenous zones, i.e., body parts most capable of arousing and deriving sexual pleasure.

Parents or Guardians of a child greatly influence children's sexual and aggressive drives during childhood and this greatly affects their psychosexual development later in life. Every individual is having childhood burdens in this way or that.

Every stage of psychosexual development must be met successfully. Failure of successful accomplishment may result in fixation at that stage.

Freud's Structural Model

According to Freud, human personality consists of three parts, i.e., Id, Ego and Super-ego. The psychosexual theory claims that parts of the personality, i.e., Id, Ego and Super-ego are unified as an individual grows and works through five stages of psychosexual development.

- **ID:** It is based on **pleasure principle.** It is the largest part of the mind and is interested to fulfilment of one's own desires and impulses without considering consequences/results. People who have dominated id are usually me centered.
- **EGO:** It is based on **reality principle**. It is the part of the mind which reasons out every detail in the environment and finds logical explanation. Here, an individual fulfils his/her needs and desires but with consideration of consequences.
- **Super-ego/conscience:** It is based on **morality principle**. It is the part of mind which develops through social interactions and it conforms to the norms/rules/ethics/morals of the society. This part of mind teaches the individual to be ethically and morally correct/righteous.

Freud believed that an individual behavior and mind activities are regulated by struggles between three parts of the personality.

Freud proclaims that our mind is like an ice-berg in the sea. Like an ice-berg, the visible or conscious part of the mind is lesser in comparison with the hidden or unconscious part. Although unconscious mind is not in our awareness but it influences our behavior and thoughts.

PSYCHOSEXUAL STAGES OF DEVELOPMENT

Freud has given five psychosexual stages of development and said that every stage is having a focused area of the body, known as **an erogenous zone.** The stages are explained in Figure 10.

1. **Oral stage (0–1 years of age):** In this stage, the erogenous zone (pleasure center) is mouth. If the child need of oral stage, i.e., sucking is met, he/she can successfully move to next stage. If oral stage needs are not met, child may develop negative habits. For example, nail biting, thumb sucking, alcoholism in later life.

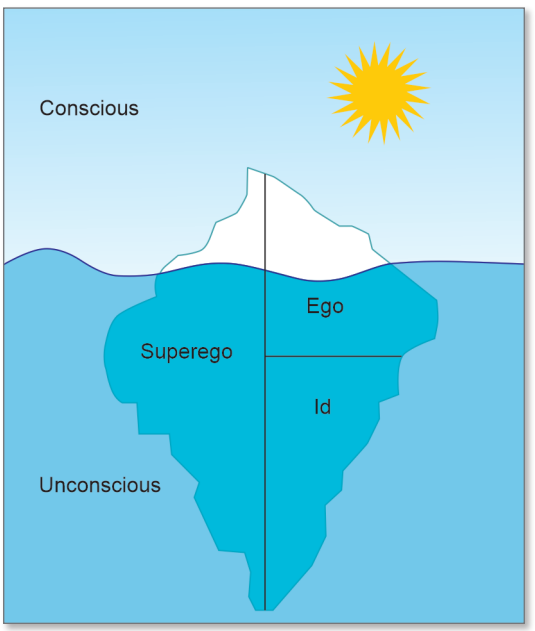


Fig. 10: Erogenous zone

2. **Anal stage (1–3 years of age):** This is toddler or preschool age. The erogenous zone is anus. Children exert control over the situation in two ways either through passing feces/urine or by retaining those. Toilet training must be done timely, not early or late. Toilet training must be disciplined but not strict.
3. **Phallic stage (3–6 years of age):** This is a preschooler stage. The erogenous zone is genitalia. This stage works through two phenomena; Oedipus complex and Electra complex.
   - **Oedipus complex:** The male child is having sexual attraction toward female parent (mother). But he fears male parent (father) because he thinks that if father will come to know about his thoughts, he will castrate his genitalia.
   - **Electra complex:** The female child is having desire for her father and having anxiety and fear toward female parent.
4. **Latency stage (6–12 years of age):** This is a resting psychosexual stage. No erogenous zone is found. Here, the child super-ego is more activated. He/she learns morals, ethics and norms of the society. The sexual behavior is absent in this stage.
5. **Genital stage (above 12 years of age):** This is the stage of re-emergence of sexual instincts. The erogenous zone is genitalia. The individual will satisfy him/herself by involving in heterosexual relationships.

CLASSIFICATION OF MENTAL DISORDERS

Classification is the technique of making categories or groups of a large number of data. There are two important classification of mental disorders, i.e.:

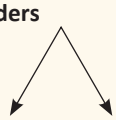
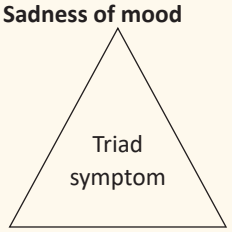
1. DSM = Diagnostic and statistical manual of mental disorders. The latest edition is DSM-5.
2. ICD = International classification of diseases. Mental disorders are classified from F00 to F99 in ICD.

In DSM, list of mental disorders is as follows:

- Neurodevelopment disorders
- Schizophrenia spectrum and other psychotic disorders
- Bipolar and related disorders
- Depressive disorders
- Anxiety disorders
- Obsessive Compulsive and related disorders
- Trauma or stressor related disorders
- Dissociative disorders
- Somatic symptom and related disorders
- Feeding and Eating disorders
- Elimination disorders
- Sleep-wake disorders
- Sexual dysfunctions
- Disruptive, impulsive control and conduct disorder
- Substance related disorders
- Neurocognitive disorders
- Personality disorders

Category	Sub-category	Brief description of disorder
Neurodevelopmental disorders	• Intellectual disability/mental retardation	• Below average IQ, i.e., Intelligent Quotient (A measure of intelligence).
	Communication disorders • Language disorder • Speech sound disorder • Fluency disorder • Social communication disorder	 • Child can't make age appropriate sentences. • Difficulty in putting thoughts into words. • Rate of speech is abnormally slow. • Difficulty in interacting with other persons.
	• Autism spectrum	• Severe impairment in social interaction and communication, child do lives in a delusional world created by own thoughts.
	• Attention deficit hyperactivity disorder (ADHD)	• Child is hyperactive with reduced attention span.
	Specific learning disorders • Dyslexia • Dyscalculia	 • Child is not able to read and write. • Child can't do simple calculations.
	Motor disorders • Developmental coordination disorder • Stereotypic movement disorder • Tic disorder	 • Milestones are delayed such as walking, crawling, etc. • Repeated motor activity such as head banging, etc. • Involuntary repeated motor activity.

Contd...

Category	Sub-category	Brief description of disorder
Schizophrenia spectrum and other psychotic disorders	• Schizophrenia	• Characterized by delusions, hallucinations and personality disorganization.
	• Delusional disorder	• Characterized by persistent delusions.
	• Brief psychotic disorder	• Characterized by delusions, hallucinations, inappropriate behavior and catatonia.
	• Schizophreniform disorder	• Schizophrenic symptoms for one month rather for 6 months' duration.
	• Schizoeffective disorder	• Schizophrenic symptoms with presence of mania or depression.
	• Substance induced psychotic disorder	• Psychotic symptoms due to use of psychoactive drugs.
	• Psychotic disorder due to medical condition	• Psychotic symptoms appear because of medical illness.
	• Catatonia	• Characterized by waxy flexibility, mutism and negativism.
Bipolar and related disorders  **Mania Depression**	• Bipolar i disorder	• Alternative episodes of mania and depression.
	• Bipolar ii disorder	• Alternative episodes of hypomania and depression.
	• Cyclothymic disorder	• A mild form of mood disorder over a period of 2 years.
	• Bipolar disorder due to medical condition	• Symptoms of mood disorder occur because of medical illness.
	• Substance induced bipolar disorder	• Symptoms of mood disorder occur because of substance use.
Depressive disorders **Sadness of mood**  	Major depressive disorder	Characterized by sadness of mood and inability to feel pleasure.
	Dysthymia	A mild form of depression
	• Premenstrual dysphoric disorder	• Characterized by mood swings, headache and irritability 1 week before menses.
	• Substance induced depressive disorder	• Depression due to substance use.

Contd...

Category	Sub-category	Brief description of disorder
	• Depressive disorder due to medical condition	• Depression due to medical illness.
	Other specified depressive disorder • Recurrent depressive disorder • Short duration depressive episode	 • Depressive episode once in a month. • Depressive episode of 4–14 days.
	Unspecified depressive disorder • Melancholia • Atypical depression • Peripartum depression • Seasonal effective disorder	 • Characterized by suicidal ideation and hopelessness. • Characterized by sadness of mood, weight gain and hypersomnia. • Depression in peripartum period. • Depression which occurs at a specific time of year.
	Disruptive mood dysregulation disorder	Depression in age of 6–18 years. Most prominent feature is temper tantrums.
Anxiety disorder	• Panic disorder	• Severe anxiety with bodily symptoms.
	• Agoraphobia	• Fear of open spaces from which escape is difficult.
	• Specific phobia	• Irrational fear of objects or events.
	• Social phobia	• Fear of feeling low in front of others.
	• Generalized anxiety disorder	• Characterized by worrying in excess with bodily symptoms.
	• Anxiety due to medical condition	• Anxiety symptoms due to mental illness.
	• Separation anxiety disorder	• Anxiety in case of separation from family and home.
	• Selective mutism	• Anxiety to speak in specific events, e.g., stage, parties, social gatherings.
Obsessive compulsive and related disorders	• OCD, i.e., Obsessive compulsive disorder	• Characterized by obsessions and compulsions.
	• Body dysmorphic disorder	• A false belief of defect in physical appearance.
	• Hoarding disorder	• A habit of collecting useless things in home.
	• Trichotillomania/hair pulling disorder	• An unusual habit of pulling hairs.
	• Excoriation or skin picking disorder	• Feeling compelled to pick skin
	• Substance induced OCD	• OCD due to use of drugs

Contd...

Category	Sub-category	Brief description of disorder
	• OCD due to medical disorder	• Symptoms of OCD occur because of medical illness.
	Other specified OC and related disorder • Obsessional jealousy • Body focused repetitive behavior disorder	 • Person has repeated thoughts that his/her partner is not faithful. • Repeated nail biting or chewing lips.
Trauma or stressor related disorders	Reactive attachment disorder	A childhood disorder in which child is not able to relate to others.
	Disinhibited social engagement disorder	A childhood disorder/adolescent disorder in which person feels fearful to talk with strangers.
	Post-traumatic stress disorder	After a traumatic event, person re-experiences the incidence of trauma again and again.
	Acute stress disorder	Acute episode of stress at least for 1 month of duration.
	Adjustment disorders	Person is not able to adapt to stressful events.
	Persistent complex bereavement disorder	Characterized by a grief period more than usual along with aggression.
Dissociative disorders	• Dissociative amnesia	• Loss of memory of most important information of one's life.
	• Dissociative fugue	• Wandering behavior (running away from home) with memory loss
	• Dissociative identity disorder (multiple personality disorder)	• Presence of two or more different personalities in one person.
	• Depersonalization/ derealization disorder	• Depersonalization, i.e., person feels that he is out of his body or in a dream. • Decreolization, i.e., person feels that this world is not real.
Somatic symptom and related disorders	• Somatic symptom disorder	• Overly concern and worrying about bodily signs and symptoms.
	• Illness anxiety disorder	• Person is having fear of being sick.
	• Functional neurological symptom disorder (conversion disorder)	• Psychological conflicts are converted into physical symptoms without evidence of a medical diagnosis.
	• Psychological factors affecting other medical conditions	• Because of a psychological problem, person is severely affected in medical illness.
	• Factitious disorder	• Purposely assuming sick role to have benefits of being sick.
	• Other specified somatic symptom and related disorder ▪ Pseudocyesis	• A woman has false belief that she is pregnant.

Contd...

Category	Sub-category	Brief description of disorder
Feeding and eating disorders	• Anorexia nervosa	• Person is having fear of gaining weight, so he refuses to eat to lose his body weight.
	• Bulimia nervosa	• Binge eating may or may not be followed with vomiting.
	• Pica	• Eating non-nutritive substances, e.g., chalk
	• Rumination disorder	• Backflow of food into mouth repeatedly.
	• Avoidant/restrictive food intake disorder	• Child lacks interest in eating, makes it difficult for the child to survive.
Elimination disorders	• Encopresis	• Involuntary passage of stool because of lack of control over bowel movement.
	• Enuresis	• Involuntary passage of urine due to lack of control over urination.
Sleep-wake disorders	• Insomnia disorder	• Person is not able to fall asleep and stay asleep.
	• Hyper somnolence disorder (hypersomnia)	• Person sleeps excessively more than required.
	• Parasomnias	• Abnormal behaviors during sleep, e.g., sleepwalking, speaking while speaking.
	• Narcolepsy	• Sleep attacks during day time.
	• Breathing related sleep disorders	• Breathing problems arise during sleep, e.g., apnea, hyperventilation, etc.
	• Restless legs syndrome	• Jerky movement of legs during sleep.
	• Substance/medication induced sleep disorder	• Sleep disorder caused by drug use.
Sexual dysfunctions	• Delayed ejaculation	• Person is not able to ejaculate in time during intercourse or masturbation.
	• Erectile disorder	• Person is not able to keep an erect penis for facilitating penetration.
	• Female orgasmic disorder	• Female are not able to experience orgasm during intercourse.
	• Genitor-pelvic pain/ penetration disorder	• Pain during intercourse.
	• Male hypoactive sexual desire disorder	• Decreased or absence of sexual desire in men.
	• Premature or early ejaculation	• Person ejaculates early in intercourse.
	• Substance/medication induced sexual dysfunction	• Sexual problems arise due to drug use.
	• Other unspecified sexual dysfunction	• Sexual problems caused by a medical condition.

Contd...

Category	Sub-category	Brief description of disorder
	• Gender dysphoria (gender identity disorder)	• Person doesn't accept his/her gender or Sexuality.
Disruptive, impulse control and conduct disorder	• Oppositional defiant disorder	• Child is having authority rivalry, doesn't like to be controlled.
	• Intermittent explosive disorder	• Uncontrolled anger in children.
	• Conduct disorder	• Child does a lot of fighting and bullying.
	• Pyromania	• Child likes to ignite fire.
	• Kleptomania	• Repeated stealing
Substance related disorders	• Substance induced disorders	• Psychological disturbances due to substance use, e.g., delirium
	• Substance use disorders	• Addictions causing dependence, intoxication, etc.
	• Alcohol related disorder	• Excessive intake of alcohol causing tolerance and dependence.
	• Gambling disorder	• Resistant to stop playing cards, gambling.
Neurocognitive disorders	• Delirium	• Cloudiness of consciousness with confusion.
	• Mild neurocognitive disorder	• Progressive mild deterioration in cognitive function.
	• Major neurocognitive disorder • Dementia	• A marked deterioration in cognitive function causes severe forgetfulness.
Personality disorders	• Paranoid personality disorder	• Extreme suspicious behavior as a part of personality of a person.
	• Schizoid personality disorder	• Shy and timid personality avoiding intimate relations.
	• Schizotypal personality disorder	• Schizoid personality features along with loneliness and withdrawal behavior.
	• OC personality disorder	• Overly disciplined, rigid behavior.
	• Histrionic personality disorder	• Characterized by attention seeking behavior involving drama.
	• Avoidant personality disorder	• Laziness with no genuine interest in life events.
	• Antisocial personality disorder	• Person is not at peace with societal norms and regulations.
	• Narcissistic personality disorder	• An excessive desire for praise, ignite self-appraisal in excess.
	• Borderline personality disorder	• Characterized by impulsive behavior with self-mutilation and boredom.
	• Dependent personality disorder	• Person is overly dependent on others.
	• Personality changes due to another medical condition	• Medical illness (e.g., brain injury) may cause personality changes.

MENTAL DISORDERS

Definition

A mental disorder is a psychological problem that causes significant distress in a person. This distress results in impaired social and personal functioning.

Mental Faculty

Mental faculty is mind's power or capability to carry out a specific function. For example, mental faculty of memory has the power of retaining and recalling the information.

Mental disorders may occur due to abnormalities in mental faculties which are listed here:

- Thought
- Motor activity (Psycho-motor activity)
- Perception
- Mood
- Speech
- Memory
- Concentration
- Judgment

Disorders of mental faculties are briefly discussed here:

Disorders of Thought

Disorders of thought may occur at two levels:

1. Thought content
2. Thought process

- **Disorders of thought content:** A human mind creates many thoughts in a day. Content of thought means what kind of thought. For example, answers to the questions being asked. What is your profession? I am working as a nurse.

  Any abnormality in content of thought is considered as a disorder when it interferes with person's personal and social functioning. These disorders of thought content are given as follows:
- **Obsessional thoughts:** Repetitive, unwanted thoughts which can't be removed by conscious effort of person.
  For example, my hands are dirty; I should wash them.
- **Compulsions:** Repetitive, troublesome behaviors which are done in response to obsessional thoughts.
  For example, washing hands repeatedly
- **Delusions:** Are false, fixed beliefs which are not shared by others and are not in accordance with one's intelligence or cultural background.

Types of Delusions

- **Delusion of grandeur:** False, fixed belief that one has high rank, extreme social importance, majesty, omnipotence, greatness in work and/or beauty.

- **Delusion of persecution:** False, fixed belief that persons (family, friends, strangers) are after him/her and tries to harm/kill him/her.
- **Delusion of reference:** False, fixed belief that persons (family, friends, strangers) are talking about him/her.
- **Delusion of control:** False, fixed belief that one is being controlled by person/persons (family, friends, strangers) or any external force such as some god/computer, etc.
- **Delusion of poverty:** False, fixed belief that one is extremely poor.
- **Delusion of jealousy:** False, fixed belief that one's spouse is unfaithful although he/she is not having any proof.
- **Delusion of infidelity:** Repeatedly accusing one's spouse that he/she is unfaithful and searches for proofs, asks questions, follow them without telling the spouse.
- **Somatic delusions:** False, fixed belief that one is having disease or his/her body is abnormal or changed.
- **Hypochondrial delusions:** False, fixed worrying issues over bodily health.

Disorders of thought Process

In thought process, we don't get the exact content of the thought but rather information that how thought was formed in the mind and how it is expressed. Disorders of thought process are given as follows:

- **Circumstantiality:** Person gives unnecessary details before reaching the goal.
- **Tangentiality:** Person gives unnecessary details, but never reaches the goal.
- **Clang association:** Rhyming of words without having any connection with their meaning. E.g., rat, cat, mat, bat, etc.
- **Derailment:** Articulating words into sentences but these sentences are not comprehensible. Comprehension means to understand.
- **Flight of ideas:** Sequence of multiple ideas jumping from one topic to another abruptly; usually accompanied by pressure of speech.
- **Neologism:** Inventing new words without a dictionary meaning.
- **Perseveration:** Repetition of same words, phrases and ideas.
- **Thought block:** A sudden stoppage or break in the continuity of ideas.
- **Incoherence:** Illogical, inconsistent and/or unclear ideas.

Disorders of Motor (Psychomotor) Activity

An individual can be hyperactive or underactive. Disorders of psychomotor activity are given as follows:

Disorders of Decreased Motor Activity

Bradykinesia: Slow motor activity.

Disorders of Increased Motor Activity

Hyperkinesia/Agitation: Increased motor activity.

Disorders of Abnormal Motor Activity

- **Tardive dyskinesia:** Stiff neck, bizarre facial and tongue movements and dysphasia.

- **Akathisia:** Restlessness accompanied by an inability to sit still.
- **Stereotype activity:** Repetitive activities.
  - **Stereotype position/waxy flexibility:** Same persistent position.
  - **Stereotype movement/mannerism:** Repeated movements. For example, blinking of eyes.
- **Negativism:** Carrying out exact opposite behavior.
- **Automatism:** Automatic carrying out one activity without conscious awareness.

Disorders of Perception

Perception means the way in which something (external stimuli) is perceived. It includes understanding and interpreting something.

If an individual is not able to perceive external stimuli correctly, his/her perception is said to be disordered. Disorders of perception are given below:

- **Illusion:** Wrong perception in the presence of external stimuli. For example, a rope may be perceived as a snake.
- **Hallucination:** Wrong perception in the absence of external stimuli.

Types of Hallucinations

- **Auditory hallucinations:** Wrong perception in the absence of voices. An individual claims that he/she hear voices which are not heard by others.
- **Visual hallucinations:** Wrong perception in the absence of objects/persons. An individual claims that he/she can see objects or persons who are not seen by others.
- **Gustatory hallucinations:** Wrong perception of taste. An individual claims that he/she can taste when real source of taste is not actually present.
- **Olfactory hallucinations:** Wrong perception of smell. An individual claims that he/she smells a pleasant or an unpleasant smell when real source of smell is not actually present.
- **Tactile hallucinations:** Wrong perception of touch. An individual claims that he/she feels the presence or pressure of something (someone's hands, insects, etc.) on his/her body.

Disorders of Mood and Affect

Mood is an internal feeling or emotion.

Affect is an outward expression of mood.

Disorders of affect can be divided into three categories:

1. Disorders of pleasurable affect
2. Disorders of unpleasurable affect
3. Disorders of abnormal affect

Disorders of Pleasurable Affect

- **Euphoria:** Moderate level of happiness.
- **Elation:** Moderate level of happiness + increased motor activity + increased biological drives.
- **Exaltation:** Extreme happiness + delusion of grandeur.
- **Ecstasy**: An emotional or religious mystic (magical) experience with great happiness.

Disorders of Unpleasurable Affect

- **Depression:** Characterized by sadness of mood + decreased psychomotor activity + poverty of ideas.
- **Grief:** Intense sorrow caused by a loss especially of a loved one.

Disorders of Abnormal Affect

- **Anxiety:** An unpleasant emotional experience of apprehension (fear) related to an assumed danger in future.
- **Panic:** An acute profound attack of anxiety accompanied by feelings of impending doom.
- **Apathy:** Dull/decreased emotional tone.
- **Incongruent/inappropriate affect:** Mood and affect are not in accordance with one another. For example, Person claims that he is happy but facial expression are sad.
- **Ambivalence:** Presence of two contradictory ideas at the same time toward the same object, person or situation. For example, love and hate for the same person.
- **Mood swings:** Oscillation of mood between two extreme poles, i.e., depression and elation.
- **Depersonalization:** A feeling of being detached from oneself in which victim states that he has been changed or is in a dream.

Disorders of Speech

When a person does not produce a correct and fluent speech, they may be having a speech disorder. Disorders of speech are given below:

- **Stereotype speech:** Repetition of words/phrases or sentences.
- **Articulation disorder:** Child is not able to articulate (form) specific types of sounds. For example, wabbit in place of rabbit because the child is unable to produce the sound of 'R'.
- **Stuttering/stammering:** Speaking with difficulty with involuntary repetition of sounds.
- **Aphasia:** Person is unable to understand/produce a speech.
- **Aphonia:** Person is unable to speak.

Disorders of Memory

- Memory is the mental faculty which helps an individual to retain and recall any learned information. It is of three types:
  - **Immediate recall:** Ability to recall instantly what is said.
  - **Immediate memory:** Ability to remember and recall the events of past minutes or hours.
  - **Recent memory:** Ability to remember and recall the events of past 24–72 hours.
  - **Remote memory:** Ability to remember and recall long-term events.

  Any dysfunction in memory may result in a disorder of memory. These disorders are given below:

- **Amnesia:** Loss of memory. It may be partial or complete.
  - **Anterograde amnesia:** Forgetting the recent events. For example, things happened past 5 minutes.
  - **Retrograde amnesia:** Forgetting the long-term memories of past; often results in an inability to create new memories.
  - **Circumscribed amnesia:** Forgetting some particular and specific life events or people.
- **Paramnesia:** False memory of those events which never occurred. For example, Déjà vu
- **Hypermnesia:** Abnormal excessive retention and recall of past events even the very minute details.

Disorders of Attention and Concentration

Attention deficit hyperactivity disorder: A childhood disorder characterized by predominant hyperactivity and impulsive behavior and having a great difficulty staying focused on a task or activity. ADHD is both a disorder of attention and concentration as well as disorder of judgment.

Disorders of Judgment

- **Attention deficit hyperactivity disorder:** A childhood disorder characterized by predominant hyperactivity and impulsive behavior and having a great difficulty staying focused on a task or activity. ADHD is both a disorder of attention and concentration as well as disorder of judgment.
- **Bipolar disorder:** Bipolar disorder is characterized by impaired judgment along with other symptoms of disease.
- **Alzheimer disorder:** Alzheimer disorder is also having a characteristic symptom of impaired judgment.

5A: PERSONALITY AND TYPES OF PERSONALITY RELATED TO PSYCHIATRIC DISORDERS

PERSONALITY

Meaning

Personality refers to the personal existence of a human being. A person is a self-aware human being, not as a machine like object that lacks self-awareness, as quoted by C Robert Cloninger. It means that an individual is aware of his unique characteristics which he uses to adapt with ever-changing internal and external environments.

Definition

Personality refers to the sum total of all inherited and acquired potentials of an individual which are dynamic and are in continuous interaction with the environment for adaptation (Fig. 11).

Fig. 11: Key characteristics of personality

PERSONALITY DISORDER

A maladaptive personality is known as a personality disorder. Personality disorders are chronic in nature. Approximately 10–20% of the general population is suffering from personality disorders. Personality disorders occur in 50% of all psychiatric patients.

At times, personality disorder is a predisposing factor for other psychiatric disorders. Another issue with patients of personality disorders is that they deny their problems and are more likely to refuse psychiatric help. The primary reason behind is that they do not routinely acknowledge pain they cause others as their symptoms. Furthermore, they do not feel anxiety about their maladaptive behavior.

Personality disorder symptoms are egosyntonic and alloplastic (i.e., adapt by trying to alter the external environment rather than themselves).

Classification of Personality Disorders

DSM-5 defines a general personality disorder as an enduring pattern of behavior and inner experiences that deviates significantly from the individual's cultural standards; is rigidly pervasive; has an onset in adolescence or early adulthood; is stable through time; leads to unhappiness and impairment and manifests in at least two of the following four areas:

1. Cognition
2. Affectivity
3. Interpersonal function
4. Impulse control

Personality disorders are classified into three clusters based on descriptive similarities (Fig. 12).

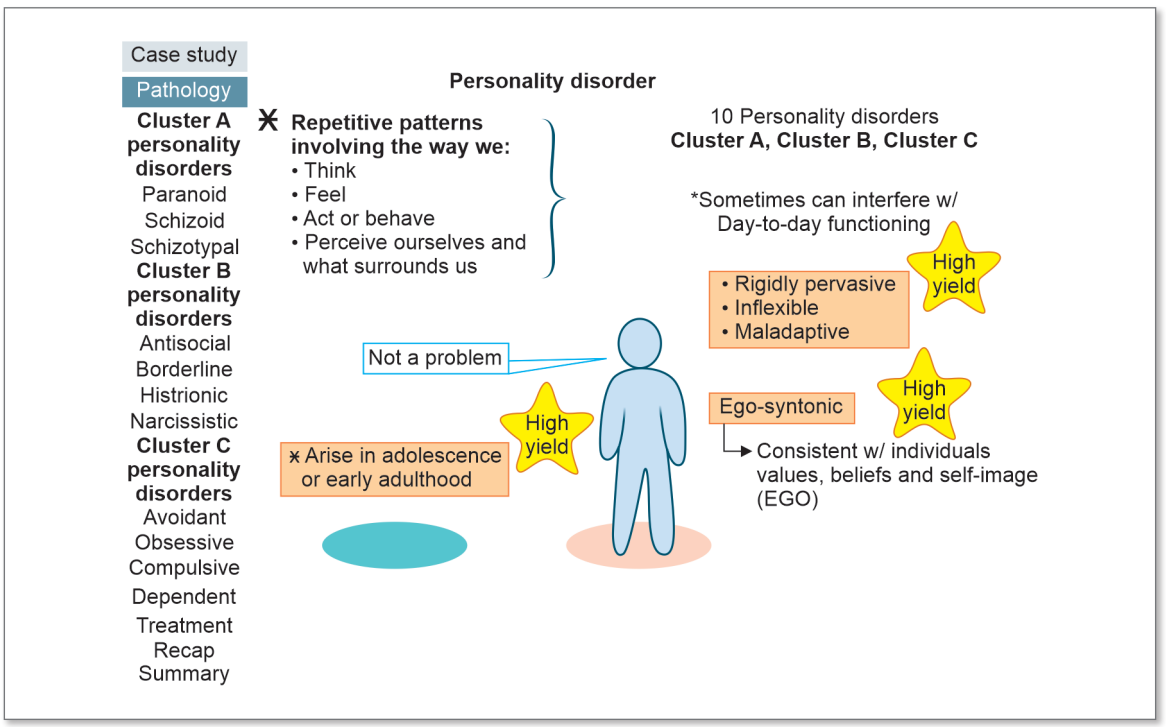


Fig. 12: Clusters of personality disorders

- Cluster A (with odd and aloof features)
  - Schizotypal personality disorder
  - Paranoid personality disorder
  - Schizoid personality disorder
- Cluster B (with dramatic, impulsive, and erratic features)
  - Borderline personality disorder
  - Antisocial personality disorder
  - Narcissistic personality disorder
  - Histrionic personality disorder
- Cluster C (with anxious and fearful features)
  - Avoidant personality disorders
  - Dependent personality disorders
  - Obsessive compulsive disorders

Etiology of Personality Disorders

Genetic Factors

- Cluster A personality disorders are more common in the biological relatives of schizophrenic patients.

- Cluster B personality disorders apparently have a genetic base. Antisocial personality disorder is associated with alcohol use disorders. Depression is common in the relatives of patients with borderline personality disorder. A strong correlation is found between histrionic personality disorder and somatization disorder.
- Cluster C personality disorders such as Avoidant personality disorders often have high anxiety levels. Obsessive compulsive disorder also has association with depression.

Biological Factors

- **Hormones:** Androgens increase the occurrence of aggression and sexual behavior in humans. High levels of testosterone are reported in persons who have impulsive traits.
- **Platelet monoamine oxidase:** Low platelet MAO levels have been reported in schizotypal personality disorders. Persons with low platelet MAO levels are more social in comparison with those having high platelet MAO levels.
- **Neurotransmitters:** Persons with impulsive and aggressive traits have reported low levels of serotonin and its metabolite in blood. These persons are more prone to attempt suicides. Increased dopamine levels are responsible for euphoric states.
- **Electrophysiology:** Personality disorders such as antisocial and borderline types show changes in electroencephalogram (EEG).

Psychoanalytic Factors

According to Sigmund Freud, personality traits are formed because of fixation at any of the psychosexual stage of development. For instance: Passive and dependent personalities are supposed to have fixation at oral stage.

- Stubborn and highly conscientious personalities may have fixation at oral stage of psychosexual development.
- Persons with paranoid personality disorder use defense mechanism of projection.
- Schizoid personality disorder patients use withdrawal.

The behavior of persons with personality disorders is egosyntonic which means that their behavior do not create any distress to them but to others.

Defense Mechanisms

We understand that ego defense mechanisms are used by every individual to overcome anxiety and depression at a conscious level. So it is well known fact to learn that persons with personality disorders are also using ego defense mechanisms. Although unhealthy in nature, the use of these unhealthy defense mechanisms helps them to deal with conflicts. If any therapist tries to suggest abandoning a defense, it increases anxiety and depression in the person with personality disorder—A major reason for poor prognosis of personality disorder.

Therefore, a therapist must learn the usage of defense mechanisms by persons with personality disorders and how to deal with them. It is discussed as follows:

- **Fantasy:** This defense is usually used by persons with schizotypal personality disorders who are eccentric, lonely and at times frightened. They always seek relief and satisfaction by creating imaginary friends and lives. They only live in their imagination and remain aloof, asocial with no real friends at all (Fig. 13).

Fig. 13: Fantasy

Therapist role:

- Understand that the cause of being asocial is the underlying fear of intimacy.
- Therapist must not criticize patient for their rejection, instead try to maintain a quiet, reassuring and genuine interest in patient without a demand for reciprocal responses.
- Recognize patient's fear of closeness.
- Respect even the odd ways of patients.

- **Passive aggression:** It literally means turning anger against oneself. The hostility in such aggression is always revealing, i.e., being performed in front of others. Such acts include wrist cutting, head banging, intentional slipping on the floor, etc. The effect of such hostility on others will be intense. They feel as much anger as if they themselves had been assaulted (Fig. 14).

Fig. 14: Passive aggression

Therapist role: Deal with passive aggression by helping patients to ventilate their anger.

- **Acting out:** This defense mechanism operates at an unconscious level. Patients show their unconscious conflicts through actions such as Tantrums, Assaults, Child abuse, etc. The persons using this defense will not feel any guilt for their misconduct.

  Therapist role:
  - Recognize that the patient has lost control and any word of consolation will be misheard.
  - Gain patient's attention.
  - Use verbal restraining if feels like it will work.
  - If a therapist feels frightened and is not able to deal with acting out of patient, he can simply leave.
  - If required, call for help from ward attendants or police.
- **Projection:** Here, patients ascribe their unrecognized emotions onto others. Patients may appear to others as faultfinder in excess and he himself will be very sensitive to criticism (Fig. 15).

  Therapist role:
  - A therapist must accept even minor mistakes of himself.
  - Discuss the chances of difficulties in near future.
  - Be honest with patient.
  - Never confront a patient with personality disorder. Confrontation guarantees a lasting enemy.
  - Use counter projection. Here, therapist gives persons with paranoid personality disorders full acceptance for their emotions and perceptions. Therapist neither disputes patients' complaints nor encourages them but consent that the world described by patients is conceivable.
  - After gaining patients' confidence, converse about real emotions and motives.

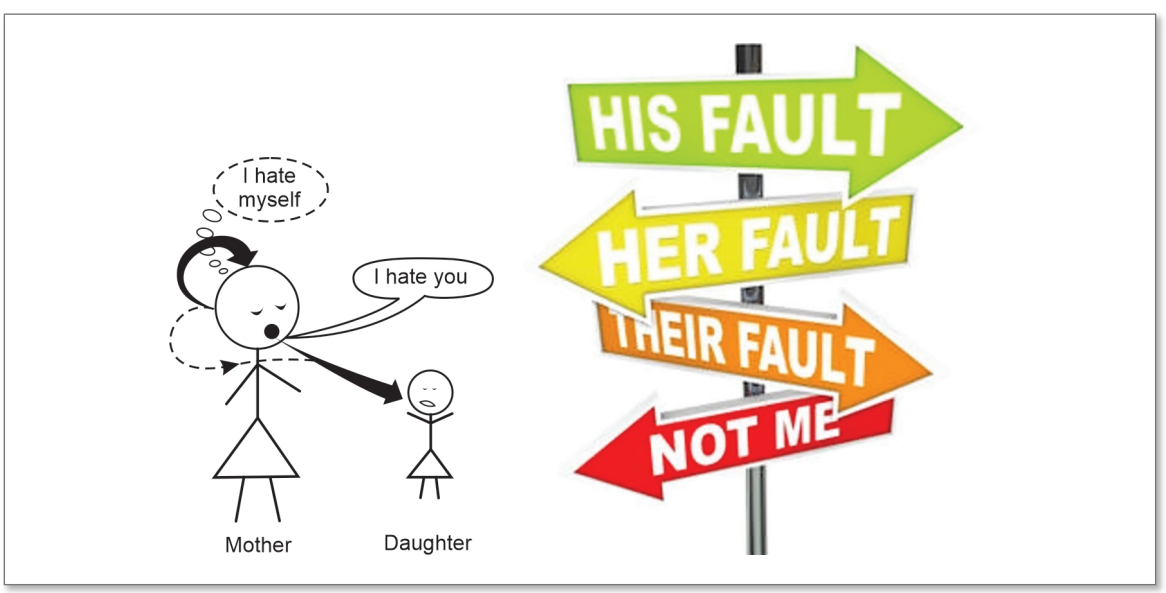


Fig. 15: Projection

- **Projective Identification:** This defense is usually used by patients of Borderline personality disorder. It happens at three levels. At first level, a feature of the individual is projected onto someone else. The projector then pressurizes the other person into identifying with what has been projected. At final stage, the receiver of the projection and the one who projects it become united and has a sense of oneness (Fig. 16).
- **Dissociation/denial:** Here the individual denies the presence of unpleasant emotions and dissociates himself. On the surface, he may appear dramatizing and emotionally shallow. Individuals would love to make him available to deal with unnecessary but exciting dangers, only to alleviate his anxiety (Fig. 17).

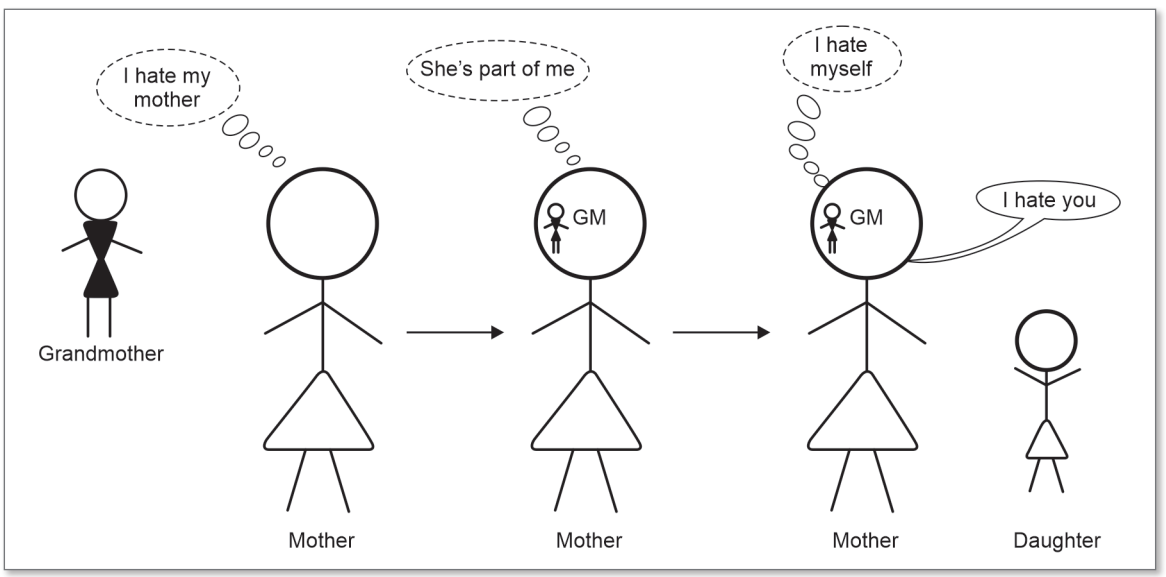


Fig. 16: Projective identification

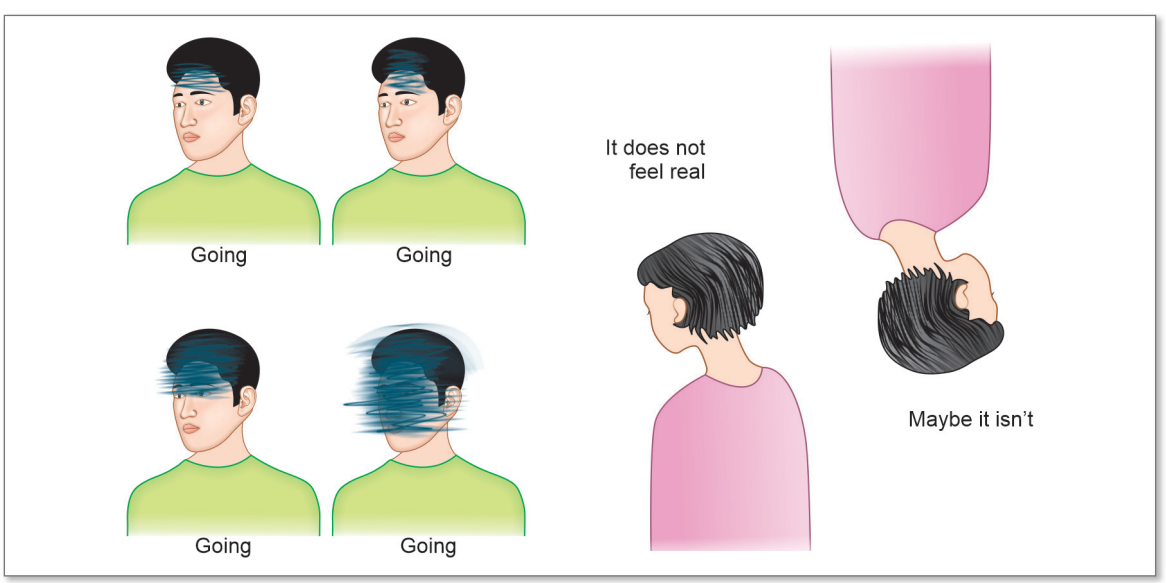


Fig. 17: Dissociation

Therapist role:

- Individuals suffering with personality disorders unintentionally speak lies. Instead of confronting the patient, remain calm and firm.
- Empathize even with denial. This will relieve patient's anxiety and he himself will bring the original topic in a non-threatening environment.
- Do not confront patient with their vulnerabilities and defects. This will bring patient's defensive side and early termination of interview.

- **Isolation:** This defense mechanism is usually used by patients with obsessive compulsive disorders. Here, patient does not deny the problem but remembers its every detail without any emotion attached to it. To deal with their anxieties, patients become overly formal, social behaved and stubborn (Fig. 18).
  Therapist role: Allow patients to control their care in their own way and not bring any battle unnecessary.
- **Splitting:** Here, patients split their emotional content into ambivalent thoughts which means the persons whom patient has to deal with will be divided into good and bad. The mind play of such person can be very disruptive and can bring about terrible consequences. One such patient in a ward who divides all staff into two categories of good and bad can ignite fights between group of people and a lot more of confusion and untoward trouble (Fig. 19).
  Therapist role: Calmly explain the patient that no one is all good or all bad.

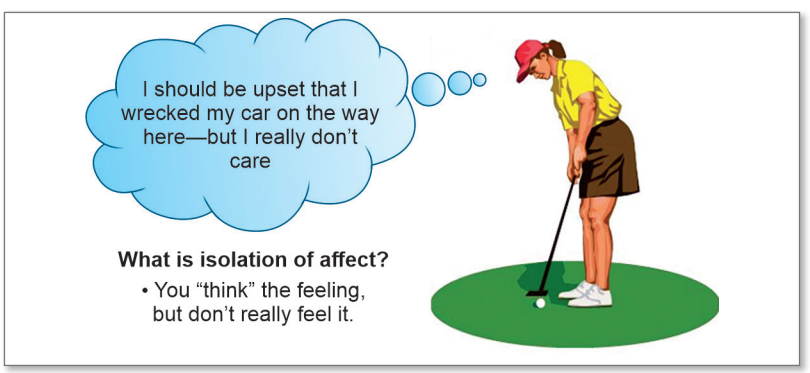


Fig. 18: Isolation

Fig. 19: Splitting

PARANOID PERSONALITY DISORDER

Definition

Paranoid personality disorder is characterized by suspiciousness and mistrust in family, friends or people in general.

Persons with paranoid personality disorders are very irritable, angry and exhibit hostility without feeling of guilt for the pain they cause others because of their behavior. They often hold others responsible for their bad emotions.

Paranoid personality disorders are often seen in pathologically jealous spouses, injustice collectors, prejudiced persons and those who are too ready or eager to sue someone in the court of law (Fig. 20).

Prevalence

About 2–4% of the general population is affected with paranoid personality disorder all over the world. The overall prevalence of personality disorder in India is 0.6%.

Research suggests that paranoid personality disorders are more common in minority groups, immigrants, and deaf as compared to general population. On the basis of gender, it is more prevalent in men. But the bitter side is that these persons will rarely seek any treatment because they never feel any distress of their symptoms.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes

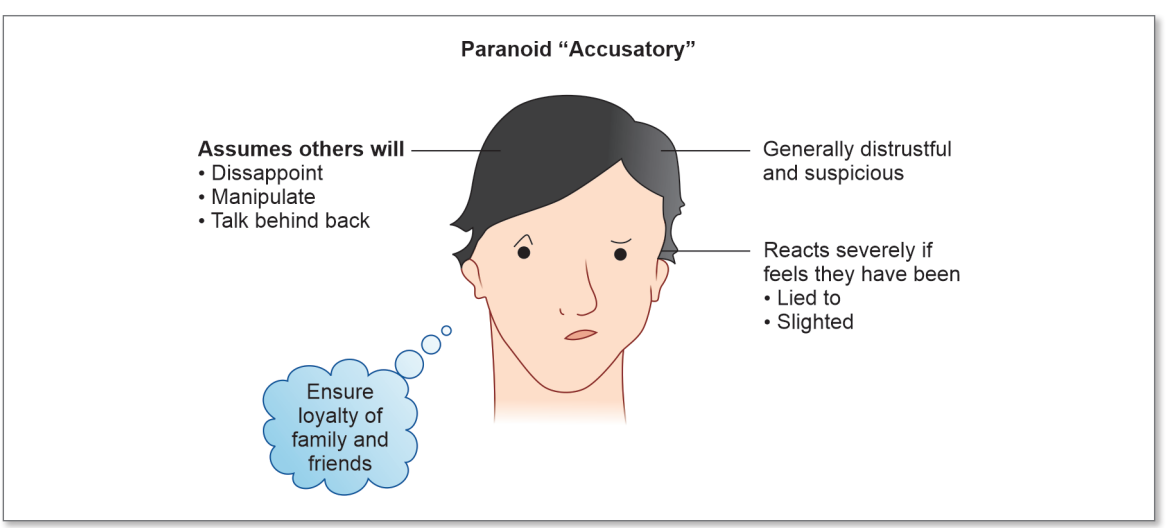


Fig. 20: Paranoid disorder

- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Suspicious behavior
- Feelings of distrust
- Doubts about loyalty of friends/spouse/family and strangers
- Holds grudges
- Takes revenges for insults
- Delusion of infidelity
- Handle criticism in a negative way
- Pathologically jealous for no reason, often questions the fidelity of their spouses or sexual partners.
- Often uses defense of projecting own painful unacceptable emotions onto others.
- Idea of reference is a common feature. Illusions are also defended logically.
- Unemotional at the face, takes pride on being logical and rationale but are not.
- Often pay close attention to and impressed with power and position.
- Hates those who are weak or less than others in any way.
- Always known for generating conflicts and fear in others.

DSM-5 Diagnostic Criteria for Paranoid Personality Disorder

- **A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:**
  - Suspects without sufficient basis that others are exploiting, harming, or deceiving him/her.
  - Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends and associates.
  - Is reluctant to confide in others because of unwarranted fear that information will be used maliciously against him/her.
  - Reads hidden demeaning or threatening meanings into benign remarks or events.
  - Persistently bears grudges (i.e., unforgiving of insults, injuries, or slights).
  - Perceives attacks on his/her character or reputation that are not apparent to others and is quick to react angrily or to counteract.
  - Have recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

Diagnosis

- On psychiatric evaluation, a paranoid personality disorder patient will appear formal, serious and humorless.

- He will do a quick scan of the environment for clues about having to seek any treatment.
- The speech of the patient will reflect projection, ideas of reference and prejudices.
- He will remain logical and goal-directed throughout the content of his speech.
- Patient will be unable to relax and will show muscular tension by facial expression and bodily gestures.

Prognosis

Prognosis is generally poor. Paranoid personality disorder is sometimes a lifelong disease affecting occupation and marriage the most.

Medical Management

- **Psychotherapy:** It is the treatment of choice for patients with paranoid personality disorder. Honesty and apology are the keys to work with these patients. Always be formal and professional in all of your dealings. Friendly and overly warm attitude will not work among such patients. Be consistent in your approach as any change may bring out the ugly side of suspiciousness. Try not to be late for an appointment.

  Do not interpret private and sexual issues, desires for intimate relations as your interpretation may significantly provoke mistrust in therapist. Instead, help patients to interpret his emotions.
- **Role play (reversal):** Role play is although useful, if patient agrees to participate. It may help in improving social skills. But the sad story is that paranoid patients usually are not willing to follow therapist instructions.
- **Behavioral therapy:** Patients with paranoid personality disorders would not like any intrusion of behavioral therapy. Patient may threaten the therapist. Therapist must set limits on the behavior of patient. Be gentle in your approach. Never show yourself weak or powerless in front of patient. Therapist anxiety will automatically be transferred in paranoid patient and he will be frightened intensely. Intervene only when therapist is sure of taking control and is able to do so.
- **Psychopharmacology:**
  - **Diazepam:** An antianxiety drug is sufficient in combating agitation and anxiety of patients.
  - **Haloperidol:** It is recommended in small doses if patient is severely agitated. It can also be used in cases where patient is having quasi delusions.
  - **Pimozide:** This antipsychotic is also useful in reducing paranoid symptoms.

SCHIZOID PERSONALITY DISORDER

Definition

Schizoid personality disorder is characterized by social withdrawal, isolation and introversion.

On the surface, persons with schizoid personality disorder are eccentric, isolated and lonely. They are introvert and have constricted affect. These persons usually adopt solitary jobs in which they have not to make any social contacts/ interaction. At times, they would like to work at nights so as to avoid dealing with people (Fig. 21).

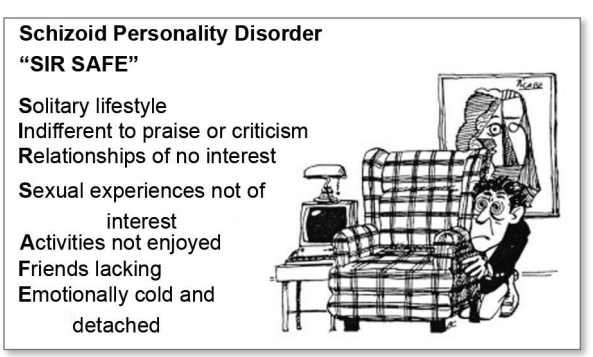


Fig. 21: Schizoid personality disorder

Prevalence

The overall world population prevalence of schizoid personality disorder is 5%. In India, statistics have reported the prevalence of personality disorders to be 0.6%.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Social withdrawal
- Inexpressible
- Does not get involved in social gatherings such as parties
- Does not feel the need to be in a close/intimate relationship
- Lack interest in sex. Male or female both disagree to marital relationships.
- Interested in activities doing alone
- Feels arrogant and less emotional to others
- Lacks close friends/no friends at all
- Does not feel happy with praise
- Does not feel sad with criticism
- Cold and aloof
- Lacks concern with others
- No involvement with everyday activities
- Seclusive
- Unsociable
- No desire for emotional attachments
- Lacks interest in knowing about new fashion/trends
- Never express anger directly. They can hold their anger for a lifetime
- At times, schizoid personality disorder persons are creative.

DSM-5 Diagnostic Criteria for Schizoid Personality Disorder

- **A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following:**

- Neither desires nor enjoys close relationships, including being part of the family.
- Almost always chooses solitary activities.
- Has little, if any, interest in having sexual experiences with another person.
- Takes pleasure in few, if any, activities.
- Lacks close friends or confidants other than first degree relatives.
- Appears indifferent to the praise or criticism of others.
- Shows emotional coldness, detachment, or flattened affectivity.

- Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical disorder.

Diagnosis

The diagnosis of the schizoid personality disorder is purely based on the clinical signs and symptoms.

Prognosis

This personality disorder affects a greater part of an individual's life but may or may not be life-long. Schizoid personality disorder usually has its onset in early childhood or adolescence.

Medical Management

- **Psychotherapy:** In psychotherapy, schizoid personality disorder persons will tell about his fantasies, imaginations and fears.
- **Group therapy:** Even if these persons take part in group therapies, they may remain silent for long times. After a passage of time, they may get involved.
- Psychopharmacology
  - Antipsychotics
  - Antidepressants
  - Psychostimulants
  - Benzodiazepines

SCHIZOTYPAL PERSONALITY DISORDER

Definition

Schizotypal personality disorder is characterized by odd behavior, magical thinking, and ideas of reference, illusions and derealization.

Prevalence

Total 3% of the world's population is having schizotypal personality disorder. In India, the overall prevalence of personality disorders is 0.6% of the total population (Fig. 22).

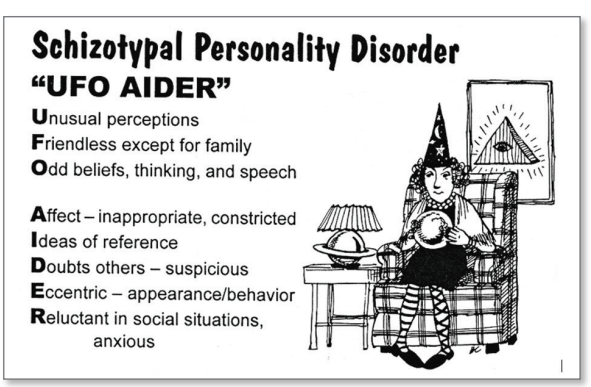


Fig. 22: Schizotypal personality disorder

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Ideas of reference
- Magical thinking
- Odd beliefs and behavior
- Bodily illusions
- Suspicious behavior
- Inappropriate affect
- **Anxiety while interacting socially:** Poor interpersonal relationships
- **Lack of close friends/no friends:** Isolated/very few friends, if any
- **Disturbed thinking and communication:** Their communication may have a meaning to them.
- Increased sensitivity and awareness of the feelings of others especially negative emotions such as anger, hatred and jealousy, etc.
- Superstitious behavior
- They often claim special power of clairvoyance, i.e., the supposed faculty of perceiving things or events in the future or beyond normal sensory contact.
- Child-like fears and fantasies
- In severe stage, person may experience Anhedonia and severe depression

DSM-5 Diagnostic Criteria for Schizotypal Personality Disorder

- A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships as well as by cognition or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  - Ideas of reference (excluding delusion of reference).
  - Odd beliefs or magical thinking that influences behavior and is consistent with sub cultural norms (e.g., superstitiousness, telepathy or sixth sense in children and adolescents, bizarre fantasies or preoccupations).
  - Unusual perceptual experiences, including bodily illusions.

- Odd thinking or speech (e.g., vague, circumstantial, overelaborate or stereotyped).
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Behavior or appearance that is odd, eccentric, or peculiar.
- Lack of close friends or confidants other than first degree relatives.
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

- Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Prognosis

This danger is a silent killer. No one may be aware of the potential danger and patient may survive normally in the society. But the prognosis may result in sudden suicide in 10% of affected individuals.

Medical Treatment

- **Psychotherapy:** While giving psychotherapy to persons with schizotypal disorder, the therapist must deal with them very sensitively especially when they talk about their strange religious practices. These mystical practices may have a life meaning to them. Therapist must not be judgmental about such beliefs or activities.
- **Antipsychotics:** These medications may help combating symptoms of ideas of reference, illusions, etc.
- **Antidepressants:** If depressive symptoms are present.

ANTISOCIAL PERSONALITY DISORDER

Definition

Antisocial personality disorder is characterized by antisocial or criminal acts on a continuous basis because of lack of conformity to social norms (Fig. 23).

Fig. 23: Antisocial personality disorder

Prevalence

The prevalence of antisocial personality disorder in world's population is 0.2–3%. In India, the overall incidence of personality disorders is 0.6%.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes

- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Does not follow rules and norms of the society
- **Repeated criminal acts:** Illegal activities
- Repeated antisocial behavior
- Repeated lying
- Deceitful behavior
- Cunning nature
- Harming others for one's profits
- Irritable behavior
- Aggression
- Lack of guilt for one's wrong doing
- Theft
- Insulting others
- Fights
- Substance abuse
- Suicide threats
- Somatic preoccupations
- Extremely manipulative
- They often behave like a con man who frequently talks with others into participating schemes for easy ways to make money or to achieve fame.
- Drunken driving
- Spousal abuse
- Child abuse
- Never embarrassed or guilty about their actions-lacks conscience.

DSM-5 Diagnostic Criteria for Antisocial Personality Disorder

- A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
  - Failure to conform to the social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
  - Deceitfulness, as indicated by repeated lying, use of aliases, or cunning others for personal profit or pleasure.
  - Impulsivity or failure to plan ahead.
  - Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
  - Reckless disregard for safety of self or others.

  - Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
  - Lack of remorse (guilt), as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- The individual is at least age 18 years.
- There is evidence of conduct disorder with onset before age 15 years.
- The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Prognosis

Prognosis of antisocial personality disorder may or may not be good. In some persons, it grows with advancing age and some persons give up these antisocial personality traits with advancement of age.

Medical Management

- **Psychotherapy:** This will only work, if clients got hospitalized and be there to receive suggestions. Whenever they are among their friends, they again lack motivation and no change in behavior occurs. Self-help groups are of more use to persons with antisocial personality disorder.
  It is often very difficult to deal with such persons as they often exhibit self-destructive behavior. It is very challenging for a therapist to distinguish between control and punishment.
- Psychostimulants if ADHD symptoms occur, e.g., methylphenidate (Ritalin)
- **Carbamazepine:** To control impulsive behavior
- Sodium Valproate
- Any medications used for antisocial personality disorder symptoms must be used with caution as these persons are usually drug abusive which poses a great risk for drug interaction.

BORDERLINE PERSONALITY DISORDER

Definition and Meaning

- As the name suggests, it is a borderline disorder, i.e., a border between neurosis and psychosis. A person who is affected with borderline personality disorder is at the urge of a full episode of psychosis and neurotic symptoms are already present (Fig. 24).
- Borderline personality disorder is characterized by labile mood, extraordinary unstable affect, and self-image, interpersonal relationships. Interpersonal relationships here mean object relations, i.e., objects refer to people or physical items

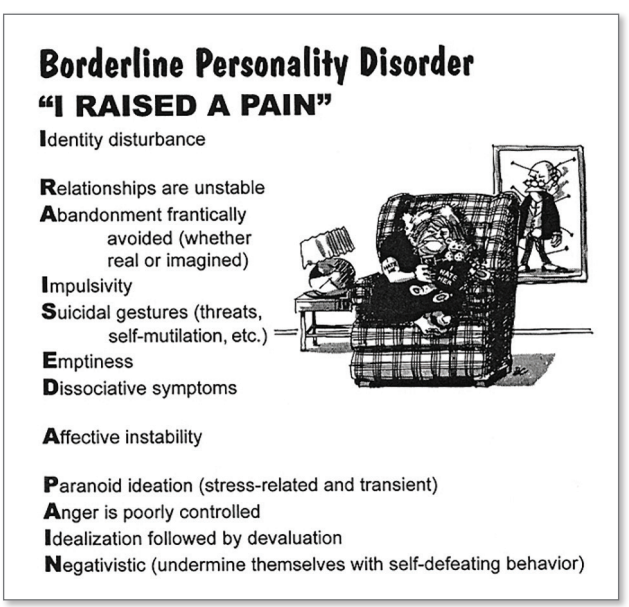


Fig. 24: Borderline personality disorder

that come to symbolically represent either a person or part of a person. Object relations, then, are our internalized relationships to those people.

- Another name of borderline personality disorder is Ambulatory Schizophrenia. In ICD-10, it is referred to as emotionally unstable personality disorder.

Prevalence

The prevalence of borderline personality disorder in world's population is 0.2–3%. In India, the overall incidence of personality disorders is 0.6%. Borderline personality disorder is twice as common in women as in men.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Extremely anxious about being abandonment, i.e., left by somebody. Always seeks companionship even if it is unsatisfactory. Even for short periods, they can't be alone so they will accept a stranger as a friend.
- Unsatisfactory interpersonal relations
- Unstable sense of self
- Impulsive behavior
- Suicidal ideation and attempts
- Self-mutilation
- Anxiety
- Dysphoria
- Aggression
- Chronic feeling of emptiness
- Irritability
- Hostility
- **Mood swings:** Argumentative at one moment, depressed later and then no complains of having any feelings
- Unpredictable behavior
- Boredom

- Use projective identification as a defense against the person
- Person with borderline personality disorder will consider each person to be either all good or all bad

DSM-5 Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- **Identity disturbance:** Markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- Effective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness
- Inappropriate intense anger or difficulty in controlling anger.
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Prognosis

Borderline personality disorder is lifelong disorder with little improvement in personality traits.

Medical Treatment

- **Psychotherapy:** It has been a treatment of choice for patients with borderline personality disorder although it would be very expensive and difficult to deal with. It must be applied along with psychopharmacology for better results.
  These persons will be very difficult to handle because of the symptoms such as hostility-inappropriate intense anger or difficulty in controlling anger. They may use positive or negative transference with therapist, i.e., either consider therapist as a good person (nurturing attachment figure) or a bad person (a hateful, disgusting creature). In both kind of transference, it is a hindrance in the improvement of behavior of person with borderline personality disorder.
- **Behavior therapy:** It may be used to control hostile impulses of patient and to handle criticism by others. Social skills training is also imposed with videotape playback. Occupational, recreational and vocational therapy can also be implemented if patient is treated in Inpatient department. In hospitals, setting limits on behavior will be quite helpful as it may create learning on how to deal effectively with anger impulses when things are not happening in one's way.
- **Dialectical behavior therapy:** This therapy is used if person with borderline personality disorder exhibits parasuicidal behavior such as frequent cutting.
- **Transference focused psychotherapy:** As we already know, borderline personality disorder patient uses transference both negative and positive. Therefore, this therapy is purely based on working with patient to make clarification on the usage of transference. Once how things are getting work out is made clear to

patient, the next step is Confrontation in which patient learns with the therapist's help that how usage of transference has distorted and interfere with patient's interpersonal relations.

- **Mentalization-based treatment (MBT):** Mentalization means person being aware and attentive to the mental state of oneself and of others. For example, when a person understands that his anger towards the person is out of jealousy and insecurity. At times, person is not aware about his mentalization. If patient with borderline personality disorder will understand his mentalization, it will help reduce many symptoms of the disorder.
- **Pharmacological treatment:**
  - Antipsychotics to control hostility and anger and brief psychotic episodes
  - MAOIs for impulsive behavior
  - Benzodiazepines for anxiety. Alprazolam is a drug of choice in the category of benzodiazepines for borderline personality disorder.
  - Anticonvulsants such as Carbamazepine might help in improving global functioning of patient.
  - SSRIs for improving gross personality
  - Antidepressants to improve the depressed mood

HISTRIONIC PERSONALITY DISORDER

Definition

Histrionic personality disorder is characterized by extroversion, colorful and dramatic way of presenting oneself with no deep emotional concerns (Figs 25A and B).

Figs 25A and B: Histrionic personality disorder

Prevalence

The overall world's population is having prevalence of 1–3% of histrionic personality disorder. In India, the overall incidence of personality disorders is 0.6%.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes

- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Dramatization
- Shallow expression of emotions
- Attention seeking behavior
- Inappropriate sexual behavior
- Provocative physical appearance
- Impressionistic speech
- Easily influenced by other people
- Exaggeration of thoughts and emotions, things are more in intensity than they actually are.
- Temper tantrums if they are not the center of attention
- Tears to acquire more sympathy and involvement
- Accusations if not receive approval or praise
- Seductive fantasies
- Coy or flirtiest
- Need endless reassurance. They always act on their sexual impulses to make sure that they are attractive to the opposite gender.
- Superficial relationships
- Overly trusting
- Easily duped or cheated
- **An interesting fact:** It is quite possible that histrionic patients do have sexual dysfunction; men may be impotent and women may be anorgasmic.

Diagnosis

Patients of histrionic personality disorder will be very comfortable in giving detailed history in interviews. The therapist may observe gestures and dramatic punctuation in their conversations. The outward expression of emotion will be displayed perfectly such as anger, sadness and sexual wishes but when asked about it, the usual response will be denial and surprise. Frequent slip of tongue can be observed although language of the patient will be very colorful. The cognitive abilities of the patient will be showing normal results.

DSM-5 Diagnostic Criteria for Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Is uncomfortable in situations in which he or she is not the center of attention.
- Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
- Displays rapidly shifting and shallow expression of emotions.

- Consistently uses physical appearance to draw attention to self.
- Has a style of speech that is excessively impressionistic and lacking in detail.
- Shows self-dramatization, theatrically and exaggerated expression of emotion.
- Is suggestible (i.e., easily influenced by others or circumstances)
- Considers relationships to be more intimate than they actually are.

Prognosis

The prognosis is good with advancement of age.

Medical Treatment

- **Psychotherapy:** Psychoanalytic Psychotherapy is the treatment of choice with patients of histrionic personality disorder. These patients are usually not aware of their true emotions, therefore psychoanalytic psychotherapy must be focused on classification of inner feelings and to make patient oriented about it. The therapy can be given in group or individually according to the needs of the patient.
- **Pharmacotherapy**
  - Combination of antidepressants (for depression and somatic complaints) and antianxiety drugs (for anxiety and apprehension)
  - Antipsychotics may also be administered to combat symptoms such as derealization and illusions.

NARCISSISTIC PERSONALITY DISORDER

Definition

Narcissistic personality disorder is characterized by self-praise, a high sense of self-importance, grandiosity and inconsideration to the feelings of others (Fig. 26).

Although on the surface, patients are having great self-esteem but underneath, are very fragile.

They do have a weak personality and very prone to get deeply hurt with even minor criticism.

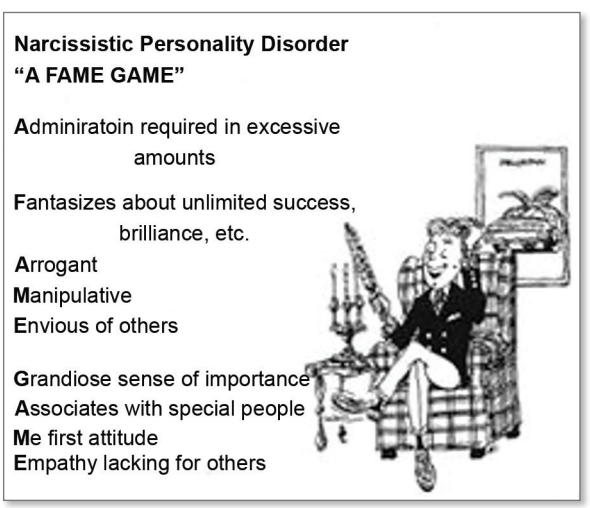


Fig. 26: Narcissistic personality disorder

Prevalence

The world prevalence of narcissistic personality disorder is 1–6%. The overall incidence of personality disorders in India is 0.6%.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.

  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Feelings of grandiose
- Exaggerated feelings of self-importance
- Fantasies of power, beauty, intelligence and ideal love
- Demands excessive admiration
- Despitefully use others for one's benefits
- Lacks consideration for the feelings of others.
- Arrogance
- Envious behavior
- Considers oneself as extremely important and unique
- Expects special treatment
- Cannot handle criticism in any form
- Ambitious for name and fame
- Refuse to obey traditions and conventional rules. They want things in their own way.
- Their behavior is always furious for others.
- Lacks empathy
- Pretend to be affected by sympathy shown by others but it is always a means to get their own selfish ends.
- Vulnerable for depression
- Their behavior often cause problems such as rejection, loss, interpersonal and occupational difficulties but in any of these problems, they are not able to handle, end up having more stress.
- Aging is handled poorly as they never know how to age gracefully. Their only true appreciation is always for beauty, strength and youth. So aging can bring midlife crisis for narcissists.

DSM-5 Diagnostic Criteria for Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.
- Believes that he/she is special and unique and can only be understood by, or should associate with, other special or high status people (or institutions).
- Requires excessive admiration.
- Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his/her expectations).

- Is interpersonally exploitative (i.e., takes advantage of others to achieve his/her own ends).
- Lacks empathy, i.e., unwilling to recognize or identify with the feelings and needs of others.
- Is often envious of others or believes that others are envious of him/her.
- Shows arrogant, haughty behaviors or attitudes.

Prognosis

Narcissistic personality disorder is difficult to treat; has a bad prognosis.

Medical Treatment

- **Psychotherapy:** May be implemented but results can't be ensured.
- **Group therapy:** Can be instituted for patient to learn how to share with others. It might help patient develop empathy.
- Pharmacotherapy
  - Lithium (mood swings)
  - Antidepressants (SSRIs)

AVOIDANT PERSONALITY DISORDER

Definition

Avoidant personality disorder is characterized by inferiority complex, a great desire for companionship, yet have socially withdrawn lives. They are very sensitive to rejection. On the surface, they may appear shy but don't take their shyness as being asocial. People often label these kinds of persons as with an inferiority complex. Children with timid personality are more susceptible to have avoidant personality disorder later in lives (Fig. 27).

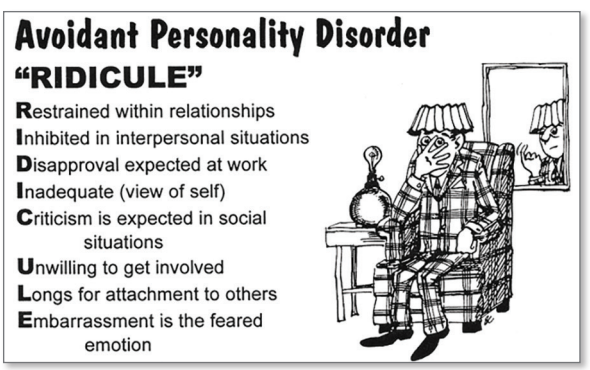


Fig. 27: Avoidant personality disorder

On clinical examination, patients will be anxious while conversation with therapist. They will exhibit nervousness and tension.

Talk will be taken very sensitively by patients with avoidant personality disorder. Any comments or suggestions by others can be interpreted as criticism.

Prevalence

The prevalence of avoidant personality disorder is 2–3%. In India, the overall incidence of personality disorders is 0.6%.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.

  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Avoids those activities which require maintaining interpersonal relations.
- Do not get involved with people much because of fear of rejection, criticism and because of uncertainty of their being liked.
- Consistent thoughts of rejection on their mind.
- Inferiority complex.
- Feeling of being socially unproductive and worthless.
- Afraid of new interpersonal relationships.
- Timid personality.
- Appreciates the affection and security of human friendships but are never able to enjoy any because of consistent fear of rejection on mind.
- Low self-confidence.
- Never indulge in public speaking.
- Susceptible to take compliments as criticism.
- Cannot make request to others because refusal of any request will further enhance social withdrawal.
- Never make use of authority even if they attain such status. Instead they are always shy and willing to please others.
- Reluctant and hesitant to enter in relationships unless being assured of uncritical acceptance.
- No close friends or confidants.

DSM-5 Diagnostic Criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval or rejection.
- Is unwilling to get involved with people unless certain of being liked.
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
- Is preoccupied with being criticized or rejected in social situations.
- Is inhibited in new interpersonal situations because of feelings of inadequacy.
- Views self as socially inept, personally unappealing, or inferior to others.
- In unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Prognosis

Prognosis of avoidant personality disorder is good with a strong social support system. With being accepted, these people with avoidant personality disorder may lead a normal life.

Medical Management

- **Psychotherapy:** Psychotherapy will work if therapist will be able to make a relationship with patient based on similarity of interests, nature or qualities. Therapist must demonstrate an unconditional acceptance to patient to combat the feelings and fears of rejection. Therapist must continuously inspire and uplift patient's spirit to enter into the world where humiliation, loss, failure and rejection are natural and at times unavoidable.
  Therapist may give some social skills assignments to perform in real world such as talking with someone, indulge and being a part of a club or group. But this must be done with caution because failure may add to patient's already lower self-esteem.
- **Group therapy:** This is executed to make patient understand that how he/she is so relatable to others and how his fear of rejection affects others.
- **Assertive training:** It implies that patient must be able to express his needs openly without being offended. It may enhance self-confidence in patient.
- **Pharmacotherapy:**
  - **Beta blockers:** To manage autonomic nervous system hyperactivity when patient is geared into fearful situations.
  - **Serotonergic agents (e.g., SSRIs):** May help in combating symptoms of depression and rejection sensitivity.
  - **Dopaminergic drugs:** Might enforce novelty seeking behavior. Therapist must prepare patient psychologically for new experiences that might happen.

DEPENDENT PERSONALITY DISORDER/PASSIVE-DEPENDENT PERSONALITY

Definition

Dependent personality disorder is characterized by dependence, lack of assuming responsibility for oneself and self-confidence. They are extremely uncomfortable with being alone.

Another name for dependent personality disorder is passive dependent personality. The most prominent features of the disorder are dependence, pessimism, and fear of sexuality, self-doubt, passivity, suggestibility and lack of perseverance.

While communicating, these patients may make an effort to cooperate. Unlike others, they always welcome guidance from others. They attempt every question being asked (Fig. 28).

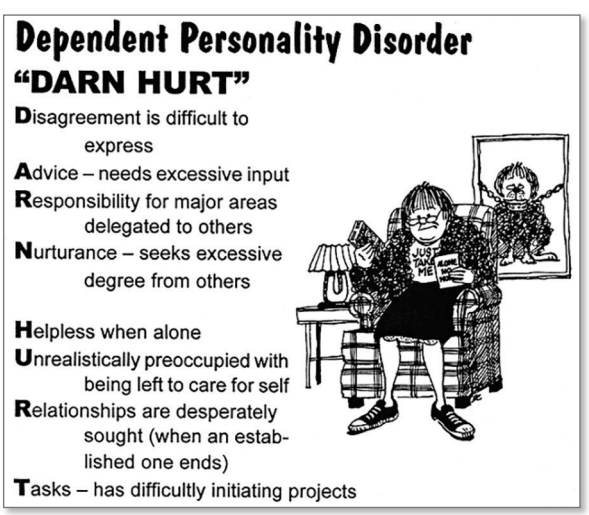


Fig. 28: Dependent personality disorder

Prevalence

The world population prevalence of dependent personality disorder is 0.6%. The prevalence of dependent personality disorder in India is 0.6%. This disorder is more common in women as compared to men. Children with chronic physical illness in childhood are more prone to develop this disorder later in their lives.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Needs advices in excess for every small or big decisions of life.
- Submissive
- Clinging behavior
- Never insults or humiliates others from whom they need support
- Never takes initiative to do any work
- Can never cope with loneliness; are in intense need of a supported relationship
- Fear of being abandon.
- Can never make decisions without an excessive amount of advice and reassurance from others
- Avoids leadership roles, always give up on positions of responsibility
- On their own, they never continue in a course of action where they face any difficulty and do not have any indication of success but they may find it easy to perform these tasks for someone else.
- Pessimism
- Self-doubt
- Passivity
- Fears of expressing sexual and aggressive feelings
- Surprising to know that they can tolerate an abusive, unfaithful or alcoholic spouse for a lifetime just to avoid detachment and being alone.
- Impaired occupational functioning
- Limited social relationships only with those on whom they can depend.
- Bear physical and mental abuse because they cannot defend their rights and be assertive about their entitlements.
- May end up having major depression if person on whom they depend is lost.

DSM-5 Diagnostic Criteria for Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- Needs others to assume responsibility for major areas of his/her life.
- Has difficulty expressing disagreement with others because of fear of loss of support or approval.
- Has difficulty initiating projects or doing things on his/her own.
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for him/her.
- Urgently seeks another relationship as a source of care or support when a close relationship ends.
- Is unrealistically preoccupied with fears of being left to take care of him/her.

Prognosis

Prognosis of dependent personality disorder is uncertain.

Medical Management

- Psychotherapy
  - **Insight oriented psychotherapy:** With the help of therapist, patient may understand what precedes their behavior. Therapist might help patient become more independent, assertive and self-reliant.
  - Behavioral therapy
  - Assertive training
  - Family therapy
  - Group therapy
  - Therapy usually does not work if patient is in need of a change in the dynamics of pathological relationship, e.g., an abused spouse, an abused parent or other significant in life. Patient will become extremely anxious and may feel torn between complying and losing a relationship. Therapist in any case, must demonstrate respect for patient's emotions and concerns.
- Pharmacology
  - Antianxiety drugs
  - **Antidepressants (imipramine):** Patients with high levels of separation anxiety can be helped with Imipramine.
  - Benzodiazepines
  - SSRIs
  - If patient feels better with psychostimulants in case of depression or withdrawal symptoms, they can be used.

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

Definition

Obsessive compulsive personality disorder is characterized by excessive concern over orderliness and person is stubborn, indecisive and preoccupied with details (Fig. 29).

The most prominent feature of OCD is extensive pattern of inflexibility and perfectionism.

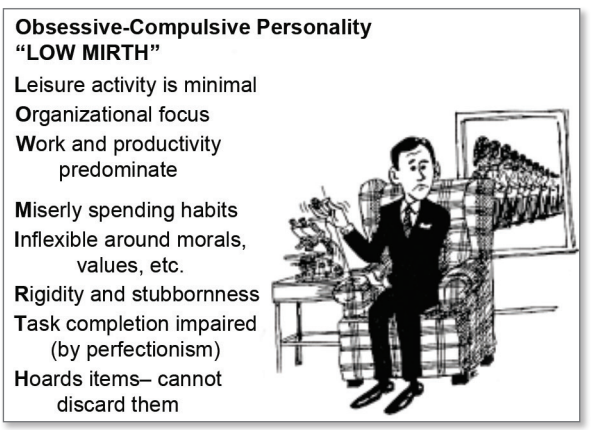


Fig. 29: Obsessive compulsive personality disorder

Prevalence

The prevalence of obsessive compulsive personality disorder in world population is 2–8%. In India, the overall incidence of personality disorders is 0.6%.

OCD is more prevalent in men. Patients often have history of harsh discipline in childhood. Difficult toilet training may also be there.

Etiology

- Genetic factors
- Biological factors
  - **Hormones:** Altered levels of testosterone and estrogens.
  - **Platelet MAO:** Low platelet MAO levels.
  - **Neurotransmitters:** Increased/decreased levels of endorphins, serotonin, and dopamine.
  - **Electrophysiology:** EEG changes
- Psychoanalytical factors
  - **Psychosexual Theory:** Fixation at any psychosexual stage of development.
  - **Use of unhealthy defense mechanisms:** Most of the individuals who have personality disorders use fantasy, dissociation, isolation, projection, splitting, passive aggression, acting out and projective identification as a way to cope with stressful life events. These defense mechanisms are either immature or unhealthy defense mechanisms.

Signs and Symptoms

- Preoccupation with details, rules and schedules up to an abnormal limit.
- Obsessed with perfection
- Hardly appreciate others' work
- Very critical (fault finding nature)
- Devotion to work and being productive
- Inflexible approach
- Makes the best out of even worthless objects
- Forbids recreation activities for work and other important pursuits
- Rigid
- Stubborn

- Appreciates legacy in every matter especially money
- Overly possessed about morals, ethics and religious matters
- General constriction of entire personality
- Intolerant
- Expert at doing prolonged routine work
- Limited interpersonal skills
- Formal and bear a serious tone
- Lack a sense of humor
- Never compromise
- Often try to please those who are greater than them in power, authority or status.
- Fear making mistakes
- Good occupational history
- Stable relationships although have few friends
- Often flourish in positions demanding detailed, methodical work
- At risk with unexpected changes

Dsm-5 Diagnostic Criteria for Obsessive Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
- Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his/her own overly strict standards are not met).
- Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by cultural or religious identification).
- Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
- Is unable to discard worn-out or worthless objects even when they have no sentimental value.
- Is reluctant to delegate tasks or to work with others unless they submit to exactly his/her ways of doing things.
- Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
- Shows rigidity and stubbornness.

Prognosis

The prognosis of OCPD varies among people. It is usually relapsing after a complete asymptomatic period.

Medical Treatment

- **Psychotherapy:** Patients with OCD often seek treatment on their own as they are usually aware of their problems. Free association works best with these patients. Problem of Countertransference may occur as a natural consequence of long and complex treatment.

- **Group therapy:** Interrupt patient in the midst of maladaptive behaviors or interactions.
- **Behavioral therapy:** As patient is aware of his wrong behavior; he is more willing to adopt a correct behavior when trained. Take caution if there is a need to prevent the completion of a habitual behavior as this will cause unnecessary anxiety in patient.
- Pharmacotherapy
  - Combination of benzodiazepine with anticonvulsants. Clonazepam from the category of benzodiazepine is effective in reducing severe symptoms of OCD with an anticonvulsant.
  - Antidepressants such as SSRIs (fluoxetine) and nefazodone. Clomipramine is also of great use.

5B: NEUROCOGNITIVE DISORDERS (ORGANIC MENTAL DISORDERS): DELIRIUM, DEMENTIA

The word 'Organic' signifies that the given disorders have their roots in organ dysfunction. Here, it is depicting the mental disorders (delirium and dementia) which occur due to illnesses that are not psychiatric in nature. Presently, these disorders are mentioned under the category of neurocognitive disorders which explains that illness is occurring because of dysfunction of brain further reducing cognition.

Cognition includes mental faculties such as memory, orientation, judgment, linguistic skills, demonstration of interpersonal relations and solving difficulties. Any disruption in any of these functions may result in cognitive disorders.

Organic mental disorders are not the term which is currently used to explain delirium and dementia. Recent advances in research have studied mental disorders at molecular level which explains the fact that any of the mental disorders including schizophrenia, anxiety, and mood disorders could be of organic in nature meaning thereby that any of the disorder may happen because of dysfunctional brain. Therefore, delirium and dementia are now covered under the heading of neurocognitive disorders.

DELIRIUM

Definition

Delirium is an acute organic mental disorder characterized by decreased consciousness and cognition. In other words, delirium is the cloudiness of consciousness and impaired cognition (Fig. 30).

Delirium is a critical life threatening, yet reversible disorder of the central nervous system which is characterized by a severe decline in level of consciousness and cognition especially attention.

Other symptoms include unusual sleep cycle, abnormal psychomotor activity and disturbances in perception. Although the Hallmark symptom of delirium remains diminished level of consciousness, it occurs along with global weakening of cognitive functions.

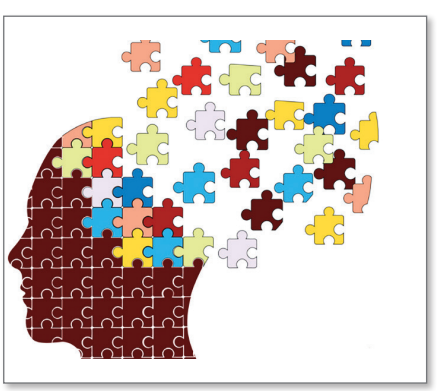


Fig. 30: Delirium in progress

The onset of delirium is sudden usually in hours or days and it has a fluctuating course. It is reversible and fast recovery is possible if the causative agent is identified and eliminated. Early recognition of etiological factors can help prevent delirium related complications such as accidents because of declined level of consciousness.

Prevalence

Delirium is a disease of old age in most of the cases. The prevalence of delirium in world's population among elderly is 1–2% in accordance with community studies. In India, prevalence rate of delirium is quite high. In geriatric ward admissions, delirium patients are found to be 10–31%.

Among elderly population in the age group of 55 years and above, 1% is certainly suffering with delirium and 13% in the age group of 85 and above. In hospital settings such as general medical and surgical wards, 5–30% of the patients may have been reported with delirium. In critical care units and emergency departments, 7–16% of the patients have delirium. The prevalence rate is surprising of 23–28% in terminally ill patients.

Aging is major contributing factor for occurrence of delirium. 30–40% of the hospitalized patients of age 65 and above have delirium symptoms.

Delirium is more common in males. Further, delirium indicates poor prognosis of every other comorbid disorder and increases morbidity and mortality altogether.

Predisposing Factors

Predisposing factors are those factors which make it likely that one will suffer from a particular illness in the future. The predisposing factors which keep any person for developing delirium are given below:

- Demographic factors
  - Age 65 and above
  - Male gender
- Perceptual disturbances
  - Hearing impairment
  - Visual impairment
- Cognitive impairments
  - Dementia
  - History of delirium and depression
- Previous falls and injury
- Neglect
- Undernutrition
- Comorbidity of medical disorders

Precipitating Factors

Following are some of the precipitating factors for delirium:

- Surgery
- Emotional stress
- Infections
- Malnutrition
- Brain attack
- Use of certain drugs such as sedatives, narcotics, anticholinergic and/or Alcohol
- Anemia
- Dehydration

- Use of bladder catheter or physical restraints.
- Hyper/hypothermia

Etiology

The etiological factors of delirium are classified according to body systems and are given below.

Organ system	Causes
CNS	• Head injury • Epilepsy (convulsions) • Cerebrovascular disease (brain attack) • Transient ischemic attacks
Cardiovascular system	• Heart attack (myocardial infarction) • Dysrhythmias
Pulmonary system	• COPD
Hematological system	• Anemia
Renal system (kidneys)	• Acute renal failure • Syndrome of inappropriate secretion of antidiuretic hormone
Endocrine system	• Adrenal gland disorders • Hyper/hypothyroidism • Parathyroid gland abnormalities
Hepatic system	• Hepatitis/hepatic failure • Liver cirrhosis
Other disorders which can cause delirium are as follows: • Diabetes mellitus • Burns • Nutritional deficiencies	
Drugs which can cause delirium are given below: • NSAIDS • Steroids • Anti-hypertensive agents • Antibiotics	
Other causes • Drug intoxication • Drug withdrawal	

Signs and Symptoms (Fig. 31)

- Altered consciousness
- Altered attention
- Impaired cognitive function
- Disorientation especially to time and space
- Psychosis

- Insomnia
- Decreased consciousness
- Decreased attention
- Wandering behavior
- Decreased memory
- Tangentiality
- Incoherence
- Illusions/hallucinations
- Psychomotor retardation/psychomotor hyperactivity
- Anxiety
- Daytime drowsiness
- Mood alterations (irritability, dysphoria, euphoria and/or anxiety)

Fig. 31: Delirium' signs and symptoms

Neurotransmitter in Delirium

The main neurotransmitter involved in causation of delirium is acetylcholine. The other neurotransmitters involved are glutamate and serotonin.

DSM-5 Diagnostic Criteria for Delirium

- A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).
- The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of the day.
- An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).
- The disturbances in criteria A and C are not better explained by another prelisting, established, or evolving Neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.
- There is evidence from the history, physical examination or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.

  Specify whether:
  - Substance intoxication delirium
  - Substance withdrawal delirium
  - Medication-induced delirium

Prognosis

Prognosis of the delirium varies among patients in accordance with its etiological factors. If the cause of the disorder is successfully treated, delirium will be cured. If the cause is a chronic disease, delirium may worsen. In other cases, where cause for delirium is drug intoxication or any other acute conditions; delirium will be cured as soon as drug effects are eliminated from the body.

Medical Treatment

- **Treatment of the delirium may undergo following series:** Treat the underlying cause. (If cause of delirium is anticholinergic toxicity, then administration of physostigmine salicylate in doses of 1 to 2 mg I/V or I/M is preferable treatment. This treatment may be repeated half hourly until condition improves.
- **Ensure safety of the patient:**
  - Raise side-rails.
  - Remove all clutter from the environment.
  - Be with the client. Patient may feel comfortable in the presence of a friend or a relative especially family member in room.
  - Ensure good lightening in rooms.
  - Do not allow patient to do those activities, which require attention and alertness such as driving, operating a machinery, etc.
  - One to one observation.
- Re-orient the patient on regular intervals.
- Place a clock having big numbers inside patient's room.
- Place a calendar of big numbers inside patient's room and cut the past day date on it to avoid confusion to the delirium patient.
- Familiar pictures should be hanged on the walls of patient's room.
- **Psychopharmacology:**
  - For psychosis, antipsychotic haloperidol (5–40 mg) is the most effective drug used for delirium patients.
  - Other atypical antipsychotics may also be used to treat delirium such as olanzapine, quetiapine, risperidone, clozapine, etc.
  - For insomnia, benzodiazepines such as lorazepam HS may be prescribed.
  - For pain, analgesics may also be prescribed.
  - Acetylcholine preparations may also be effective for delirium patients as a role of acetylcholine in causation of delirium.

DEMENTIA

Definition

Dementia is a progressive neurodegenerative disorder characterized by impairment of cognitive functioning without loss of consciousness.

Cognitive impairment is the loss of previous cognitive strength and ability (Fig. 32).

Dementia is also known as major neurocognitive disorder. Dementia causes significant impairment in social, personal and occupational functioning.

Although we see dementia as a progressive and a permanent disorder but depending upon the underlying pathology, dementia can be static

Fig. 32: Dementia is progressive and reaching to global dementia

and reversible disorder. Early diagnosis and extensive treatment might help reducing further progress of dementia.

Prevalence

Dementia is a disease of old age and usually occurs in the age group of above 65. The world's population prevalence of dementia among elderly is 5%. The most common type of dementia among elderly population is Alzheimer's disease. In India, prevalence of dementia among elderly population varies according to different regions. For example, in south India, prevalence rate of dementia is 4.8%. The overall incidence of dementia in India was difficult to calculate statistically because of many unreported cases, but approximately 4–5% of the elderly population of India is suffering from Dementia in old age.

Types of Dementia

- Alzheimer's disease
- Vascular dementia
- Frontotemporal dementia dementia of Lewy bodies
- Dementia due to other causes such as head injury, Parkinson's disease, huntington disease, neurological disorders

Etiology

Individuals older than 65 years of age who are diagnosed with dementia usually have Alzheimer's disease and Vascular dementia as their etiological factor which contributes for 90% of the cases. Another 10% etiological factors include Lewy body dementia; Pick's disease; frontotemporal dementias and/or infectious dementia. Other factors are alcoholic dementia and Parkinson's disease.

Some of the dementias are reversible in nature because etiological factors responsible for causing dementia are either treatable or manageable such as nutritional deficiencies of vitamin β_{12} or folate, dementia caused by depression and metabolic abnormalities such as hypothyroidism.

Following is a list of etiological factors of dementia:

- Genetic factors
- Neurodegenerative disorders such as
  - Alzheimer's disease
  - Parkinson's disease
  - Huntington disease
  - Lewy body dementia
  - Pick's disease (frontotemporal dementia)
  - Wilson's disease
- Psychiatric disorders such as depression and schizophrenia may also cause dementia in their later stages nutritional deficiencies such as vitamin B_{12}, folate
- Presence of urea in blood (uremia) may be another cause for dementia certain tumors
- Traumatic head (brain) injury
- Infectious diseases such as AIDS, syphilis
- Myocardial infarction
- Vascular diseases

- Drug toxicity (anticholinergics and carbon monoxide)
- Alcohol addiction
- Anoxia
- Endocrinal disorders such as hypothyroidism
- Irradiation

Neurotransmitters Involved in Causation of Dementia

- Acetylcholine
- Norepinephrine

Dementia of the Alzheimer Disease

This type of dementia is explained in DSM criteria in seven stages. Onset of Alzheimer's disease is insidious (Fig. 33).

Stages of Alzhiemer's disease are as follows:

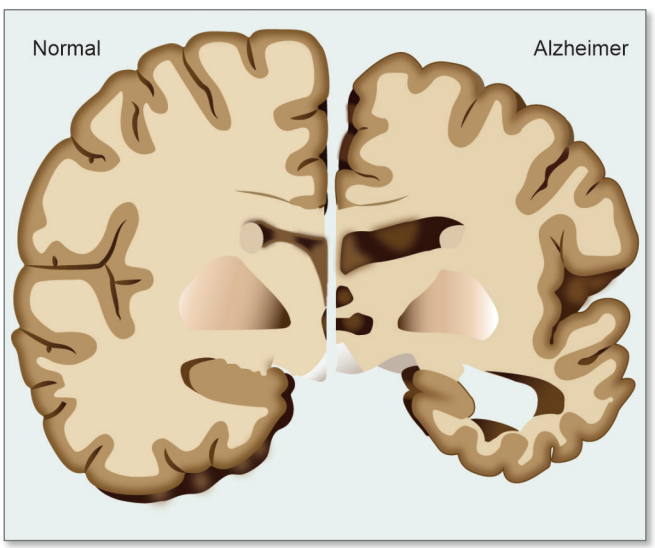


Fig. 33: Dementia of the Alzheimer disease

- **Asymptomatic stage:** This is the first stage in which no visible changes in personality or memory of the person are seen.
- **Forgetfulness:** This is the beginning of short-term memory loss. Individual will forget names of people and things. Individual will be able to recognize decline in his cognitive ability and may feel embarrassed for not being able to remember small things. It makes patient anxious and depressed. This stage is often unobserved by others.
- **Mild cognitive decline:** This is the stage in which symptoms of individual are observed by family, friends and colleagues. Work performance is hampered. The individual may have lost his way home. The individual will not be able to organize things.
- **Mild to moderate cognitive decline:** This is the moderate level of decline in intellect of person and is quite noticeable to others which is why patients usually deny the existence of problem at this stage and use confabulation, i.e., filling up of memory gaps to cover up his shortcomings.
- **Moderate cognitive decline:** This stage is also known as early dementia. Here, individual is aware about his identity but loses recognition of family and friends and become disoriented about time and place. ADLs, i.e., activities of daily living such as personal hygiene, dressing, combing hairs, grooming are not being done by individual alone and he/she may need assistance on a daily basis. That's why individuals withdraw from near and dear ones, become frustrated and angry on minor issues.
- **Moderate to severe decline:** This stage is also known as middle dementia. This stage is characterized by Sundowning syndrome which means as sun goes down, symptoms of the patient get worse. Individual is disoriented to persons also at this stage and may even forget the names of close relatives and family members. The individual forgets his major life events till this point that he may forget the name of his

spouse with whom he spent all of his life. Linguistic skills also get started to lose which makes conversation difficult. The major problem of this stage is urinary and fecal incontinence. Family may decide for hospitalized care at this stage. Other symptoms include aggressiveness, agitation and wandering behavior.

- **Severe cognitive decline:** This is the end stage of dementia. It is characterized by following symptoms.
  - Aphasia is the most prevalent symptom of this stage. Aphasia is a language disorder that affects a person's ability to communicate.
  - The individual becomes bedridden. Individual is bedfast and it results in complications of decubitus ulcer.
  - Weight loss is a common occurrence in the last stage of dementia.
  - Aphasia is more severe now, makes it very difficult to communicate for individual.
  - The caregiver has to perform all the activities of daily living for patient.
  - Person experiences alterations in sleep wake cycle usually dozing and is not aware of his environment.
  - Contractures is another major issue with individuals at the end stage of dementia. It is a condition of shortening and hardening of muscles, tendons, or other tissues which result in deformity and rigidity of joints.
  - CNS depression and weak immune system further worsen the condition of patient.
  - In last stage of dementia, urinary tract infections (UTI) and sepsis are also commonly observed.
  - Dysphagia is also present and often results in aspiration. Because of aspiration, pneumonia may also further damage the already worsen situation.

Causes of Dementia of Alzheimer's Type

- **Traumatic brain injury:** Individuals who have had history of head injury are more prone to experience Alzheimer's disease in older age.
- **Genetic factors:** Research evidenced that there is an association between Alzheimer's disease and alteration of one gene found on chromosome 21. Any familial predisposition results in more chances of occurrence of Alzheimer's disease. Some researchers suggest that there is clearly a link between Alzheimer's disease in Down syndrome patients with an extra copy of chromosome 21 they carry. Other genes which are supposed to have a link with Alzheimer's disease are PS-1 gene on chromosome 14, PS-2 gene on chromosome 1 and apolipoprotein epsilon 4 (ApoE4) gene found on chromosome 19.
- **Plaques and tangles:** APP, i.e., amyloid precursor protein is when broken in fragments, it is reduced to a protein known as beta-amyloid. When the fragments of beta-amyloids make clusters together and join with molecules and cellular matter, they form plaques. An increased number of plaques in brain causes Alzheimer's disease.

  Tau protein's normal function is to provide stability to the neuron. In case of Alzheimer's disease, this protein doesn't function normally and its strands become tangled together which further alter the neuronal transport of brain. This may lead to destruction of more neurons and end with death of neurons. As we know that neurons are not regenerable. This is the concern with Alzheimer disease because this is the reason why this kind of dementia is progressive and never reversible. Neuronal death results in major symptoms of Alzheimer disease such as personality disorganization, severe memory loss and self-care deficit.
- **Altered levels of acetylcholine:** Pharmacological data clearly indicate that both muscarinic and nicotinic acetylcholine receptors play a role in encoding of new memories. Any alterations or lesions cause dysfunction of acetylcholine and may result in inability to form new memories and loss of stored memory. This causes inability to initiate or maintain learning.

It has been observed by researchers that Alzheimer's disease patients' brains have remarkably reduced levels of acetylcholine. Decreased levels of acetylcholine reduce the amount of neurotransmitter released at the receptor site and further disrupt the learning process. Cognitive decline in Alzheimer disease can be attributed to decreased levels of acetylcholine in brain.

Other neurotransmitters which may play a role in causation of dementia of Alzheimer type are serotonin, dopamine, amino acid glutamate and norepinephrine.

Vascular Dementia

Vascular dementia is also known as multi-infarct dementia. It is the second most prevalent cause of dementia and is a result of complications of cerebral vascular disease. Vascular dementia is more prevalent in men who are having history of hypertension or other cardiovascular disorders. These disorders affect blood vessels in brain and result in progressive degenerative cognitive decline.

- Vascular dementia is suddenly diagnosed as compared to Alzheimer's disease.
- The **course of the vascular dementia** is such as that in the beginning when small symptoms occur, individual starts to realize that he needs treatment and may show some improvements in the first place but this condition doesn't last longer and condition of the patient get worsen abruptly. Patient may appear to have a better memory to family members but only to be disappointed by further decline and worsening of symptoms.
- As vascular dementia is the result of brain infarctions, therefore, symptoms of the disorder will be in accordance with the brain area which got infarcted.

Causes of Vascular Dementia

As the name suggests, it is vascular dementia, it means that etiological factor for its occurrence must be related to blood vessels. Therefore, following causes may result in vascular dementia.

- Diseases that cause interference with blood flow to the brain which consequently end in brain infarctions.
- Death of the neurons which are supplied by diseased blood vessels.
- **Hypertension** is the major etiological factor of vascular dementia. High blood pressure does damage to the walls of blood vessels which further results in breakage in the lining of blood vessels. This end up individuals having hemorrhage usually internal. Internal bleeding may happen to be an accumulated plaque in the brain later on and damage the brain region it supplies.
- **Fibrin** is a tough protein substance that is arranged in long fibrous chains; it is formed from fibrinogen which is a soluble protein produced by liver and found in blood plasma. When tissue damage results in bleeding, fibrinogen is converted at the wound site into fibrin by the action of a clotting enzyme named thrombin.

  When an internal bleeding occurs within the brain, fibrin gets accumulated at the bleeding site and consequently, it leads to formation of plaques and infarcts in the brain. These plaques and infarcts cause interruption to blood flow in the regions of the brain and results in vascular dementia.
- Arteriosclerotic plaques
- Thromboemboli
- Enlarged cardiac chambers
- Cardiomyopathies

- **Binswanger's disease:** It is a progressive neurological disorder caused by arteriosclerosis and thromboembolism affecting the blood vessels that supply the white matter and deep structures of the brain (basal ganglia and thalamus).
- Any kind of heart disease which may cause interruption in the blood vessels of the brain, could be a cause for vascular dementia.

Mixed Dementia

When the individual is having both Alzheimer's disease and vascular dementia at the same time because of small silent ischemic attracts over a period of time, then this is known as mixed dementia.

Pick's Disease

It is also known as **frontotemporal dementia.**

Atrophy, i.e., destruction of the tissue. When the neurons of the frontotemporal region gets atrophied, then it results in frontotemporal dementia. Masses of cytoskeleton in the brain are known as Pick's bodies. The accumulation of the pick's bodies is the cause of irreversible kind of dementia known as Pick's disease. Pick's disease usually occurs in the age above 75 years of age.

Lewy Body Disease (LBD)/Dementia with Lewy Bodies

It is a disease associated with abnormal deposits of a protein called alpha-sunuclein in the brain. These accumulations are known as Lewy bodies. Lewy bodies affect levels of neurochemicals in the brain which results in disturbances of thinking, movement, behavior and mood. The most prominent feature of Lewy Body Disease is hallucinations. The individual may show symptoms of Parkinsonian's disease as follows:

- A tremor in one hand
- Slow movement
- Stiffness
- Loss of balance
- Difficulty with body movements, e.g., walking, standing, etc.
- Shuffling gait
- Sleep disturbances
- Amnesia
- Confusion in evening hours
- Difficulty thinking and understanding
- Difficulty speaking
- Soft speech
- Voice box spasms
- Distorted or loss of sense of smell
- Dribbling or leaking of urine
- Anxiety
- Apathy
- Depression
- Drooling
- Weight loss

Another major clinical feature of Lewy body dementia is reduplicate paramnesia, i.e., it is a delusion in which a person believes that a place or location has been duplicated or the same location is existing in two or more places simultaneously. This also includes belief that location has been relocated to another site.

Subcortical Dementia or Dementia of Huntington's Disease

This kind of dementia has prominent features of more motor abnormalities and fewer language abnormalities. The good news about this kind of dementia is this that mental faculties of language and memory remain intact in early and middle stages of disease. But when dementia gets worsen then depression and psychosis make patient very sick.

Dementia Associated with Parkinson Disease

Parkinson's disease affects basal ganglia in brain which is the reason of occurrence of dementia with this disease in older people. Cognitive decline is so apparent in dementia associated with Parkinson's disease. Another feature of the disorder is Bradyphrenia, i.e., slowness of thoughts, delayed responses and lack of motivation.

Dementia due to Human Immunodeficiency Virus/HIV-1 Associated Cognitive/ Motor Complex

As we know that AIDS is a disease which affects the immune system and makes it weak. This weak immune system makes an individual with AIDS more prone to infectious diseases which affect brain cells and cause atrophy of nervous tissue. When nervous tissue is destroyed, it causes dementia. The prominent features are behavioral changes, confusion and psychotic symptoms.

Head Injury Related Dementia

Any nervous tissue insult to the brain due to head trauma may result in dementia. Amnesia is the main prominent feature in case of head injury related dementia.

Dementia Pugilistica

It is also known as **boxer dementia (Fig. 34).**
Repeated head trauma brings extreme nervous tissue insult and could be the reason for mild to moderate cognitive decline, short-term memory loss. Another features of **dementia pugilistica** are physical tremors, dysarthria, i.e., difficulty in speech, changes in gait, loss of balance. The psychological symptoms which are observed are pathological jealousy and paranoia, i.e., an unrealistic distrust in other people and delusion of persecution.

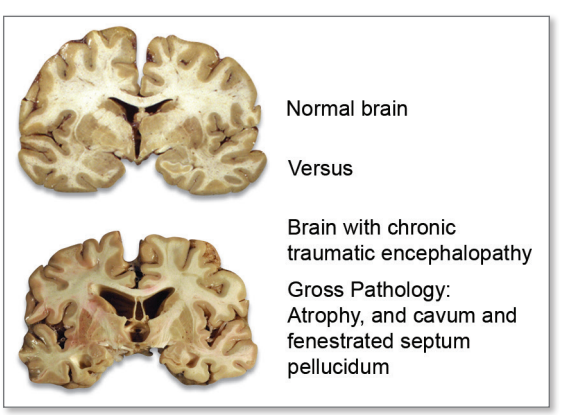


Fig. 34: Normal brain versus brain with chronic traumatic encephalopathy

Dementia Related to Medical Disorders

There are certain diseases which may cause dementia:

- Hepatic or renal failure
- Fluid and electrolyte imbalances
- Nutritional deficiencies
- Hypoglycemia
- Hypothyroidism
- CNS infections
- Other infectious diseases
- Multiple sclerosis

Drug Induced Dementia

Certain drugs if used for a longer period of time may have adverse reactions so extreme that individual end up having dementia. Medications such as sedatives, hypnotics, antianxiety drugs and Anticonvulsants may cause persistent symptoms of dementia. Some toxins, for example mercury, lead and carbon monoxide may also cause dementia.

DSM-5 Diagnostic Criteria for Dementia

- Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor or social cognition) based on:
  - Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
  - A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, other quantified clinical assessment.
- The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications.
- The cognitive deficits do not occur exclusively in the context of delirium.

The cognitive deficits are not better explained by another mental disorder (e.g., major depression, schizophrenia).

Mini Mental Status Examination for Making a Diagnosis of Dementia

This is a small clinical evaluation usually performed by clinicians and psychiatric nurses to make a diagnosis of dementia. The test includes simple questions and instructions to follow for which patient is being scored. The maximum score for MMSE is 30.

- The score of 29–30 is considered normal.
- The score of 26–28 is borderline cognitive dysfunction
- The score of 18–25 is marked cognitive dysfunction; dementia may be diagnosed.
- The score of 17 or less than 17 is severe dysfunction or severe dementia.

It is a very reliable and inexpensive tool to diagnose dementia in hospital in patient settings.

Patient's Name: _____ **Date:** _____

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum score	Patient's score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for soaring. The examiner repeats them until patient learns all of them, if possible. Number of trials:_____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65,...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: No its, ands, or buts."
3		"Take the paper in your right hand, fold it in half, and put it on the floor."
1		"Please read this and do what is says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two musty intersect.) 

Signs and Symptoms of Dementia

The most salient and early to noticeable feature of dementia is memory loss. Individuals in their early stage come in clinical settings with complaints such as that they are experiencing a decline in their intellect and **recent memory loss** although the long-term memory remains intact usually in the early stages of dementia (Fig. 35).

Fig. 35: Signs and symptoms of dementia

This **intellectual decline** starts affecting life of an individual personally, socially and occupationally. Family, friends and colleagues interpret these symptoms of the individual as **personality disorganization.** The symptoms which affect the individual in a very bad way is **disorientation.** Individual does not recognize familiar faces, i.e., disorientation to person, he/she doesn't remember way to his room, house, i.e., disorientation to place, often results in wandering behavior and sometimes individuals are never able to reach home again. Individual may also exhibit disorientation to time in severe dementia but there is **no impairment in consciousness** of the patient. Consciousness remains intact throughout the course of dementia.

Following is a list of the signs and symptoms of dementia which are usually observed in clinical settings.

- Decreased memory
- Personality disorganization
- Forgetfulness
- Defense mechanisms of denial and rationalization will be used to cover up the symptoms of dementia by patients
- Wandering behavior
- Social withdrawal
- Outbursts of anger
- Labile mood (mood swings)
- Less grooming
- Dirty clothes
- Unable to recognize family, friends and others such as colleagues, neighbors
- Forgets ways to home
- Apathy, i.e., dull emotional tone
- Progressive memory loss as disease progresses
- Complete loss of memory in advanced stages

Symptoms in Advanced Stage

- Hallucinations
- Delusions
- Fecal/urinary incontinence
- Psychosis
- Personality changes
- Sundown syndrome: As day progresses, symptoms worse till dark. This syndrome is also known as Sundowning. It is characterized by increased intensity of the symptoms of the disorder in late afternoons and evenings or at night.

Prognosis

The cause of dementia in 15% of the cases is reversible and in those cases, prognosis of dementia is good. The causes which are not reversible rather brings a poor prognosis of dementia patients.

Medical Management

The successful management of dementia demands early and accurate diagnosis. The disease is progressive in nature; therefore, prevention is more important than cure. Following measures should be taken for prevention of dementia and its further progression at early stages:

- Vitamin B_{12} supplements
- Folate supplements
- Balanced diet
- Control of hypertension/diabetes
- Angiotensin converting enzyme inhibitors (increases the concentration of acetylcholine in CNS)
- Surgical intervention (removal of infarcted areas of brain tissue to stop further progression of dementia)
- Exercise
- Supportive medical care
- Emotional support

Other Treatment Modalities for Dementia

- **Psychosocial therapies-supportive and educational psychotherapies:** The individual is aware of cognitive decline in the early stages of dementia because it is the recent memory which is lost but remote memory is still there and this affects the psychology of the individual in a bad way. The individual now only can recall about his past where he was able to function very efficiently and remembering old golden days gives client anxiety spells and depression. At times, overthinking about how well he was before in his intellect results in catastrophic fear to accompany patient's mind. Every individual is so fond of himself. Watching one's own decline is so painful for the dementia patients.
  At this time, **educational psychotherapy** in which patient is taught about the nature and course of the disease may benefit him. He/she may understand that all of the symptoms are because of the disease and there is very little he could do to prevent its occurrence.
- **Supportive therapy** is also very beneficial. Any individual would do better with care and support. A therapist must support individual's grieving process and help individual to have a sense of self-esteem which will come by maximizing use of individual's remaining potentials.

It also includes keeping big sized calendars and wall clocks. Ask patient to keep a diary for maintaining schedules. Appreciate every single task accomplished, however, small it may be. Keeping a journal also helps patient to vent out his emotions.

- **Family therapy:** Caretaker of the dementia patient also needs family therapy along with patient. Sometimes caretaker experiences anger outbursts and guilt feelings about patient's illness and condition. Caregiver often end up having self-sacrifice in the course of caring for the patient. This always leads to resentment and exhaustion. Care giver must be counsel regarding this he/she also needs care and it were never a fault of him/her that patient's condition is worsen till this very stage. A therapist must make caregiver understand this he/she is not the one to be blamed for patient's illness.
- **Psychopharmacology**
  - Benzodiazepines to treat insomnia and anxiety
  - Antidepressants to treat depression
  - Antipsychotics to treat delusions and hallucinations
  - Cholinesterase inhibitors such as donepezil, galantamine, tacrine, etc. (These drugs increase the concentration of acetylcholine at receptor sites)
  - Calcium channel blockers
  - Serotonergic agents
- **Other treatment modalities**
  - **Ondansetron (zofran) is a 5HT receptor antagonist drug** which is nowadays used for dementia patients and has shown some improvements.
  - **Estrogen replacement therapy:** This therapy is believed to reduce the risk of cognitive decline in post-menopausal women.
  - **Nonsteroidal anti-inflammatory drugs (NSAIDS):** In some cases, these drugs have proved to reduce the occurrence of Alzheimer's disease.

5C: SCHIZOPHRENIA SPECTRUM DISORDERS

WHAT IS PSYCHOSIS

Generally, we agree on this fact about psychosis that it is a very serious mental disease that affects the whole personality of the individual and causes severe impairment in personal, social and occupational functioning of the patient (Fig. 36).

Another prominent feature of the psychotic disorder is NO TOUCH WITH REALITY which means that patient lives in his own world and this world is not at all relatable with the real world. This imaginary world is at times attributing to delusional beliefs, and patient then comes with autistic thinking and autism.

Autism and autistic thinking are mostly seen in schizophrenic patients. Autism is a disorder in which an individual lacks social skills, verbal and non-verbal

Fig. 36: Psychosis symptoms

communication and has differently-abled unique potentials beyond understanding because of patient's presence in his/her own delusional world. Autistic thinking comprises day dreaming and fantasies.

Although every psychotic disorder does have similar signs and symptoms; delusions and hallucinations are the main features for any disorder to be called psychosis.

DSM-5 has included schizophrenia spectrum and other psychotic disorders, such as schizophrenia, and schizotypal (personality) disorder come under the category of psychotic disorders. They are defined by abnormalities in one or more of the following five domains: Delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

The following are the essential features that define the psychotic disorders.

- Delusions
- Hallucinations
- Disorganized thinking (speech)
- Grossly disorganized or abnormal motor behavior (including catatonia)
- Negative symptoms

DSM-5 Classification of Schizophrenia Spectrum and Other Psychotic Disorders

- F21-Schizotypal personality disorder
- F22- Delusional disorder
- F23-Breif psychotic disorder
- F20.81-Schizophreniform disorder
- F20.9
  - Schizophrenia
  - Schizoeffective disorder
- F25.0-Bipolar type
- F25.1-Depressive type
  - Substance/medication-induced psychotic disorder
  - Psychotic disorder due to another medical condition
- F06.1-Catatonia associated with another medical disorder
  - Unspecified catatonia
- F28-Other specified schizophrenia spectrum and other psychotic disorder
- F29-Unspecified schizophrenia spectrum and other psychotic disorder

SCHIZOPHRENIC DISORDERS/SCHIZOPHRENIA

DSM-5 has described schizophrenia not as a single disorder but as a syndrome, i.e., a group of schizophrenias. No other mental disorder is more crippling than schizophrenia.

Eugene Bleuler coined the term schizophrenia. Previously, it was known as dementia praecox; a name given by Emil Kraepelin in the light of fact that schizophrenia symptoms resemble dementia in cognitive decline and schizophrenia may be considered as a previous stage of a full-blown dementia.

Eugene Bleuler described schizophrenia as a different disorder with schisms among thoughts, emotions and behavior in patients who suffer from schizophrenia.

Eugene Bleuler identified four fundamental symptoms of schizophrenia which were common in all schizophrenics. These are known as Eugene Bleuler's 4As of schizophrenia.

- **Associations loosening** (there is no association between ideas of patient).
- **Autism** (lacks social skills, verbal and non-verbal communication and has differently abled unique potentials beyond understanding because of patient's presence in his/her own delusional world).
- **Affect inappropriateness** (mood and affect are not congruent with one another).
- **Ambivalence** (presence of two contradictory ideas toward the same object, person or situation at the same time).

Eugene Bleuler also identified **secondary symptoms** of schizophrenia. These are also known as **accessory symptoms** which include hallucinations and delusions.

COURSE OF SCHIZOPHRENIA

The course of schizophrenia usually undergoes the following stages:

Premorbid Personality

The schizophrenic patients usually have a premorbid personality with characteristics as follows:

- Remains aloof
- Does not have friends. Even if have, number of friends will be very few
- Shy
- Withdrawn
- Poor relationships among family and friends
- Poor school performance
- Antisocial behavior
- Talks very less

Early Signs and Symptoms

Any person's personality can't be a clear evidence of disorder and not a prediction for its occurrence. Early signs and symptoms can more visibly manifest that schizophrenia is developing in an individual. This stage is also known as prodromal phase. This begins with the manifestations of psychotic symptoms in patient. Functioning of the individual is severely impaired. Depression occurs.

Any disease, if early diagnosed and early treated, can prevent further decline and deterioration. Therefore, it would be significantly important if we recognize early signs and symptoms of schizophrenia at prodromal stage. It would be a perfect opportunity to prevent full-blown schizophrenia.

At this stage, some individuals also experience cognitive decline and obsessive compulsive traits.

Active Schizophrenic Phase

This is the active and acute phase of schizophrenia which becomes a diagnostic criterion for evaluation and diagnosis of schizophrenia. Active phase usually lasts for 1 month followed by continuous signs and symptoms of disability which persist for at least 6 months. The following are the clinical manifestations in schizophrenic patients:

- Delusions
- Hallucinations

- Disorganized speech
- Derailment
- Incoherence
- Personality disorganization
- Catatonic behavior
- Avolition, i.e., a total lack of motivation that makes it hard to get anything done. Individual can't start or finish even simple, everyday tasks.
- Apathy
- Non-fulfilment of interpersonal, academic or occupational functioning. Significant decline/Failure in the level of functioning.
- Odd beliefs
- Unusual perceptual experiences.

Residuary Phase

Although schizophrenia is a chronic disorder, it is manifested as episodes in the lifetime of schizophrenic patients. The active phase may be followed by remission and exacerbation. Remission refers to a period of time during which schizophrenia (any chronic illness) improves for some time and the patient seems to recover. The period of remission is asymptomatic. On the other hand, exacerbation refers to an increase in the severity of signs and symptoms of disease.

In the residuary phase, negative symptoms remain which may or may not improve over a period of time. The following is a list of negative symptoms of schizophrenia:

- Blunted affect
- Lack of intonation, i.e., the rise and fall of voice while one speaks
- No movement of hands and head while communicating with others
- Monotonous tone
- No performance of activities of daily living
- Alogia, i.e., poverty of speech/lack of conversation
- Mutism
- Withdrawn behavior
- Diminished abstract thinking. Individual can't make conclusions from abstract ideas.

TYPES OF SCHIZOPHRENIA

DSM-5 has no longer appreciated use of types of schizophrenia; they are obliterated from DSM-5 classification. These types are listed in ICD-10 and are used for clinical purposes:

Paranoid Schizophrenia

Paranoid schizophrenia is characterized by delusion of persecution, delusion of reference, delusion of grandeur and/or auditory hallucinations. Other features of paranoid schizophrenia are suspicious behavior, tense and reserved minds. Figure 37 shows the paranoid schizophrenia symptoms.

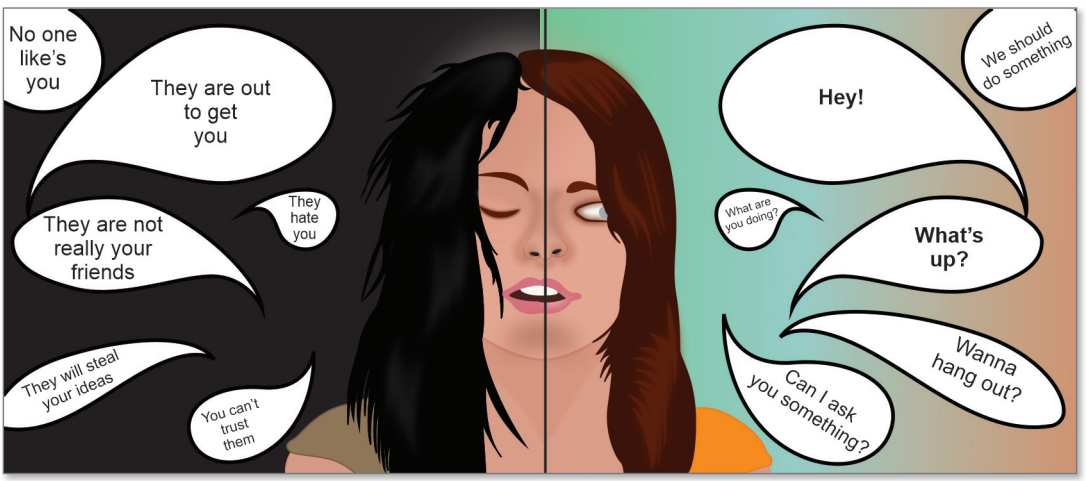


Fig. 37: Paranoid schizophrenia symptoms

Disorganized Type

Disorganized type of schizophrenia as name suggests is mainly characterized by uninhibited and disorganized behavior (Fig. 38). Disorganized schizophrenics are usually involved in purposeless activities in a non-constructive manner. Reality touch is absent with poor personal hygiene and social behavior. Disorganized schizophrenics are silly behaved with inappropriate emotional responses.

Fig. 38: Disorganized schizophrenia

Catatonic Type

Catatonic schizophrenia is characterized by stupor, negativism and rigidity. Other features of catatonic schizophrenics are waxy flexibility, stereotypy and mannerism.

Waxy flexibility is a symptom of mental disorder in which a patient adopts an immobile posture and does not change it unless another person intervenes.

Mannerism is a habitual repetition of activity, speech or posture.

Undifferentiated Type

If the symptoms of schizophrenia are not distinguishable from other types of schizophrenia, it is also known as undifferentiated schizophrenia.

Residual Type

The absence of an active phase of schizophrenia is known as residual type of schizophrenia which is characterized by emotional blunting, social withdrawal and eccentric behavior.

PREVALENCE

The overall 1% of the world's population is suffering from schizophrenia. In India, prevalence rate of schizophrenia is 4.3–8.7% approximately among general population. Schizophrenia prevalence is equal in men and women.

Fig. 39: Residual type schizophrenia with catatonic features

EPIDEMIOLOGY

Epidemiology is the scientific study of the spread and control of diseases (Fig. 39).

- **Age:** The disease of schizophrenia is more commonly seen in the age group of 15–55 years. Schizophrenia rarely occurs before the age of 10 and after the age of 60 years.
- **Gender:** Both genders are equally affected by schizophrenia. The disorder is having an early onset in men as compared to women. In females, usual onset of schizophrenic disorder is after age of 40 years. Women do have better social functioning than men. Negative symptoms are more seen in males and that is the reason males are more impaired than females.
- **Physical illness:** Schizophrenic patients usually exhibit concurrent medical illness. Comorbidity is the reason for high mortality rate in schizophrenic patients.
- **Substance abuse:** Schizophrenic patients are seen using common street drugs. Alcohol abuse is accountable for increased psychotic symptoms in schizophrenic patients. Any drug abuse will only further worsen the course of schizophrenia. Cocaine and amphetamines are proved to increase psychotic symptoms by research investigations.
- **Infectious diseases:** Any viral infections during pregnancy make a child more prone to develop schizophrenia in later stages of life. The most commonly seen association is with influenza virus.
- **Birth complications:** Any birth anomalies in the child, any brain insult during child birth increases the risk of developing schizophrenia later in life.
- **Seasonal effects:** It has been evidenced by research that children who are born in winters and those born in early spring are more at risk for developing schizophrenia.
- **Maternal starvation:** Maternal starvation during pregnancy also is a potential risk factor for developing schizophrenia.
- **Children born of schizophrenic patients:** People born of schizophrenic patients are having ten times greater risk for developing the disease as compared with general population.

ETIOLOGY

Psychoanalytical Theories

Sigmund Freud proclaimed that schizophrenia results from fixations at an early stage of psychosexual development. The second most trusted cause of schizophrenia is symbiotic mother-child relationship which

is characterized by an inseparable relationship and if mother and child are forced to separate, it causes anxiety and psychological problems. This often results in an insecure identity of child and ego dysfunction.

Ego Disintegration

An individual's ego (reality principle) is developed along the course of life meaning thereby a child who has not developed ego yet is not in touch with reality. When ego is developed, a sense of reality touch is developed. But as we know, every individual is different so thereby ego integrity is also unique for each and every one of us. Therefore, when fixation happens at that stage where ego is not yet developed through an unhealthy immature defense mechanism of regression that is reverting to the previous level of development, then ego disintegrity results.

Furthermore, Ego helps us to interpret the reality and control of internal urges. In schizophrenia, an individual reverts to that stage where he did not even have developed ego. So, as an adult, now he will misinterpret the reality which will be manifested as symptoms of schizophrenia such as personality disorganization, intense hostility, insecurity, vulnerability to stress, etc.

Psychopathological communication also results in schizophrenia. It constitutes content of speech in this way that leads to confusion because of double meaning. For example, a mother said to her child, "Go out and play but make sure your clothes should not get dirty".

Sigmund Freud's Psychoanalytical theory exclaimed the following propositions in relation with schizophrenia:

- Every symptom of schizophrenia is having a symbolic meaning attached to it.
- Nihilistic delusions (world is coming to an end) are having symbolic meaning to the internal world of the patient which is broken.
- Delusion of grandeur signifies symbolic presentation of inferiority complex. An individual may have become grandiose after an injury to his self-esteem.
- Patient may experience autism (loss of reality touch and remaining in a delusional world) because he/she is not being able to cope with real-life stressors.
- Delusions are also made up stories of mind to get rid of reality of life.
- Hallucinations may exhibit inner wishes and desires.

Impaired Interpersonal Relatedness

Anxiety is the hallmark symptom of every mental disorder. A schizophrenic patient lacks interpersonal relatedness. This will result in massive anxiety. As we all must have experienced in our life, whenever we find ourselves in any situation where we consider ourselves not fitted or outnumbered, then we would like to escape such situations. Avoidance will be the defense mechanism used by us. In the same way, because schizophrenic patient does not find oneself relatable with others which results in anxiety, panic, terror and disintegrated sense of self. The conclusion is: Individual uses schizophrenia as a defense of escapism, i.e., no touch with reality and creates his own delusional world.

Any traumatic experience will be accumulated in our mind and when consequently, the collection of traumatic experiences is increased and person is not able to bear the stress caused by it will result in intense anxiety and subsequently schizophrenia.

Skewed Family Relations

If one parent is overly affectionate with a child of opposite gender, it may form the basis of schizophrenia pathology. For example, a mother loves her son more than her daughter while a father loves his daughter more than his son.

Wrong Role Modelling/Wrong Learnings

The first and foremost method of learning in children is imitation. A child may learn from his/her parents irrational outbursts and distorted patterns of thinking where parents themselves have some psychological problems or do not deal with life problems effectively. This wrong role modelling may lead to development of schizophrenia in later life.

Double Bind

At times, parents confuse their children by a double bind communication and way of conduct. For example, teaching a child to speak truth and then in certain situations forcing him/her to tell a lie. A child speaks lie about his parent that he is not at home when door bell is rung by a neighbor.

Another situation is: Teaching a child about caring and sharing and when a child shares his lunchbox with someone needy then scolding the child for being so innocent.

ENDOCRINE DISORDERS

Hormones such as luteinizing hormone, FSH, growth hormone, prolactin, thyrotropin releasing hormone, etc. are having research evidences of relation with causation of schizophrenia.

IMMUNE SYSTEM

A weak immune system may cause schizophrenia.

An autoimmune disease can be a causative factor for developing schizophrenia as evidenced by research studies. Another conditions such as: (a) decreased T-cell interleukin-2 production, decreased peripheral lymphocytes, abnormal cellular and hormonal activity in brain cells especially neurons, anti-brain antibodies, etc.

BRAIN STRUCTURAL AND FUNCTIONAL ABNORMALITIES

Brain parts such as Limbic system (emotional area of brain), cerebral ventricles, prefrontal cortex, thalamus, Basal-ganglia, cerebellums are found to be structurally and functionally abnormal in schizophrenic patients.

Genetic Factors

Increased prevalence of schizophrenia among biologically-related relatives of schizophrenics is found in research studies. First and second degree relatives are more having more likelihood of developing schizophrenia. However, by monozygotic twin studies, it had been clearly evidenced that genetic factors can't be solely responsible for a person to suffer with schizophrenia but there is as much involvement of environment for the disorder.

It is clearly understood that genetic predisposition poses a risk for occurrence of schizophrenia but even then, other factors such as environment and biochemical factors may prevent or cause schizophrenia.

Another research evidenced that children who are born of older fathers (above age of 60 years) are having greater chance of schizophrenia. The reason suggested is this that sperm of an older father is sure to have more epigenetic damage.

Neurotransmitters

The neurotransmitters involved in causation of schizophrenia are: Dopamine, serotonin, norepinephrine, GABA, glutamate, acetylcholine, etc.

Increased Dopaminergic Activity in the Brain

Dopamine hypothesis postulates that increased dopaminergic activity in the brain can cause schizophrenia. More dopamine release in schizophrenic patient results in more positive symptoms of schizophrenia.

Other Causes

They may include trauma, head injury and/or cerebrovascular accidents; Transient Ischemic Attacks.

SIGNS AND SYMPTOMS

Before we discuss the clinical features of schizophrenia, we must understand the concept of normalcy. What is considered normal in one society may be considered abnormal in another society or culture. For example, kissing is a sign of greeting in western cultures but the same sign will be considered abnormal in Indian settings. From this, we can conclude that there is no standard for normalcy. We must not be so quick to label someone as abnormal or having mental sickness. We as health care professionals are having this duty that we must not jump to conclusions so quickly.

The second most important consideration is that schizophrenic symptoms do resemble the symptoms of many other mental disorders such as mood disorders, personality disorders, etc. Therefore, diagnosis of schizophrenia can't be accomplished only on the basis of findings of mental status examination.

Furthermore, patient's symptoms may vary from time to time. One time, he may seem adequately performing in the society and another time suffering from delusions and hallucinations. We must make out the distinction between remission and exacerbation periods of disease.

While asking questions about *abstract thinking*, one must take into account the educational background of the patient. Not able to understand abstract concepts may be a reflection of illiteracy or less education.

One another thing to ponder over is the *cultural background* of the patient. Many things which seem abnormal to outsiders may be acceptable within a cultural setting. For example, wait to start over again if a cat crosses someone's path is considered normal in Indian society but outsider may label it as madness.

PREMORBID HISTORY OF SCHIZOID OR SCHIZOTYPAL PERSONALITY DISORDER

The schizoid personality disorder is characterized by:

- Social withdrawal
- Inexpressible
- Not getting involved in social gatherings such as parties
- Does not feel the need to be in a close/intimate relationship
- Lack interest in sex
- Being interested in activities doing alone
- Feels arrogant and less emotional to others

- Lacks close friends/no friends at all
- Does not feel happy with praise and does not feel sad with criticism.

The schizotypal personality disorder is characterized by:

- Ideas of reference
- Magical thinking
- Odd beliefs and behavior
- Bodily illusions
- Suspicious behavior
- Inappropriate affect
- Anxiety while interacting socially
- Lack of close friends/no friends. These premorbid symptoms are full blown in schizophrenia later.

DISORDERS OF PERCEPTION SUCH AS ILLUSIONS AND HALLUCINATIONS

The most common type of hallucinations a schizophrenic patient experiences are auditory hallucinations, visual hallucinations and kinesthetic hallucinations.

Auditory Hallucinations

Auditory hallucinations, i.e., patient hears voices that are not heard by others. These voices are often threatening for patient. Voices extremely scare the patient. The content of the voices is usually accusatory meaning thereby voice says that patient is guilty of something or have done something really bad which can't be forgiven ever. Voices are insulting to patient. Voices are connected with sex in a way that most people find disgusting and which causes offence.

These voices trouble patient so much that at times, patient might feel that the only way to stop this is to kill oneself. That's the reason schizophrenic patients commit suicide.

Visual Hallucinations

Visual hallucinations, i.e., patient sees things or people which are not seen by others. These are common in schizophrenic patients.

If schizophrenic patient does have tactile, olfactory or gustatory hallucinations then the physician must rule out any underlying medical or neurological pathology because these hallucinations are unusual in schizophrenia.

Kinesthetic Hallucinations

Kinesthetic hallucinations, i.e., a false perception of body movement. For example, patient feels a burning sensation in the brain or a cutting sensation of the blood vessels.

DISORDERS OF THOUGHT

These are considered as core symptoms of schizophrenia.

Disorders of Thought at Content Level

- Delusion of persecution
- Delusion of grandeur
- Religious delusions
- Somatic delusions-patient is having very bizarre and weird somatic delusions

For example, patient will say that he is having some small living creatures in his genitalia, he is a having an extra pair of kidneys, his lungs are so huge and only by his breath, there is air in the atmosphere.

- Ideas of reference-patient may say that TV, newspapers, radio, his colleagues, friends and family members including the therapist, everyone just talks about him or her.
- Delusion of control in which patients have a firm false belief that an outer object is controlling his brain. The patient expresses this in this way—there is a chip in my brain which controls me. In another case, patient may think that he is controlling the world. For example, he has caused the sun to rise and by his order only at night, moon will replace the sun.
- At the surface, patient will appear very intelligent, and will be having more abstract, psychological and philosophical ideas in his talk.
- Loss of ego boundaries: Individual has no touch with reality (ego). Patient might explain to you that he has been infused with anything or any person. At times, he might say that he has been mingled with entire universe. This phenomenon is known as *cosmic identity*. It is explained as this that patient says that everything in the universe has now become him and he has become everything in the universe. For example, patient is tree and tree is patient.

Disorders of Thought at Formation Level

- Loosening of associations
- Incoherence
- Tangentiality
- Circumstantiality
- Neologism
- Echolalia
- Word salad
- Mutism
- Derailment
- **Verbigeration:** In verbigeration, a person repeats random words as he is obsessed with repeating those words. This occurs without any stimulus (any person's talk or questioning).

Schizophrenic patients talk will mostly be about invisible and abstract things such as witchcraft, religion, an imaginary god or some symbols which may have a significant meaning to patient only.

Disorders of Thought at Process Level

- Flight of ideas
- Thought blocking
- Impaired attention
- Poverty of ideas

- Poor abstract thinking
- Thought control
- Thought broadcasting

Disorders of Affect

- Inappropriate affect
- Apathy
- Anxiety
- Anhedonia (inability to feel pleasure)
- Religious ecstasy (is an altered state of consciousness in which external awareness is greatly reduced and internal mental and spiritual awareness is greatly expanded)
- Rage
- Flat or blunted affect
- Isolation
- Ambivalence

Disorders of Orientation

Usually oriented, but may answers inappropriately because of hallucinations and delusions. For example, I am in heaven. I am in future.

Disorders of Memory

Mild cognitive deficits. Usually memory of the schizophrenic patient is intact.

Other Symptoms

- Lack of awareness about mental illness (insight is absent).
- Impulsive behavior
- Suicidal ideation/homicide behavior
- Agitation
- Bizarre posture/behavior
- Waxy flexibility
- Negativism
- Automatic obedience
- Social withdrawal
- Poor personal hygiene
- Poor grooming
- Stereotype behavior (speech, movement, posture)
- Echoparaxia (repetition of action of other person)
- Mannerism

There is another classification for the signs and symptoms of schizophrenia which divide all the clinical features of schizophrenia into two categories—positive and negative symptoms.

Positive Symptoms

If patient has positive symptoms, then patient is usually having normal brain structure and this patient will respond well to treatment. As time advances, positive symptoms become less and less severe (Table 1).

Negative Symptoms

Negative symptoms do not respond very well to treatment but newer psychotropic drugs are doing better in the advancement of research (Table 1). Negative symptoms make a schizophrenic patient very debilitating in society. For example, lack of emotional expression in communication: A negative symptom makes a schizophrenic patient very vulnerable in social gatherings.

Table 1: Positive and negative symptoms of schizophrenia

	Positive symptoms	Negative symptoms
1.	**Delusions** • Delusion of persecution • Delusion of grandeur • Delusion of reference • Delusion of control • Somatic delusion • Nihilistic delusion	Disorders of affect • Inappropriate affect • Blunted affect • Apathy • Avolition—inability to initiate goal directed activity
2.	Paranoia, i.e., extreme suspicious behavior	Impaired Interpersonal Interaction
3.	Magical thinking	Anosognosia—lack of insight
4.	Disorders of thought process • Loosening of associations • Neologisms • Clang associations • Word salad • Circumstantiality • Tangentiality • Perseveration • Echolalia	Anergia—lack of energy
5.	Disorders of perception • Hallucinations ▪ Auditory ▪ Visual ▪ Tactile ▪ Gustatory ▪ Olfactory • Illusions	Anhedonia—Inability to feel pleasure
6.	Echopraxia, i.e., imitation of actions of others	Impaired abstract thinking
7.	Waxy flexibility-adopting bizarre or uncomfortable positions	
8.	Posturing	
9.	Hyperactivity, hostility and agitation	
10.	Catatonia-stupor and excitement	

DSM-5 Diagnostic Criteria for Schizophrenia

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less, if unsuccessfully treated). At least one of these must be (1), (2) or (3):
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior negative symptoms (i.e., diminished emotional expression or avolition)
- For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas of functioning, such as work, interpersonal relations, or self-care, is markedly below the level achieved before the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- Continuous signs of disturbance persist for at least 6 months. This 6 months' period must include at least 1 month of symptoms (or less if unsuccessfully treated) that meet criterion A.
- Schizoeffective disorder and depressive or bipolar disorders with psychotic features have been ruled out.
- The disturbance is not attributable to the physiological effects of a substance or another medical condition.
- If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least one month (or less if unsuccessfully treated).

Prognosis

The prognosis of schizophrenia in 50% of schizophrenic patients is poor. Others have a relapse but may survive with follow-up and rehabilitation.

Medical Treatment

Hallucinations and delusions can't be corrected by logical explanations or any kind of psychological intervention in the active phase of schizophrenia. Therefore, in active phase, antipsychotic medications are the mainline treatment of schizophrenia and will be implemented in the remission and exacerbation periods also.

As we know that schizophrenic patient's personality is grossly impaired and there is potential risk of harm to oneself and others, therefore the first thing in the treatment to be implemented is hospitalization.

A combination of treatment modalities (psychopharmacology + psychotherapy) will be useful in schizophrenic patients.

Hospitalization

Acute phase of schizophrenia requires hospitalization for managing symptoms of schizophrenia which can be harmful for patient and others. There is potential risk for suicidal or homicidal ideation, inability to carry out activities of daily living and neglect of personal hygiene make it mandatory for schizophrenic patient to be hospitalized.

Schizophrenic patient must not be kept for custodial stay; instead a short hospitalization of 4–6 weeks will work best for the patient. After that, patient must be managed by aftercare facilities such as day care centers and halfway homes.

Pharmacotherapy

The disease process can come to remission in almost 70% of the schizophrenic patients with the use of antipsychotics. Remission refers to be asymptomatic after treatment of a disorder. The following is a list of antipsychotics which are used for treatment of schizophrenia (Table 2).

Typical antipsychotics (first generation antipsychotics)

- Phenothiazines
  - Chlorpromazine (50–1200 mg/24 hours in divided dosages)
  - Fluphenazine (1–20 mg/24 hours in divided dosages)
  - Perphenazine (6–64 mg/24 hours in divided dosages)
  - Prochlorperazine (15–150 mg/24 hours in divided dosages)
- Butyrophenone:
  - Haloperidol (2–100 mg/24 hours in divided dosages)
- Dibenzoxazepine:
  - Loxapine (15–100 mg/24 hours in divided dosages)
  - Atypical antipsychotics (second generation antipsychotics)
- Benzisoxazole
  - Risperidone
- Dibenzodiazepine
  - Clozapine
- Thienobenzodiazepine
  - Olanzapine
- Benzothiazolylpiperazine
  - Ziprasidone
- Dibenzothiazepine
  - Quetiapine

Table 2: Treatment modalities in acute and stable phase of schizophrenia

Treatment in acute phase of schizophrenia	Treatment in stable phase of schizophrenia

• Immediate attention
• **Duration:** 4–8 weeks
• **Symptoms:** Severe agitation
  ▪ Suspiciousness
  ▪ Horrible hallucinations and delusions
  ▪ Akathisia
• **For active violence:** Use a combination of antipsychotic agent plus benzodiazepine.
• **For severe agitation:** Intramuscular antipsychotic agent (for example, haloperidol, fluphenazine, olanzapine, ziprasidone) along with a benzodiazepine such as lorazepam.
• **Alternative to I/M antipsychotic agent:** Oral preparation of olanzapine
	• Prevention of relapse
	• Improved quality of life
	• Only few psychotic symptoms
	• Do not stop medications; instead lower their doses according to symptoms.
	• Occupational therapy
	• Insight-oriented psychotherapy
	• Psychoeducation about disorder
	• **Effective deal with non-compliance:** On long-term pharmacotherapy, schizophrenic patient usually becomes non-compliant to medications which increases the risk of relapse. Some patients can be worked out by using **long-acting injectable medications in the place of oral preparations**.

TREATMENT FOR REGISTANT PATIENTS

In psychiatry, there are a vast number of etiological factors for one particular disease therefore, it is always a hit and trail method in treatment. Many of the patients (almost 60%) respond well to antipsychotics for treatment of schizophrenia but remaining 40% of the schizophrenics may show resistance to conventional treatment modalities. In that case, every patient is put to a trail of treatment for 4–6 weeks. A mild improvement is a bonus and can be the basis for the treatment regime to be followed in the stable phase of schizophrenia.

The dosages of the antipsychotic medication should be adequate and must be evaluated in plasma concentration.

If one kind of antipsychotic is not helping the patient, use alternative. For example, clozapine is effective for those patients who do not respond to other drugs.

Table 3 explains the side-effects of antipsychotic drugs along with nursing management

Table 3: Side-effects of antipsychotic drugs along with nursing management (role a nurse in administration of antipsychotic drugs)

Sl. no.	Side-effect	Nursing management (role of a nurse)
1.	Orthostatic hypotension	• Assess blood pressure in three positions, i.e., lying, sitting and standing. • Keep records of all the assessment of blood pressure and report to the consultant. • **Health education:** Teach patient to rise slowly from a lying or sitting position.
2.	Sedation	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time or any other antipsychotic with a lesser side-effect can be administered. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
3.	Photosensitivity	• **Health education:** Teach client to wear protective clothing, sunscreens and sunglasses when they are out in the sun.
4.	Nausea	• Administer antipsychotics with food to combat the effects of nausea.
5.	Skin rash	• Report any signs of skin rashes and intervene accordingly.
6.	Agranulocytosis	• A rare complication. • Symptoms are sore throat, fever and malaise. • Assess complete blood count.
7.	Anticholinergic effects • Dry mouth • Blurred vision • Constipation • Urinary retention	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water. • **Health education:** Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls. • Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity. • Report to the consultant if patient complains of any difficulty in urination. • Monitor intake and output of the patient.

Contd...

Sl. no.	Side-effect	Nursing management (role of a nurse)
8.	Hormonal disturbances • Decreased libido • Gynecomastia • Retrograde ejaculation • Amenorrhea • Weight gain	• Reassure the patient that the symptoms will be reversed when after discontinuation of the drug. • Discuss with the consultant about the symptoms and another antipsychotic may also be prescribed. • Reassure the patient that the symptoms will be reversed when after discontinuation of the drug. • **Health education:** Ask the patient to continue with the contraceptives because amenorrhea is a side-effect of antipsychotics and ovulation is occurring naturally with no effect of drugs. • Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient.

In schizophrenia, the **major adverse drug reactions are extrapyramidal symptoms (EPS).** EPSs are untoward adverse drug reactions due to use of antipsychotic drugs for treatment of psychotic disorders (Table 4).

Extrapyramidal symptoms and their treatment with nursing management are depicted in Table 4.

Table 4: Extrapyramidal symptoms and their treatment with nursing management

EPS	Clinical manifestations	Treatment/nursing management
Tardive dyskinesia	Involuntary movements of mouth, neck and trunk	• Discontinue/decrease the offending drug. • Choose an alternative drug to deal with psychosis.
Dystonia	Spasm of neck, face, jaw and tongue muscles	• Discontinue/decrease the offending drug. • IM benztropine or diphenhydramine
Akathisia	Motor restlessness	• Discontinue/decrease the offending drug. • Mirtazapine (15 mg OD) • Benzodiazepines • Propranolol (30–120 mg/day in divided doses) • Anticholinergics
Parkinsonism	Rigidity, bradykinesia (slowness of movement), tremor	• Discontinue/decrease the offending drug. • Anticholinergics
Neuroleptic malignant syndrome	Fever, hypertension, altered mental status, muscular rigidity, profuse perspiration and salivation	• Discontinue the offending drug. • Maintain nutritional status to restore water and nutrient levels. • Skeletal muscle relaxants (dantrolene). • Treat hypoxia and metabolic acidosis. • Electroconvulsive therapy as a last resort with varying results.

PSYCHOLOGICAL MANAGEMENT

Psychotherapies

- **Social-skills training:** It is also called behavioral skill therapy. This therapy is given to the patient for developing social skills such as maintaining eye-contact, normal reaction time, normal facial expressions,

spontaneity in social situations and accurate perception of emotions. This is achieved through videotapes of others and of the patient and role play therapy. Homework assignments for specific skill are also given.

- **Family therapies:** When patient enters into the family set-up again, it is not as usual as we think. The patient has experienced stressful events in the same environment and now he is returning to it in a diseased condition which is partially treated but not fully recovered. There are chances that problems do emerge with the patient in the family. Therefore, family therapy is given to the patient and family with the aim of resolution of problems.
- **Insight oriented psychotherapy:** In this therapy, the patient spends many days per week with the therapist. The therapist may use psychoanalysis for personal insight orientation for the patient. The patient will understand what life stressors trigger anxiety and stress in patient.
- **Individual therapy:** It should be used as an adjunct with other treatment modalities. The first and foremost goal in individual psychotherapy is to establish trust which in turn will reduce anxiety and increase comfort of the patient. Although the schizophrenic patient is extremely lonely yet he will be guarded against a relationship because of his/her mistrust. A therapist's efforts to establish a trusting relationship will be taken as a danger by schizophrenic patient and can further increase the anger and anxiety in the patient.

  Consistency in behavior will be therapeutic hammer which can strike and break all the suspiciousness and anxiety in client's mind. Be honest with client and always give simple instructions.

  Always respect client's privacy and dignity. Do not be over friendly with a schizophrenic patient.
- **Group therapy:** It is given to increase social interaction and reduce the symptom of withdrawal. Group therapy given in a supportive manner can be very useful for schizophrenic patient.
- **Cognitive behavioral therapy:** It is to correct errors in the judgment of the patient. It is also helpful to reduce distractions of the mind.
- **Vocational therapy:** The self-esteem of the schizophrenic patient is extremely low. By vocational therapy, patient' confidence will be enhanced and there are increased chances of survival in the society.
- **Art therapy:** As we know, schizophrenic patients live in their delusional (imaginary) world. Therefore, art therapy becomes a channel for expression of their imagery and they will be able to share their inner horrifying world through art therapy.

Table 5 explains the nursing care plan for schizophrenic patients.

Table 5: **Nursing care plan for schizophrenic patients**

Nursing diagnosis	Nursing interventions	Outcome criteria
Disturbed thought process related to etiological factors of mental disorder as evidenced by delusions and hallucinations.	• Accept the patient as he is. • Discourage delusions and shift the focus on reality. • Call patient by name. • Always talk about real people and real events with patient. • Be consistent in ward routine. • Change of shift may change staff, but keep the staff same as possible. • Don't talk in vain, whisper and talk in ears in front/beside the patient; it may trigger suspicious. • Always be honest with patient; don't give false reassurance.	Patient will understand disease psychopathology and will develop an insight.

Contd...

Nursing diagnosis	Nursing interventions	Outcome criteria
Risk for harm: Self-directed or other directed related to suspicious behavior as evidenced by refusal to eat, withdrawal and anxiety.	• Keep ward staff same as possible. • Any change needs to be reported to patient in a very calm manner. • Keep room lights low. • Keep room noise free. • Observe the patient; one-to-one relationship should be ensured. • Demonstrate staff strength to the patient. • Restraint the patient, as needed. • Administer tranquilizers as required. • Maintain ward routine.	Patient will not demonstrate any harm to self or others.
Impaired social interaction related to delusional thinking as evidenced by client's speech.	• Convey an attitude of acceptance. • Always give positive reinforcement. • Always treat patient with regard. • Group therapy should be initiated for patient who is having impaired social interaction.	Patient will interact with other patient.
Disturbed sensory perception: Auditory/visual hallucinations related to disease psychopathology as evidenced by rapid mood swings, disorientation and poor concentration	• Observe for hallucinations as if patient is self-muttering, staring at wall. • Look for other signs of hallucinations such as pose as he is listening to someone, laughing to self. • Do not touch the client without first giving him a verbal warning. • Ask the client about voices he does hear. Ask what voices are said to him (content of hallucinations). • Don't discuss hallucinations in details, rather discourage talking about hallucinations. Tell client very directly that even though you realize the voices are real for the patient but nurse do not hear any voices. • Provide distraction to patient's mind when he/she talks about hallucinations. • Don't support or validate hallucinations. • Administer medications as prescribed. • Give Psychoeducation to make patient understand that anxiety is increased when patient is hallucinating.	Patient will be oriented to real objects and situations.
Impaired verbal communication related to withdrawal and delusional thinking as evidenced by associative looseness, neologisms, word salad, etc.	• Use therapeutic communication techniques such as validation and clarification. Ask patient what does it mean? Please explain yourself. Can you clarify me on this? • Support the silence of the patient. Sit quietly with patient. Mere presence of the nurse can bring comfort to the patient's mind. • For patient who does not want to speak. Do not force to verbalize, instead verbalize on his behalf. For example, I understand that coping with a huge loss like your son is not so easy. I do empathize with you.	The client will be able to verbalize his thoughts after effective nurse patient relationship maintenance.

Contd...

Nursing diagnosis	Nursing interventions	Outcome criteria
	• Call client by name. This increases the self-esteem of the patient. • Speak slowly with patient. • Give only one instruction at a time. • Be consistent in the ward routine.	
Self-care deficit related to withdrawal, cognitive impairments as evidenced by neglect of personal hygiene, dressing, grooming, eating and toileting	• Assist the client in activities of daily living. • If client is completely withdrawn, then total care should be given by psychiatric nurse. • Give positive reinforcement for tasks patient accomplished independently. • Always instruct the client step by step for any task. For example, take your clothes from closet and come to me. • For refusal of food, ask client to open his own packaged food. Serve the client in the family style serving. • Establish a structured schedule for toileting. For example, at 6 o'clock, patient is instructed that he must go to washing area for toilet purposes.	Client will be able to perform some tasks independently and for others, he may accomplish the task with assistance.

5D: OTHER SCHIZOPHRENIC DISORDERS

SCHIZOEFFECTIVE DISORDER

Definition

Schizoeffective disorder is characterized by symptoms of both schizophrenia and effective disorders.

The following are the categories of schizoeffective disorder (Fig. 40):

- Schizophrenic patient with mood disorders.
- Mood disorder patient with schizophrenia symptoms.
- Patients who are having both schizophrenia and mood disorder.

Name	Description
Schizoeffective disorder	It is characterized by symptoms of schizophrenia and effective disorders, both.
Schizophreniform disorder	It is an acute onset of schizophrenic symptoms lasting for 1 month and is associated with decreased conscious, mood disorders.
Delusional disorder	It is mainly characterized by delusions lasting for duration of 1 month along with bizarre behavior.
Shared psychotic disorder	As name suggests, it is a **shared disorder** whose symptoms are shared by two close associates with prominent feature of psychosis.
Brief psychotic disorder	It is characterized by a brief period of psychosis usually less than 1 month with full remission after treatment.

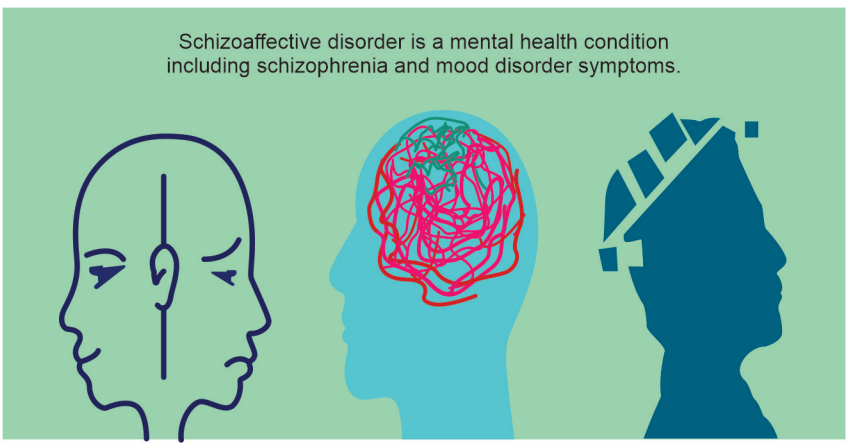


Fig. 40: Schizoeffective disorder

Epidemiology

The prevalence rate of schizoeffective disorder is 0.5–0.8% among general population. Males and females are equally affected with schizoeffective disorder. Men are affected sooner in their lives with schizoeffective disorder as compared with females.

Etiology

The exact cause of schizoeffective disorder is unknown. Although some of the studies relate this disorder with family histories and biological markers, others consider that schizophrenia and mood disorders are entirely different disorders with distinctive short-term treatment responses and outcomes.

The prognosis of schizoeffective disorder is better as compared to schizophrenia but prognosis of mood disorders alone is better than schizoeffective disorders.

Signs and Symptoms

- An uninterrupted period of illness during which the individual continues to display active or residual symptoms of psychotic illness.
- Isolation
- Idea of reference that he/she is an heir of someone great
- Aggression
- Argumentative
- Delusion of grandeur
- Suspicious
- Arrogant
- Symptoms of mania or depression (usually occurs as episodes)
- Orientation to person, time and place is present
- May be good in personal functioning if gets treated or on medication
- Initiates tasks but does not finish

- The diagnosis is usually, but not necessarily, made during the period of psychotic illness. At some time during the period, Criterion A for schizophrenia has to be met. Criteria B (social dysfunction) and F (exclusion of autism spectrum disorder or other communication disorder of childhood onset) for schizophrenia do not have to be met.
- In addition to meeting Criterion A for schizophrenia, there is a major mood episode (major depressive or manic) (Criterion A for schizoeffective disorder).
- Episodes of depression or mania are present for the majority of the total duration of the illness (i.e., after Criterion A has been met) (Criterion C for schizoeffective disorder).
- To separate schizoeffective disorder from a depressive or bipolar disorder with psychotic features, delusions or hallucinations must be present for at least 2 weeks in the absence of a major mood episode (depressive or manic) at some point during the lifetime duration of the illness.

DSM Criteria for Schizoeffective Disorder

- An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.
  Note: The major depressive episode must include Criterion A1: Depressed mood.
- Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
- The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify Whether

- **295.70 (F25.0) bipolar type:** This subtype applies if a manic episode is part of the presentation.
- Major depressive episodes may also occur.
- **295.70 (F25.1) depressive type:** This subtype applies if only major depressive episodes are part of the presentation.

Specify if

- With catatonia
- 293.89 (F06.1) catatonia associated with schizoeffective disorder to indicate the presence of the comorbid catatonia.

Specify if

- The following course specifiers are only to be used after a 1 year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.
- **First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.
- **First episode, currently in partial remission:** *Partial remission* is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

- **First episode, currently in full remission:** *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.
- **Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).
- Multiple episodes, currently in partial remission

Multiple Episodes, Currently in Full Remission

- **Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with sub threshold symptom periods being very brief relative to the overall course.
- Unspecified

Specify Current Severity

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Prognosis

If the disorder is dominated by schizophrenic symptoms, it is going to have a poor prognosis as compared to the schizoeffective disorder which is dominated by mood disorders.

Medical Treatment

- For bipolar disorder, mood stabilizers are the drug of choice.
- Carbamazepine is found to be more effective in schizoeffective disorder than lithium.
- In clinical settings, mood stabilizers are either used alone according to the dominant episode of the disease (mania or depression) or it is used in combination with antipsychotic medications.
- If the dominant symptom of schizoeffective disorder is depression, then a choice should be made for antidepressant drug. SSRIs are the first line of treatment if patient responds well. If patient is experiencing agitation or insomnia, then tricyclic antidepressants can be beneficial.

Psychological Treatment

- Family therapy
- Social skills training
- Cognitive Therapy

SCHIZOPHRENIFORM DISORDER

Definition and Meaning

Schizophreniform disorder is characterized by a benign course of schizophrenia with mood disorder symptoms and cloudiness of consciousness. The major difference between schizophrenia and schizophreniform disorder is the duration of the symptoms (Fig. 41).

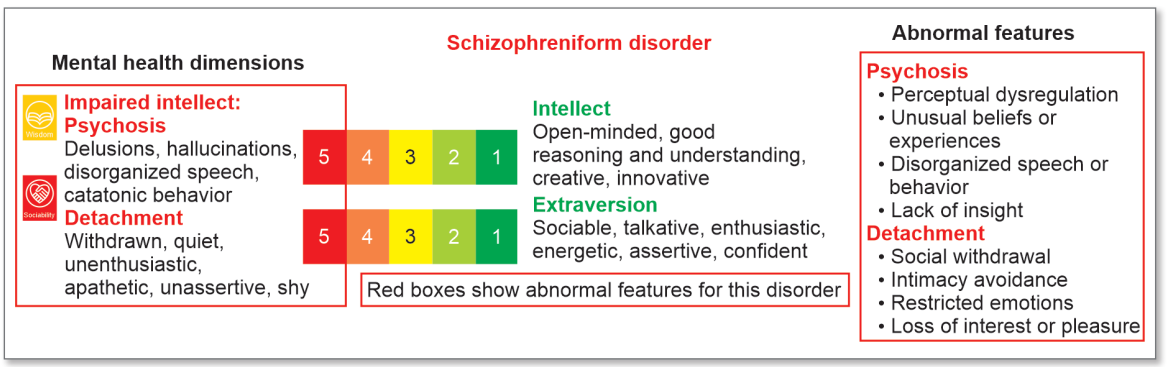


Fig. 41: Schizophreniform disorder

Schizophreniform disorder lasts for at least one month but the total duration will never be of 6 months as it occurs in schizophrenia.

Once patient got treated for schizophreniform disorder, patient can return to previous level of functioning.

Epidemiology

This disorder is mostly prevalent in young adults and is usually diagnosed in adolescent age. The prevalence rate is 0.2 among the general population.

Etiology

Genetics

The exact cause of schizophreniform disorder is unknown. But as it is having good prognosis and association with mood disorders, studies suggest that it has a close genetic relation with mood disorders.

Anatomical Changes

Inferior prefrontal region of the brain is supposed to have dysfunctional properties in schizophreniform disorder. The deficit is found in left hemisphere and patient usually shows enlarged cerebral ventricles on computer tomography and MRIs.

DSM-5 Diagnostic Criteria for Schizophreniform Disorder

Diagnostic Criteria 295.40 (F20.81)

- Two (or more) of the following, each presents for a significant portion of time during 1-month period (or less, if successfully treated). At least one of these must be (1), (2), or (3):
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (i.e., diminished emotional expression or avolition)

- An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional."
- Schizoeffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if

- **With good prognostic features:** This specifier requires the presence of at least two of the following features: Onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; confusion or perplexity: Good premorbid social and occupational functioning; and absence of blunted or flat affect.
- **Without good prognostic features:** This specifier is applied if two or more of the above features have not been present.

Specify if

- With catatonia
- **Coding note:** Use additional code 293.89 (F06.1) catatonia associated with schizophreniform disorder to indicate the presence of the comorbid catatonia.

Specify Current Severity

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizophreniform disorder can be made without using this severity specifier.

Signs and Symptoms

- The characteristic symptoms of schizophreniform disorder are identical to those of schizophrenia
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence).
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (i.e., diminished emotional expression or avolition).
- **Schizophreniform disorder is distinguished by its difference in duration:** The total duration of the illness, including prodromal, active, and residual phases, is at least 1 month but less than 6 months.
- **May or may not present:** Impaired social and occupational functioning.
- No progressive decline in social and occupational functioning.
- Cognitive impairments.
- Depression symptoms.
- Mania symptoms.

Prognosis

About 60–80% of the patients with schizophreniform disorder may progress to a full blown schizophrenia which would be a bad prognosis. But there are chances that only one episode of schizophreniform disorder which may last up to one month but never of the duration of 6 months may recover fully and patient may lead a very normal life. This will be a good prognosis as always wished by family members.

Treatment

- **Hospitalization:** It is mandatory for schizophreniform disorder because this disorder is having a rapid onset with severity of symptoms. Therefore, to avoid the potential harm for patient and others, hospitalization is the first-line treatment regime.
- **Antipsychotic drugs:** Risperidone, an atypical antipsychotic drug over a three to six months course can be beneficial in schizophreniform disorder. The response to antipsychotic drugs in case of schizophreniform disorder is better as compared with schizophrenia.
- **Psychotherapy:** Usually insight-oriented psychotherapy is given to help patient understand the course of the disorder.
- **Electroconvulsive therapy:** It is given in the cases of schizophreniform disorder with severe catatonia or depression symptoms.

DELUSIONAL DISORDER

Definition and Meaning

As we understand that delusions are false fixed beliefs which are not in accordance with one's intelligence and cultural background. So as the name suggests, delusional disorder is characterized by non-bizarre delusions. Bizarre means very strange or unusual. But in delusional disorder, the delusions are non-bizarre meaning thereby the nature of the delusion is not weird but very usual. For example, even in real life, these things can happen such as being followed, poisoned, and deceived or being loved from a distance, etc. But these situations in patient's life are not true but only the misinterpretation of the perceptions (Figs 42A to D).

The duration of the delusional disorder is of 1 month duration.

Epidemiology

The overall prevalence of delusion disorder in general population is 0.2–0.3%. This disorder is a rare occurrence and usually not being reported by patients.

Delusional disorder can affect any age group from 18 years to 90 years but the onset is usually occurring in the 40s. Females are affected more than males. This disorder is commonly seen in low-economic status people and immigrants.

In men, paranoid delusions are more prevalent and females suffer more with erotomania, i.e., a female has strong firm belief that someone of a higher status is in love with her.

Etiological Factors

The exact cause of the disorder is unknown.

Figs 42A to D: Delusional disorder

Biological Factors

Many medical disorders and substance use can cause delusional disorder. Any nervous system disorder affecting the limbic system or basal ganglia may be responsible for causing delusions.

Disorders of perception at the extreme can also cause delusions.

Psychodynamics

Premorbid personality of a patient with delusional disorder may suggest social isolation and attainment of less than expected level of achievement. Use of unhealthy defense mechanisms such as reaction formation, projection and denial are also responsible for patient experiencing delusional disorders.

The following is a list of some of the life situations, which may cause delusional disorders later in life.

- Social isolation
- Life circumstances that increase envy (jealous behavior) in a person
- Life circumstances that increase distrust and suspiciousness
- Lower self-esteem

- Frustration
- Anxiety
- Withdrawn behavior
- **Rumination:** Continuously thinking about the same sad thoughts.
- If a person is in continuous fear of judgment—means every time he/she has to give an explanation for his/her mistakes he/she will attribute it to delusional world of imaginary audience under extreme stress.
- Hostile family environment
- An over-controlling mother
- A sadistic father—tends to demonstrate aggressive and cruel behavior

Defense Mechanisms

- Reaction formation
- Denial
- Projection
- Anger and hostility
- Avoidance

Others

- Personality disorders
- Low socioeconomic status
- Social isolation
- Sensory deprivation
- Deaf people
- Visual impairments

Signs and Symptoms

- Eccentric behavior
- Good general appearance
- Odd behavior
- Suspiciousness—a clinical picture of persecutory delusions
- Hostility
- Euphoria—a clinical picture of grandeur delusions
- Mild depression symptoms
- In extreme stage of delusional disorder, patient may experience hallucinations—Auditory.
- Delusion of persecution
- Delusion of infidelity
- Delusion of being infected with a virus
- Delusion of being loved by a famous person
- Acting out—a delusional patient may act upon his/her delusions such as suicide, homicide or other directed violence.
- Lack of insight-awareness about mental illness

Types of Delusional Disorder

Erotomanic Type

This subtype applies when the central theme of the delusion is that another person is in love with the individual. Another person according to patient is usually of a very high status and is a famous personality. This is also known as psychose passionelle (Fig. 43).

Clinical Features

- Solitary
- Withdrawn
- Sexually inhibited
- Poor social and occupational functioning
- The patient is usually a woman who is unattractive and of a low-level job
- Paradoxical conduct—interpreting all denials of love as secret affirmations of love. Meaning thereby that other person has clearly indicated that they are not in love with that person but their indication of No is taken as an affirmation of love.
- Resentment
- Rage
- Violent behavior in the pursuit of love

Grandiose Type

This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery (Fig. 44).

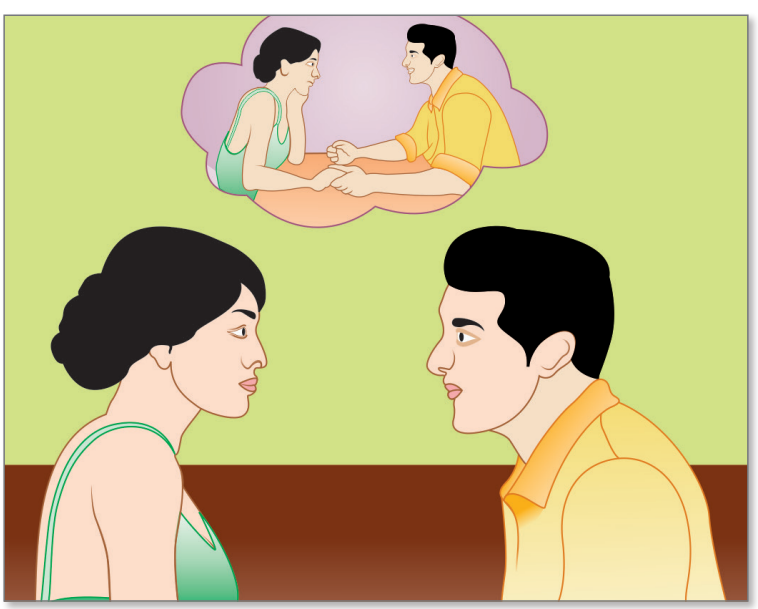


Fig. 43: Erotomanic type of schizophrenia

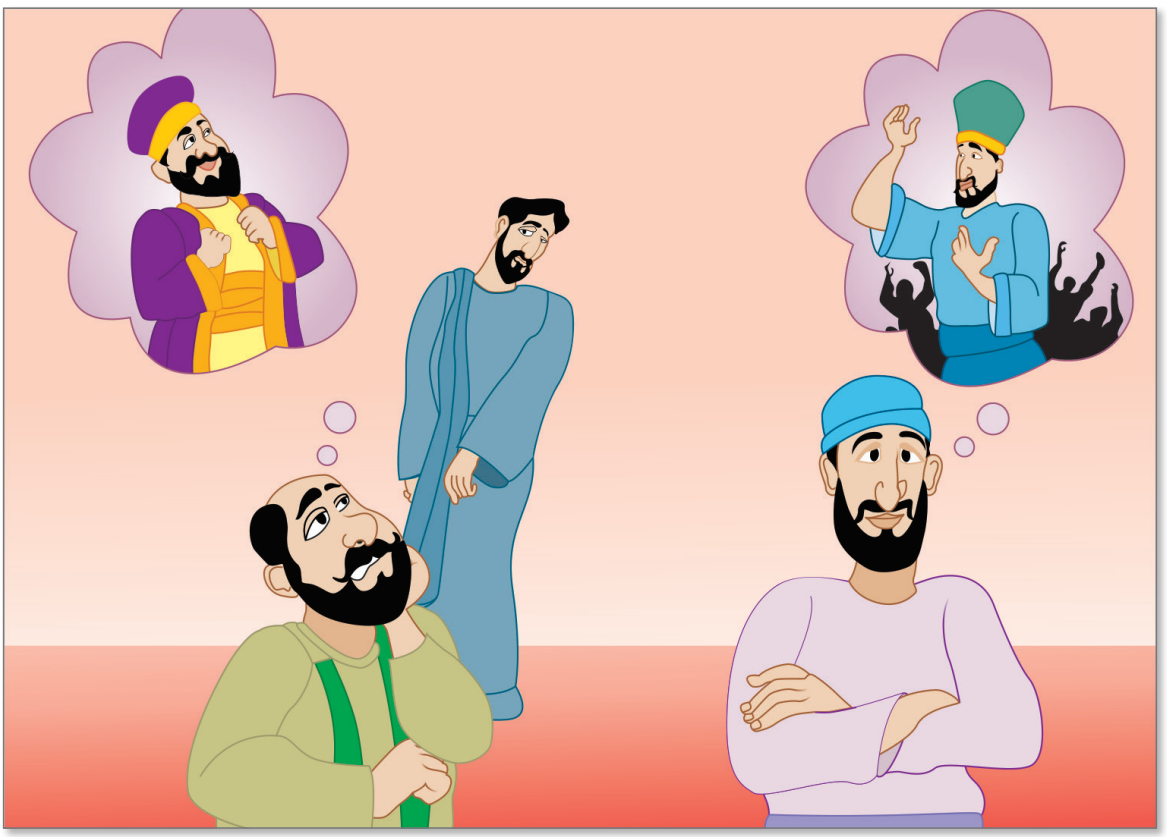


Fig. 44: Grandiose type of schizophrenia

Jealous Type

This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful. This is also known as **conjugal paranoia** (Fig. 45).

Fig. 45: Delusional jealousy

Persecutory Type

This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

Somatic Type

This subtype applies when the central theme of the delusion involves bodily functions or sensations.

The patient may have a delusion of following types:

- Delusion of infestation—a large number of insects are present.
- Delusion of dysmorphophobia—such as of misshapenness, personal ugliness or large sized body parts.
- Halitosis—delusion of foul body parts.

Mixed Type

This subtype applies when no one delusional theme predominates (Fig. 46).

Unspecified Type

This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

Fig. 46: Mixed type of schizophrenia

DSM-5 Diagnostic Criteria for Delusional Disorder

Diagnostic Criteria 297.1 (F22)

- The presence of one (or more) delusions with a duration of 1 month or longer.
- Criterion A for schizophrenia has never been met.
  Note: Hallucinations, if present, are not prominent, and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
- Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
- If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
- The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

Specify Whether

- **Erotomanie type:** This subtype applies when the central theme of the delusion is that another person is in love with the individual.
- **Grandiose type:** This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.
- **Jealous type:** This subtype applies when the central theme of the individual's delusion is that his/her spouse or lover is unfaithful.
- **Persecutory type:** This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

- **Somatic type:** This subtype applies when the central theme of the delusion involves bodily functions or sensations.
- **Mixed type:** This subtype applies when no one delusional theme predominates.
- **Unspecified type:** This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

Specify if

With bizarre content: Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars).

Specify if

The following course specifiers are only to be used after a 1 year duration of the disorder:

- **First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An *acute episode* is a time period in which the symptom criteria are fulfilled.
- **First episode, currently in partial remission:** *Partial remission* is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.
- **First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present. Multiple episodes, currently in acute episode:**
  - Multiple episodes, currently in partial remission
  - Multiple episodes, currently in full remission
- **Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with sub-threshold symptom periods being very brief relative to the overall course.

Unspecified

Specify Current Severity

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).
Note: Diagnosis of delusional disorder can be made without using this severity specifier.

Treatment

The delusional disorder can be treated in psychiatric inpatient/outpatient department. Patients don't usually come on their own for treatment, they are brought against their will by their family members many times.

Psychotherapy

Individual therapy is beneficial for patients with delusional disorder. This could be of any type such as insight-oriented psychotherapy, supportive psychotherapy, cognitive psychotherapy. Behavioral therapy can also be executed.

Family therapy is also useful for patients with delusional disorder.

Hospitalization

It is recommended for controlling violent behavior, suicidal or homicidal behavior. Patient's delusions may have adverse effects on his personal and occupational functioning. Therefore, patient will be benefitted from being relieved from job or personal life stress for some time in hospitalization.

Pharmacotherapy

For emergency conditions, intramuscular injections of antipsychotic drugs can be given.

Even in under control situations, antipsychotics will be the drug of choice for treating delusional disorders.

Begin with low dosages of antipsychotic medications—haloperidol (2 mg) or risperidone (2 mg). Then continue with maintenance dosages.

SHARED PSYCHOTIC DISORDER

Shared psychotic disorder is characterized by transfer of delusions from one person to another. It is also known as *shared paranoid disorder or induced psychotic disorder*.

In this disorder, delusion of one person is shared by another person who is closely associated with him and both are living together for a long period of time.

The first person is usually having a strong influence on the other person and the primary case is chronically suffering from the delusion. The secondary person is having a dependent relationship with the first person and is less intelligent, easily manipulated with a low self-esteem.

DSM Criteria for Shared Delusional Disorder

- A delusion develops in an individual in the context of a close relationship with another person (s), who has an already established delusion.
- The delusion is similar in content to that of the person who already has the established delusion.
- The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Treatment

If the second person is separated from the primary case, he may overcome the delusions which were previously shared but it is not the case always. Sometimes, both the persons need to go through the various treatment modalities.

The delusional disorder can be treated in psychiatric inpatient/outpatient department. Patients don't usually come on their own for treatment, they are brought against their will by family members many times.

Psychotherapy

Individual therapy is beneficial for patients with delusional disorder. This could be of any type such as insight oriented psychotherapy, supportive psychotherapy, cognitive psychotherapy. Behavioral therapy can also be executed.

Family therapy is also useful for patients with delusional disorder.

Hospitalization

It is recommended for controlling violent behavior, suicidal or homicidal behavior. Patient's delusions may have adverse effects on his personal and occupational functioning. Therefore, patient will be benefitted from being relieved from job or personal life stress for some time in hospitalization.

Pharmacotherapy

For emergency conditions, intramuscular injections of antipsychotic drugs can be given.

Even in under control situations, antipsychotics will be the drug of choice for treating delusional disorders.

Begin with low dosages of antipsychotic medications—haloperidol (2 mg) or risperidone (2 mg). Then continue with maintenance dosages.

BRIEF PSYCHOTIC DISORDER

Brief psychotic disorder is characterized by sudden onset of psychotic symptoms, which usually lasts for more than one day but less than one month. As its name suggests, it is of a short duration.

The prognosis is good and patient may resume normal level of functioning after treatment. Sudden onset is defined as change from a nonpsychotic state to a clearly psychotic state within 2 weeks, usually without a prodromal stage. An episode of the disturbance lasts at least 1 day but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning.

Etiology

The etiology of the brief psychotic disorder is unknown but certain risk factors can be listed for causation of brief psychotic disorder:

- Major life stressors which caused extreme emotional upset
- Loss of a close family member
- A severe automobile accident
- A series of moderate life stressors

DSM-5 Criteria for Brief Psychotic Disorder

Diagnostic Criteria 298.8 (F23)

- Presence of one (or more) of the following symptoms. At least one of these must be **(1), (2), or (3):**
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence).
  - Grossly disorganized or catatonic behavior

Note: Do not include a symptom if it is a culturally sanctioned response.

- Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
- The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder, such as schizophrenia or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if

- **With marked stressor(s) (brief reactive psychosis):** If symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.
- **Without merited stressor(s):** If symptoms do not occur in response to events that singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.
- **With postpartum onset:** If onset is during pregnancy or within 4 weeks postpartum.

Specify if

- With catatonia
- **Coding note:** Use additional code 293.89 (F06.1) catatonia associated with brief psychotic disorder to indicate the presence of the comorbid catatonia.

Specify Current Severity

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Signs and Symptoms

- The essential feature of brief psychotic disorder is a disturbance that involves the sudden onset of at least one of the following positive psychotic symptoms:
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly abnormal psychomotor behavior, including catatonia
- Labile mood
- Confusion
- Impaired attention
- Emotional volatility
- Bizarre behavior
- Mutism or scream
- Impaired memory
- Acute paranoid reactions
- Excitation
- Depression

Prognosis

Generally, brief psychotic disorder is having good prognosis. Patients usually return to previous level of premorbid functioning.

Treatment

Hospitalization is required because the disorder is having an acute onset.

- **Pharmacotherapy**
  - Antipsychotics—haloperidol, ziprasadone
  - Benzodiazepines
  - Antianxiety drugs
- **Psychotherapy**

5E: MOOD (EFFECTIVE) DISORDERS: MANIA, DEPRESSION AND BIPOLAR EFFECTIVE DISORDER (BPAD)

MOOD DISORDERS

Mood is the internal emotion or feeling. Affect is the outward expression of mood (Fig. 47).

Disorders of mood are also called effective disorders.

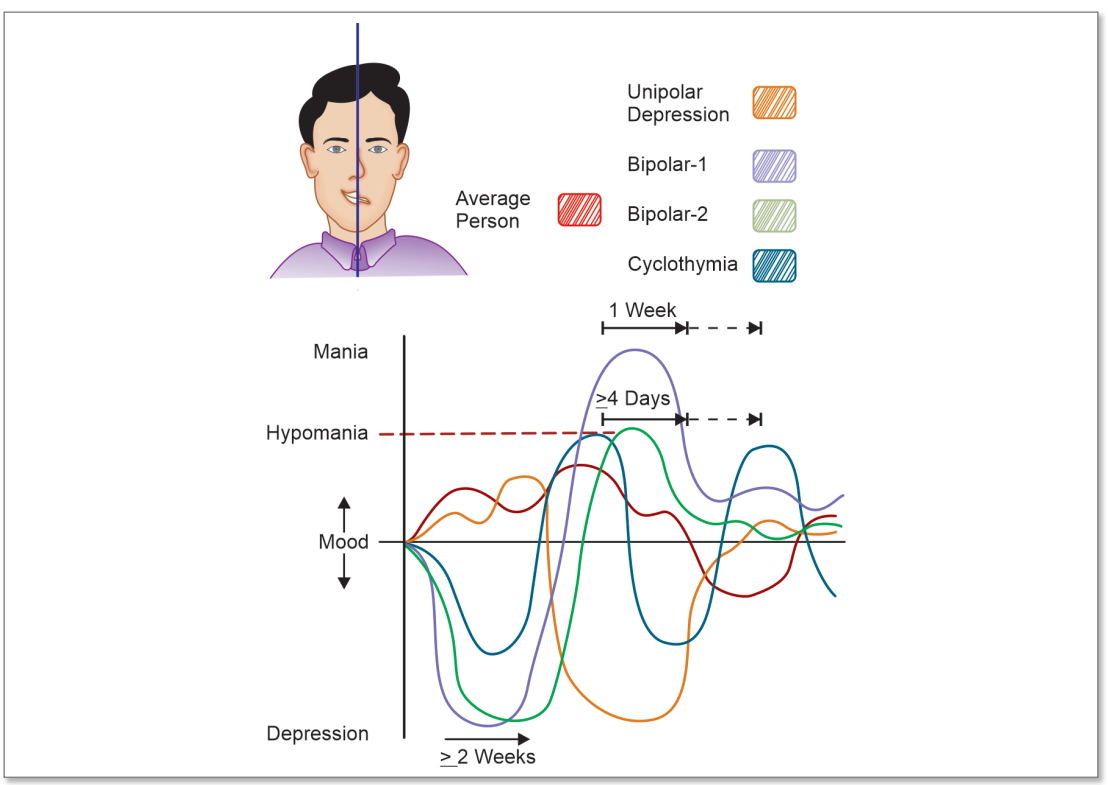


Fig. 47: Comparison of mood in various effective (mood) disorders

The following are some of the categories in which an individual's mood can be described:

- Depressed
- Sad
- Empty
- Melancholic
- Distressed
- Irritable
- Elated
- Euphoria
- Mania
- Gleeful

Mood is a labile property which means that it can fluctuate at different frequencies from laughing to tearfulness. Any mood disorders do affect activity level of an individual. For example, a manic patient of elated mood is having hyperactivity, whereas a depressive patient is having psychomotor retardation. An individual's mood can also affect other physiological functions such as sleep, appetite, circadian rhythms and speech, etc.

Classification

Mood disorders can be classified as follows:

- **Major depression/unipolar depression (only depressive episode):** Patients with only major depressive episodes are said to have major depressive disorder or unipolar depression.
- **Bipolar disorder (depressive and manic episodes alternatively):** Patients with both manic and depressive episodes or patients with manic episodes alone are said to have bipolar disorder.
- **Hypomania:** A patient is said to have hypomania if the symptoms of mania are not severe enough or mania is not full blown. Patient is showing mild forms of mania symptoms.
- **Unipolar mania/pure mania:** The terms "unipolar mania" and "pure mania" are used for patients who are bipolar but who do not have depressive episodes.
- **Cyclothymia:** Less severe form of BPAD.
- **Dysthymia:** Less severe form of major depression.

DEPRESSION/MAJOR DEPRESSIVE DISORDER/UNIPOLAR DEPRESSION

Definition

Depression is a mood disorder characterized by three or four symptoms mentioned in DSM-5 criteria, mainly sadness of mood, poverty of ideas and psychomotor retardation (Fig. 48).

We call it a major depressive disorder when depression happens without any episode of mania, mixed or hypomania. The duration of major depressive disorder is 2 weeks. Depression affects appetite, sleep, activity level of an individual and he/she will be having guilt feelings, difficulty in decision making and suicidal ideation leading to suicide attempts or commit.

Fig. 48: Depression: An illustration

Types

Psychotic Depression

This is the major depressive disorder which occurs with psychotic features. Psychotic depression is severe and has a bad prognosis as compared to major depression alone. These patients usually have a premorbid history of poor social adjustment.

Melancholic Depression

Melancholic depression is characterized by following symptoms in addition to the major depressive symptoms:

- Severe anhedonia
- Early morning awakening
- Weight loss
- Guilt feelings to the extreme
- Suicidal ideation

Sometimes, melancholic depression is also referred to as **Endogeneous Depression** because MRI of melancholic depressive patients shows anatomical changes in autonomic nervous system and endocrine functions are also impaired in melancholic depressive patients. These patients commonly do not have any premorbid history of life-stressful events.

Atypical Depression

The following are the characteristic features of atypical depression. These features are also known as **Reversed Vegetative symptoms.**

- Overeating
- Oversleeping

- Severe psychomotor retardation
- Severe anxiety (panic)

Catatonic Depression

The following are the features of catatonic depression:

- Stupor
- Blunted affect
- Withdrawal behavior
- Negativism
- Severe psychomotor retardation

Postpartum Depression

Postpartum depression occurs when depressive symptoms occur to a woman within 4 weeks of her postpartum period.

Seasonal Effective Disorder (SAD)

SAD happens when a patient experiences depression in a specific season only. Seasonal effective disorder commonly occurs in winters.

Childhood/Adolescence Depression

The depressive symptoms are at times observed in children and adolescents with the following characteristics:

- School phobia
- Poor academic performance
- Substance abuse
- Antisocial behavior
- Excessive clinging to caregivers
- Intentional illegal absence from compulsory education
- Running away
- Engaging in sexual activities with different partners

Geriatric Depression

- Depression is very common in older adults because they are financially dependent on children and may be alone because partner is dead.
- Loneliness and dependence lead to depressive symptoms.
- Depression in older adults is related to physical diseases sometimes.
- Social isolation is another characteristic symptom of depression in older adults.

Prevalence

The major depression is among the most prevalent psychiatric disorders. The overall world's 17% population is suffering from mood disorders. Depression is more common in women, single, unmarried, separated

or divorced. Depression is having the highest lifetime prevalence of 17% as compared to any other psychiatric disorder.

As we understand that women suffer more with major depressive disorder as compared to men; the underlying reason is the hormonal shooting in females during menstruation, child-birth.

Another reason for women suffering more than males is their Learned Helplessness. When a female is born, family and society always treats women as a weaker vessel and train her in such a way that she always needs a man who is stronger and sharer than her.

This in turn develops a psychology of dependence and females learn helplessness from their childhood itself. When a girl child becomes an adult woman, she has now become a personality of learned helplessness and personalities are very difficult to alter. This personality of dependence and learned helplessness is a potential risk for developing depression in later years of life.

The onset of major depressive disorder is usually between 20 and 50 years. Depressive disorder may also have onset in childhood and old age. Life stressors have increased so very much in recent years and there are chances of occurrence of depressive disorders among the age group of less than 20 years.

Major depressive disorder is also common occurrence among alcoholics and drug addicts. Depression is more common in rural areas than in urban areas. There is no influence found between socioeconomic status and major depressive disorder meaning thereby major depressive disorder can happen to any socioeconomic class.

Etiology

Biological Factors

Neurotransmitters (Decreased Levels of Norepinephrine and Serotonin)

The neurotransmitters involved in causation of mood disorders are norepinephrine, dopamine, serotonin and histamine.

No one neurotransmitter can be held responsible for causation of major depressive disorder as it was previously stated that decreased levels of serotonin is sole responsible for causation of disease. But we can say that among all biogenic amines, norepinephrine and serotonin are mostly implicated in the Pathophysiology of mood disorders.

- **Dopamine:** Dopamine is found to play a role in the causation of mood disorders. Dopamine activity is reduced in major depressive disorder.
- **Acetylcholine:** Acetylcholine levels are altered in depressive patients.
- **Gamma aminobutyric acid (GABA):** It is found to be having decreased levels of concentrations in plasma and cerebrospinal fluid in depressive patients. Chronic stress can reduce the levels of GABA in brain cells.

Hormonal Disturbances (Elevated HPA Activity; Increased Levels of Thyrotropin Stimulating Hormone [TSH])

In childhood, when a child suffers early stress in severe forms, it can have alterations in hormonal levels permanently. Hormonal levels indicate a person's behavioral responses later in life. Separation anxiety and maternal deprivation both can cause altered hormonal levels in an individual permanently.

Elevated hypothalamic-pituitary adrenal (HPA) activity is an indication of stress response in human brains.

Increased levels of thyroid stimulating hormone are also associated with major depressive disorder.

Immunological Disturbances

Weak immune system responds to stress in an ineffective way and often results in depression.

Structural and Functional Abnormalities in Brain

Periventricular regions, thalamus, basal-ganglia, cortical atrophy, Limbic system structural and functional abnormalities can cause major depressive disorder.

Genetic Factors

- Twin studies and adoption studies have clearly identified the role of genetics in causation of mood disorders.
- The major genetic alterations in major depressive disorders are found in chromosome 18, chromosome 21q and chromosome 22q.

Psychosocial Factors

Stressful Life Events

Stressful life events are leading to major depressive disorders. Stress accompanied with depression can cause major biological changes in brain structure and functions. This can further cause alterations in neurotransmitters levels.

Even without the presence of an external stressor, major depressive disorder can occur. But we can assume that life events play the major contributing factor for major depressive disorder.

Losing a parent in early years of life may lead to major depressive disorder in later years of life. Loss of a spouse may also lead to depressive disorders.

Other contributors for major depressive disorder are unemployment; Unemployed persons are more prone to depression than those who are working.

- Environmental stressors (usually situational such as loss of a loved one)
- Disturbances in infant-mother relationship during oral stage of development
- Weak or no emotional support

Personality Factors

- OCD personality disorder
- Histrionic personality disorder
- Borderline personality disorder

These personality disorders are more prone to get depression.

Learned Helplessness

Some people do learn to behave in certain ways to respond to life stressors from family or significant others in life. The way one's mother responds, child will automatic learn it. An anxious mother will be able to teach the child about anxiety. So, a learned helplessness may also be a psychodynamic factor in causation of depression.

Signs and Symptoms

- Feelings of sadness almost every day during most of the time
- Anhedonia
- Loss of interest in pleasurable activities
- Weight loss
- Insomnia/Hypersomnia
- Psychomotor agitation/retardation
- Fatigue
- Loss of energy
- Feelings of worthlessness, hopelessness
- Guilt feelings
- Decreased attention and concentration
- Indecisiveness
- Suicidal ideation
- Delusion of sin and guilt
- Reduced energy
- Difficulty finishing tasks
- Impaired personal, occupational and social functioning
- Less motivation to initiate any new tasks
- Trouble sleeping
- Early morning awakening—it is also known as terminal insomnia
- Increased appetite
- Weight gain
- Hypersomnia
- Anxiety
- Abnormal menstrual cycles
- Decreased interest and performance in sexual activities
- **Impulse control:** It is a characteristic symptom of depression that depressed individuals are more prone to have suicidal ideation (about 2/3rd of all depressed individuals) and about 10 to 15% of all depressed patients commit suicide.
- **Depression with psychotic features:** The most commonly observed psychotic feature is delusions. Patient may have persecutory delusions. This may lead them to kill someone. But if the patient is severely depressed, he won't be able to carry out this impulsive act because such person lacks energy and motivation to do so.
- **Paradoxical suicide:** In severe depression, patients lack the energy and motivation to commit suicide although they have a plan to execute for suicide. When their condition begins to improve and they regain the energy required to carry out their suicide plan, they commit suicide. This is known as paradoxical suicide.

Mental Status Examination of Depressive Patients

General Description

- General psychomotor retardation
- Psychomotor agitation in older patients

- Stooped posture
- Downcast gaze

Mood, Affect and Feelings

- Sadness of mood
- Social withdrawal
- Decreased activity

Speech

- Decreased rate and volume of speech
- Single-word answers
- Delayed reaction time (approximately 2–3 minutes)

Disorders of Perception

Any patient with mood disorders, if having psychotic symptoms, may experience hallucinations.

Disorders of Thought Process

- Depression is known as **Psychotic depression** if patient is having major depression with clinical features such as mute, neglect of personal hygiene, etc.
- Thought blocking
- Profound poverty of content
- Delusion of guilt
- Delusion of sinfulness
- Worthlessness
- Poverty of ideas
- Negative view of oneself and of the world
- Suicidal ideation
- Thought of loss and grief

Orientation

Depressive patients are usually oriented to time, place and person but may not answer adequately because they don't have energy to communicate.

Memory

Mild cognitive impairment

Judgment

- Overemphasis on symptoms of depression and life problems.
- Difficult to convince about positive outlook of life.

Insight

Insight is present if psychotic features are not there.

DSM-5 Diagnostic Criteria for Major Depressive Disorder

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, and hopeless) or observation made by others (e.g., appears tearful).
  - Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day.
  - Significant weight loss when not dieting or weight gain, or decrease/increase in appetite nearly every day.
  - Insomnia or hypersomnia nearly every day.
  - Psychomotor agitation or retardation nearly every day.
  - Fatigue or loss of energy nearly every day.
  - Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
  - Diminished ability to think or concentrate or indecisiveness, nearly every day.
  - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The episode is not attributable to physiological effects of a substance or any other medical condition.
- The occurrence of the major depressive episode is not better explained by schizoeffective disorder, schizophrenia, schizophreniform disorder, delusional disorder and other psychotic disorders.
- There has never been a manic episode or a hypomania episode.

Prognosis

Depression is usually chronic and relapsing. Prognosis is good in those who are early diagnosed and accurately treated. Relapse rate is also lower in those patients who took prophylactic treatment after first episode of major depression.

Medical Treatment

Goals of Treatment

- Patient's safety
- Early diagnosis and treatment
- An effective treatment plan to deal with present problems and to prevent complications and comorbidity.

Hospitalization

For acute stage, patient requires hospitalization for treatment in the active phase of disease condition. Patients who are having more of the suicidal ideation or previous history of suicidal attempt require intensive care and one to one observation in hospitalization.

Risk for suicide is a clear indication for hospitalization. If the patient can frequently visit outpatient department for diagnostic evaluation and follow up; he/she can be treated effectively even without hospitalization.

A strong support system is so effective in treating depression at the earliest. The support system must not be overly involved although.

Depressive patients are having insight about their diagnosis but they are not able to take decisions firmly because of poverty of ideas. They may come involuntarily to get hospitalized.

Psychosocial Therapy

There are three treatment regimes in the case of treatment of depressive patients.

1. Combined use of pharmacology and psychosocial therapy
2. Pharmacology alone
3. Psychosocial therapy alone

The results vary according to the patient but currently, clinicians recommend use of one therapy at a time to reduce extra cost of treatment and to reduce unnecessary adverse effects of treatment.

Cognitive Therapy

A depressive patient is often having distorted thinking. He believes that there are not any chances of improvement of his circumstances. Things are only going to get worse and will never get better again. Cognitive therapy is given to target these distorted thinking patterns. In cognitive therapy, therapist helps the depressive individual to develop positive and flexible patterns of thinking and behave accordingly.

Cognitive therapy is effective and having fewer side-effects as compared to pharmacological interventions. Research supports the use of combined psychotherapy and pharmacology to be far more effective than the use of either therapy alone.

Interpersonal Therapy

The depressive patient is often withdrawn, socially isolated and lacks success in interpersonal relationships. Interpersonal therapy is focused to help the depressive patient to develop and maintain healthy interpersonal relations. The interpersonal therapy can be administered in 12 to 16 sessions to resolve and address interpersonal conflicts.

Behavior Therapy

Psychology believes that every pattern of behavior is learned and incorporated in an individual by his interaction with family, friends and society.

Depressive individual is having a typical negative view of the world which he must have learned from his experience and interaction with society. The behavior therapy is focused on changing the perception of the depressive patient and gives him a positive reinforcement which will in turn change his behavioral patterns.

Typically, depressive patients are rejected from the society and they receive a little positive feedback from people for any of the good works of them. This brings maladaptive patterns of behavior in depressive patients.

Family Therapy

Family therapy is given to depressive patients to build up his confidence and support system in society. Support system helps patient cope with life stressors and lessens the chance of reoccurrence of depressive symptoms.

Phototherapy

Light therapy is given to patients who are suffering with seasonal effective disorder (SAD). In light therapy, patient is exposed to a bright light ranges from 1500 lux to 10,000 lux with a light box. Patient sits in front of this light box for 1–2 hours approximately. It is found to be useful to treat depression as an adjunct with antidepressants.

Psychopharmacology

- **Tricyclics**
  - Amitriptyline (75–300 mg/24 hours in divided dosages)
  - Clomipramine
  - Desipramine
  - Doxepin
  - Imipramine (75–300 mg/24 hours in divided dosages)
  - Trimipramine
- **Selective serotonin reuptake inhibitors (SSRIS)**
  - Citalopram
  - Fluoxetine
  - Escitalopram
  - Paroxetine
  - Sertraline
- **Monoamine oxidase inhibitors (MAO inhibitors)**
  - Isocarboxazid
  - Phenelzine
  - Tranylcypromine
- **Others**
  - Bupropion
  - Mirtazapine
  - Trazodone
  - Nefazodone
  - Venlafaxine
  - Duloxetine

Side-effects of antidepressants along with nursing management depicted in Table 6.

Table 6: Side-effects of antidepressants along with nursing management (role a nurse in administration of antidepressants)

Sl. no.	Side-effects	Nursing management (role of a nurse)
1.	**Tricyclics**	
	• Dry mouth	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water.
	• Blurred vision	• **Health education:** Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls.
	• Constipation	• Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity.
	• Urinary retention	• Report to the consultant if patient complains of any difficulty in urination. • Monitor intake and output of the patient.
	• Weight gain	• Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient.
	• Photosensitivity	• **Health education:** Teach client to wear protective clothing, sunscreens and sunglasses when they are out in the sun.
	• Sedation	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time or any other antipsychotic with a lesser side-effect can be administered. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
2.	**Selective serotonin reuptake inhibitors**	
	• Insomnia	• Administer the drug early in day. • **Health education:** Teach patient to avoid caffeinated beverages, such as tea, coffee etc. Teach the patient about relaxation techniques.
	• Sexual dysfunction	• MEN-Abnormal Ejaculation • Women-inability to feel pleasure in sexual activity • Consultant can prescribe another antidepressant on complains of patient.
	• Weight loss	• Weight management strategies. • Calorie intake should be in required proportions. • Keep a record of patient's weight on a daily basis. • On prolonged use of SSRI, weight gain may occur.

Sl. no.	Side-effects	Nursing management (role of a nurse)
	• Headache	• Do administer prescribed analgesics. • If analgesics could not alleviate headache, another antidepressant may be prescribed.
	• Serotonin syndrome	**Definition:** It is a drug interaction in which two drugs which upsurge serotonin neurotransmission are administered concurrently. **Clinical manifestations:** • Altered mental status • Agitation • Blood pressure changes • Profuse sweating • Tremors • Hyperreflexia **Nursing management:** • Discontinue the antidepressant immediately. • Report the symptoms to consultant promptly. • The consultant should prescribe drugs which inhibit serotonin neurotransmission. • The symptoms will be reversed after discontinuation of offending agent.
3.	**Monoamine oxidase inhibitors (MAOIs)**	
	Hypertensive crisis	**Definition:** MAOIS have dietary interactions with foods containing tyramine. Therefore, if a person is on MAOIS, he/she must change his/her diet accordingly to avoid hypertensive crisis. **Foods containing tyramine:** • Cheese • Smoked meats • Smoked fish • Some beers • Overripe fruits • Soya products • Beans **Clinical manifestations:** • Occipital headache (severe) • Nausea/vomiting • Nuchal rigidity • Fever • Diaphoresis • Hypertension (severe) • Palpitations • Chest pain • Coma **Treatment/nursing management:** • Discontinue the offending drug promptly. • Assess vital signs and keep a record. • Prescribe and administer short-acting antihypertensive drugs. • Control fever by cold sponging and other methods.

Contd...

Sl. no.	Side-effects	Nursing management (role of a nurse)
4.	**Other side-effects**	
	Reduction of seizure threshold	**Nursing management:** • Take history of seizures, if any. • Use drugs cautiously, if patient has history of seizures. • Take seizure precautions. • Anticonvulsants may be administered.
	Priapism (persistent erection of penis which is painful)	**Nursing management:** • It usually occurs with trazodone. • Report the symptom to consultant. • Discontinue the drug. • If symptom do not reverse, surgical intervention may be required.
	Hepatic failure	**Nursing management:** • Report clinical manifestations of hepatic failure such as jaundice, anorexia, GI complaints, or malaise, etc. • Intervene promptly.

MANIA

Definition

Mania is a mood disorder characterized by an abnormal elevation of mood, increased psychomotor activity and pressure of speech lasting at least one week for which hospitalization is mandatory. The other associated features are inflated self-esteem, less sleep requirements, distractibility and indulging in pleasurable activities at extreme levels (Fig. 49).

Hypomania is diagnosed when a less severe manic symptom lasts for 4 days and causes no impairment in social and personal functioning of an individual.

Typical features of mania are:

- Inflated self-esteem
- Distractibility
- Decreased need for sleep
- Over indulging in pleasurable activities even if it involves risk
- Increased physical activity
- Increased mental activity

Prevalence

The world's prevalence of mania in general population is 2.4–4.8%. Manic episodes are more common in men as compared to women.

Etiology

Biological Factors

- Neurotransmitters (increased levels of norepinephrine and serotonin)

Fig. 49: Signs of a manic episode

- Hormonal disturbances (Abnormal HPA activity; Altered levels of TSH)
- Immunological disturbances (weak immune system responds to stress in an ineffective way and often results in mood disorder)
- Structural and functional abnormalities in brain (periventricular regions, thalamus, basal-ganglia, cortical atrophy, limbic system)
- Loss of nervous tissue or synaptic contacts in the brain
- Even in the absence of any stressful life events, mood disorders can develop if the biological factors contributing to it are present.

Genetic Factors

Twin studies and adoption studies have clearly identified the role of genetics in causation of mood disorders.

Psychosocial Factors

- Stressful life events
- Environmental stressors (usually situational such as loss of a loved one)
- Disturbances in infant-mother relationship during oral stage of development
- Weak or no emotional support
- When any stressful life events occur, it often leads to development of mood disorders in the absence of effective coping strategies.
- Long-lasting stressful events may alter the functional properties of neurotransmitters in brain nervous system. Stress can cause lasting changes in the structure and function of the brain. These alterations may lead to cause mood disorders.

- Losing a parent in early childhood
- Losing a spouse
- Any environmental stressor
- Unemployment
- Guilt which is embedded in the psychology of a person for a long period negative self-concept
- Poor self-esteem
- Negative mind set as a result of learned patterns of behavior

Personality Factors

- Anti social personality disorder
- This personality disorder is more prone to get mania.

Psychodynamic Factors

- Mania in patients is sometimes a defense to cover up the underlying depression. Some people are so intolerant with the failures of their life that when they can't bear it, they cover with delusions, especially delusion of grandiosity; underneath which is inferiority complex. In the same way, on the surface, patient is demonstrating mania symptoms but underneath there is depression.
- Loss in any form (parent, finances, status, position)
- **Tyrannical superego,** i.e., People who are having tyrannical superego have intolerable self-criticism meaning thereby they can't tolerate their faults being exposed. So they use repression and forget the reality of having commit mistakes and replace it with euphoric self-satisfaction.
- Faulty defense mechanisms use—impulsive behavior, omnipotence, fear and aggression.

Cognitive Factors

- Distorted thinking
- A negative self-percept
- Experience of the world as hostile and demanding
- Expectation of future as suffering and failure

Signs and Symptoms

- Elevated/expansive mood
- Goal-directed activities but never completed
- Decreased need for sleep
- Increased appetite
- Loss of weight
- Increased psychomotor activity
- Pressure of speech
- Distraction
- Flight of ideas
- Delusion of grandeur
- High self-esteem
- Inability to sit still
- An elevated, expansive or irritable mood

- Euphoria
- Never take responsibility of their acts; often blames others for breaking rules and non-compliance
- Exploitation of weakness and limits of others
- Tendency to create conflicts among others, especially family members
- Excessive alcohol intake in premorbid history
- Excessive use of telephone—long hour calls in the morning times. They often forget to hang up phones.
- Pathological gambling
- Manic patients have a tendency to take off one's clothes in public places
- Impulsive behavior—wear bright clothes
- Wear jewelry in bright color and in unusual combinations
- Preoccupation with religious, political, financial and sexual delusions.
- Although this is a rare symptom, at times, patient play with their urine and feces.

Clinical Features of Mania In Adolescents

- Psychosis
- Alcohol or other substance abuse
- Suicide attempts
- Academic problems
- Philosophical views which do not meet an expected set of philosophical standards. This is known as philosophical brooding.
- OCD symptoms
- Somatic complaints
- Irritable behavior indulging in fights
- Antisocial behavior

Mental Status Examination of Manic Patient

General Appearance and Behavior

A mania patient first appearance will be of an excited person. Patient will be very hyperactive and talkative. At times, you may find patient very entertaining and other times, he may get violent and you will find yourself in danger with patient. A violent manic patient needs to be managed with restraints and sedatives through intramuscular routes.

Mood and Affect

The characteristic symptom of mania is elated mood. But the mood of the manic patient is labile. He may throw frustration and hostility at one time and other times, he switches to laughter. The change of the mood can happen in minutes or hours.

Speech

Another characteristic symptom of mania is pressure of speech. Manic patient is very talkative and wants to speak thousand words in one sentence. That's why their speech is incomprehensible sometime and disturbed. The manic patient is usually loud and rapid in speech. Loosening of associations, flight of ideas, clang association and neologism are also present in mania patients.

Disorders of Perception

Delusion is grandiosity is often observed in mania patients. They believe that they are very wealthy and having supernatural powers that they are the one responsible for sunrise and sun-setting. Manic patient sometimes experiences bizarre hallucinations.

Disorders of Thought

Delusion of grandiosity makes patient very confident and outspoken. They initiate the task but are not able to finish it because they are easily distracted. They have flight of ideas.

Orientation

Manic patients are usually oriented to time, place and person.

Memory

The memory of mania patient is intact.

Judgment

The judgment of mania patient is impaired. They are a kind of antisocial. They are fond of breaking rules and do not want to follow instructions. They are extravagant and spend lavishly. Sometimes they will end up ruining their family finances completely.

Insight

Mania patient do not have insight, i.e., awareness about their mental sickness.

DSM-5 Diagnostic Criteria for Mania

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal directed activities or energy, lasting at least 1 week and present most of the day, nearly every day.
- During the period of mood disturbance, an increased activity or energy, three (or more) of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior.
  - Inflated self-esteem or grandiosity.
  - Decreased need for sleep.
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility as reported or observed
  - Increased in goal-directed activities or psychomotor agitation
  - Excessive involvement in activities that have a high potential for painful consequences
  - The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- The episode is not attributable to the physiological effects of a substance

Prognosis

The prognosis of mania varies among patients. Early diagnosis and treatment may result in good prognosis.

Medical Treatment

Hospitalization

For acute stage, patient requires hospitalization for treatment in the active phase of disease condition. Patients who are violent and aggressive, require intensive care and one to one observation in hospitalization.

Restraining and isolation may be mandatory for some manic patients. Patients with acute mania can be best treated only in hospital settings where aggressive dosing can be administered. In hospital settings, patient's condition will be improved within days or weeks.

Even in hospital settings, drug compliance is difficult to achieve because patients lack insight about their disease and they become reluctant to medications. Still it is mandatory to medicate a manic patient to avoid potential risk to oneself and others.

The following drugs are used for treatment of acute mania.

- **Lithium carbonate:** It is the typical antimanic drug. The therapeutic lithium levels are between 0.6 and 1.2 mEq/L. With lithium therapy, the level of blood is frequently monitored. This makes lithium carbonate not a favorable drug for treating mania as there are many alternatives available. There are many manic patients who got benefitted from lithium therapy therefore, it is still in use.
- **Sodium valproate/valproic acid:** It is used to treat acute mania. The therapeutic doses are between 750 and 2500 mg/day in divided dosages.
- **Carbamazepine:** It is the first line treatment for acute stage of mania. The therapeutic doses are between 600 and 1800 mg/day.
- **Benzodiazepine anticonvulsants:** These include two drugs named clonazepam and lorazepam. These are effective for treating mania symptoms, such as agitation, insomnia, aggression and elated mood.
- **Antipsychotics:** Both typical and atypical antipsychotics can be used for treating acute mania. In atypical antipsychotics, the following can be used:
  - Olanzapine
  - Risperidone
  - Quetiapine
  - Ziprasidone
  - Aripiprazole

  In case of typical antipsychotics, haloperidol and chlorpromazine are both effective.

Other Treatment

- Psychosocial therapy
- Interpersonal therapy
- Behavior therapy
- Family therapy
- **Psychopharmacology**

  Mood-stabilizing agents (antimanic drugs)

  Antimanic drugs
  - Lithium carbonate (acute mania: 1800–2400 mg/maintenance: 900–1200 mg)

Anticonvulsants
- Clonazepam
- Carbamazepine
- Valproic acid
- Gabapentin
- Lamotrigine
- Topiramate

Calcium channel blockers
- Verapamil

Antipsychotics
- Olanzapine
- Chlorpromazine
- Quetiapine
- Risperidone
- Ziprasidone

BIPOLAR EFFECTIVE DISORDER

Definitions

- Bipolar effective disorder (BPAD) is defined as episodes of major depression and mania alternatively or periodically.
- Bipolar I disorder is characterized by one or more manic episodes and sometimes, major depressive episodes.
- A mixed episode is a period of at least 1 week in which both a manic episode and a major depressive episode occur on a daily basis.
- A variant of bipolar disorder in which episodes of major depression and hypomania rather than mania occurs is known as bipolar II disorder.

Types

- BPAD-I (patient is having his first episode of mania and no episode of depression has yet occurred)
- BPAD-II (patient is having episodes of mania, hypomania and depression alternatively)

Prevalence

The overall prevalence of BPAD-I and BPAD-II ranges from 0% to 4.8% of the world's general population. Bipolar I disorder is more common in divorced and single persons than among married persons. Bipolar I disorder is mostly common occurrence in upper socioeconomic class. The onset of BPAD has a great variance. It can occur as early as 5 years and as late as 50 years or older.

Etiology

Biological Factors

Research suggested that there are biological abnormalities found in patients with BPAD-I and BPAD-II. The major disturbances are found in neurotransmitters, such as norepinephrine, dopamine, serotonin and histamine.

- Neurotransmitters (Altered levels of norepinephrine and serotonin)
- **Dopamine:** Dopamine levels are reduced in depression and increased in mania. The dopamine pathways are altered in BPAD.
- **Acetylcholine:** Acetylcholine neurotransmitters are also important in regulation of mood and physical activities of an individual. Alterations in the levels of acetylcholine can contribute to BPAD.
- Altered hypothalamic-pituitary adrenal (HPA) activity
- Altered levels of GABA. GABA levels are reduced in depression. Chronic stress can lead to decreased levels of depression.
- **Hormonal disturbances (abnormal HPA activity; altered levels of TSH):** There is an altered levels of thyroid stimulating hormones in BPAD patients. Hormonal replacement therapy in such cases can improve patient's conditions.
- **Growth hormone:** The growth hormone, i.e., somatostatin is increased in mania and its levels are decreased in depression.
- **Prolactin:** Prolactin levels are altered in depressive phase of BPAD.
- Immunological disturbances (weak immune system responds to stress in an ineffective way and often results in mood disorder)—Depression is common among those who are having immunological abnormalities.
- Structural and functional abnormalities in brain (periventricular regions, thalamus, basal-ganglia, cortical atrophy, limbic system)

Genetic Factors

- Twin studies and adoption studies have clearly identified the role of genetics in causation of mood disorders.
- A family history of bipolar disorder poses a greater risk for mood disorders. There is a much greater risk for bipolar disorder.

Psychosocial Factors

- Stressful life events
- Environmental stressors (usually situational such as loss of a loved one)
- Disturbances in infant-mother relationship during oral stage of development
- Weak or no emotional support
- Long chronic stress can produce lasting changes in patients with major depressive disorder and Bipolar-I disorder because of permanent disturbances in the brain's biology. These changes include loss of neurons in the nervous system. Therefore, when any stressful event occurs again in person's life, it may lead to development of mood disorders even in the absence of an external stressor.
- Loss of a spouse
- Unemployment
- Guilt feelings

Personality Factors

- Antisocial personality disorder
- Histrionic personality disorder

- OCD personality disorder
- Borderline personality disorder
- Paranoid personality disorder
- Use of faulty defense mechanisms such as projection, repression, etc.
- **Personal meaning of the stressor:** How you view the stressor determines what you are going to be in the future. Stress is prevalent in life but the response to stressors is an individual's unique property. Some get better and others get bitter. If stress means a punishment to you, you are more prone to develop mood disorders and if it means an opportunity for learning and a challenge, one may grow from it.
- **Negative self-esteem**

Signs and Symptoms

Signs and symptoms of depression, mania and hypomania do appear in the present episode of BPAD.

Mania

- Elevated/expansive mood
- Goal-directed activities but never completed
- Decreased need for sleep
- Increased appetite
- Loss of weight
- Increased psychomotor activity
- Pressure of speech
- Distraction
- Flight of ideas
- Delusion of grandeur
- High self-esteem
- Inability to sit still

Depression

- Feelings of sadness almost every day during most of the time
- Anhedonia
- Loss of interest in pleasurable activities
- Weight loss
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue
- Loss of energy
- Feelings of worthlessness, hopelessness
- Guilt feelings
- Decreased attention and concentration
- Indecisiveness
- Suicidal ideation
- Delusion of sin and guilt

Hypomania

Mild manic symptoms

DSM-5 Diagnostic Criteria for BPAD

For a diagnosis of Bipolar disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomania or major depressive episodes.

Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activities or energy, lasting at least 1 week and present most of the day, nearly every day.
- During the period of mood disturbance, an increased activity or energy, three (or more) of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior.
  - Inflated self-esteem or grandiosity.
  - Decreased need for sleep.
  - More talkative than usual or pressure to keep talking.
  - Flight of ideas or subjective experience that thoughts are racing.
  - Distractibility as reported or observed.
  - Increased in goal-directed activities or psychomotor agitation.
  - Excessive involvement in activities that have a high potential for painful consequences.
- The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- The episode is not attributable to the physiological effects of a substance.

Hypomania

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least for 4 consecutive days and present most of the day, nearly every day.
- During the period of mood disturbance, an increased activity or energy, three (or more) of the following symptoms have persisted, represent a noticeable from usual behavior and have been present to a significant degree:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking.
  - Flight of ideas or subjective experience that thoughts are racing.
  - Distractibility as reported or observed.
  - Increased in goal directed activities or psychomotor agitation.
  - Excessive involvement in activities that have a high potential for painful consequences.
- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- The disturbance in mood and the change in functioning are observable by others.

- The episode is not severe enough to cause marked impairment in social or occupational functioning and to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- The episode is not attributable to the physiological effects of a substance.

Major Depressive Episode

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, and hopeless) or observation made by others (e.g., appears tearful).
  - Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day.
  - Significant weight loss when not dieting or weight gain, or decrease/increase in appetite nearly every day.
  - Insomnia or hypersomnia nearly every day.
  - Psychomotor agitation or retardation nearly every day.
  - Fatigue or loss of energy nearly every day.
  - Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
  - Diminished ability to think or concentrate or indecisiveness, nearly every day.
  - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The episode is not attributable to physiological effects of a substance or any other medical condition.

BIPOLAR DISORDER

- Criteria have been met for at least one manic episode (Criteria A to D under Manic episode above).
- The occurrence of the manic and major depressive episode(s) is not better explained by schizoeffective disorder, schizophrenia, schizophreniform disorder, delusional disorder and other psychotic disorders.

Prognosis

Patients with BPAD have a poor diagnosis in comparison with mania and major depressive disorder. This poor prognosis may be due to a coexisting mental disorder and a previous history of major depressive disorder. Other factors responsible for poor prognosis of BPAD are alcohol or other substance abuse, anxiety disorders. Prognosis is poor in men as compared to women.

Treatment

BPAD has dual treatment approach.

Mania

Treat manic episode as an emergency condition with load sodium valproate and lithium; lamotrigine slowly. Taper the medications slowly. Don't discontinue the drug abruptly.

Hospitalization

For acute stage, patient requires hospitalization for treatment in the active phase of disease condition. Patients, who are violent and aggressive, require intensive care and one to one observation in hospitalization.

Restraining and isolation may be mandatory for some manic patients. Patients with acute mania can be best treated only in hospital settings where aggressive dosing can be administered. In hospital settings, patient's condition will be improved within days or weeks.

Even in hospital settings, drug compliance is difficult to achieve because patients lack insight about their disease and they become reluctant to medications. Still it is mandatory to medicate a manic patient to avoid potential risk to oneself and others.

The following drugs are used for treatment of acute mania.

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- **Sodium valporate/valporic acid:** It is used to treat acute mania. The therapeutic doses are between 750 and 2500 mg/day in divided dosages.
- **Carbamazepine:** It is the first-line treatment for acute stage of mania. The therapeutic doses are between 600 and 1800 mg/day.
- **Benzodiazepine anticonvulsants:** These include two drugs named clonazepam and Lorazepam. These are effective for treating mania symptoms such as agitation, insomnia, aggression and elated mood.
- **Antipsychotics:** Both typical and atypical antipsychotics can be used for treating acute mania. In atypical antipsychotics, the following can be used:
  - Olanzapine
  - Risperidone
  - Quetiapine
  - Ziprasidone
  - Aripiprazole

Depression

Treat with antidepressants with combination of psychotherapies

Initiate suicidal precautions.

Hospitalization

For acute stage, patient requires hospitalization for treatment in the active phase of disease condition. Patients who are having more of the suicidal ideation or previous history of suicidal attempt require intensive care and one to one observation in hospitalization.

Risk for suicide is a clear indication for hospitalization. If the patient can frequently visit outpatient department for diagnostic evaluation and follow up; he can be treated effectively even without hospitalization.

A strong support system is so effective in treating depression at the earliest. The support system must not be overly involved although.

Depressive patients are having insight about their diagnosis but they are not able to take decisions firmly because of poverty of ideas. They may come involuntarily to get hospitalized. In case of typical antipsychotics, Haloperidol and Chlorpromazine are both effective.

Other treatment modalities include the following:

Psychosocial Therapy

There are three treatment regimes in the case of treatment of depressive patients.

- Combined use of pharmacology and psychosocial therapy
- Pharmacology alone
- Psychosocial therapy alone

The results vary according to the patient but currently, clinicians recommend use of one therapy at a time to reduce extra cost of treatment and to reduce unnecessary adverse effects of treatment.

Cognitive Therapy

A depressive patient is often having distorted thinking. He believes that there are not any chances of improvement of his circumstances. Things are only going to get worse and will never get better again. Cognitive therapy is given to target these distorted thinking patterns. In cognitive therapy, therapist helps the depressive individual to develop positive and flexible patterns of thinking and behave accordingly.

Cognitive therapy is effective and having fewer side-effects as compared to pharmacological interventions. Research supports the use of combined psychotherapy and pharmacology to be far more effective than the use of either therapy alone.

Interpersonal Therapy

The depressive patient is often withdrawn, socially isolated and lacks success in interpersonal relationships. Interpersonal therapy is focused to help the depressive patient to develop and maintain healthy interpersonal relations. The interpersonal therapy can be administered in 12–16 sessions to resolve and address interpersonal conflicts.

Behavior Therapy

Psychology believes that every pattern of behavior is learned and incorporated in an individual by his interaction with family, friends and society.

Depressive individual is having a typical negative view of the world which he must have learned from his experience and interaction with society. The behavior therapy is focused on changing the perception of the depressive patient and gives him a positive reinforcement which will in turn change his behavioral patterns.

Typically, depressive patients are rejected from the society and they receive a little positive feedback from people for any of the good works of them. This brings maladaptive patterns of behavior in depressive patients.

Family Therapy

Family therapy is given to depressive patients to build up his confidence and support system in society. Support system helps patient cope with life stressors and lessens the chance of reoccurrence of depressive symptoms.

Phototherapy

Light therapy is given to patients who are suffering with seasonal effective disorder (SAD). In light therapy, patient is exposed to a bright light ranges from 1500 lux to 10,000 lux with a light box. Patient sits in front of this light box for 1–2 hours approximately. It is found to be useful to treat depression as an adjunct with antidepressants.

Psychopharmacology

- Tricyclics
- Amitriptyline (75–300 mg/24 hours in divided dosages)
- Clomipramine
- Desipramine
- Doxepin
- Imipramine (75–300 mg/24 hours in divided dosages)
- Trimipramine

Selective Serotonin Reuptake Inhibitors (SSRIS)

- Citalopram
- Fluoxetine
- Escitalopram
- Paroxetine
- Sertraline

Monoamine Oxidase Inhibitors (MAO Inhibitors)

- Isocarboxazid
- Phenelzine
- Tranylcypromine

Others

- Bupropion
- Mirtazapine
- Trazodone
- Nefazodone
- Venlafaxine
- Duloxetine

Table 7 explains the nursing care plan for depression/depressive phase of BPAD.

Table 7: Nursing care Plan for depression/depressive phase of BPAD

Nursing diagnosis	Nursing interventions	Outcome criteria
Risk for suicide related to sadness of mood	• Encourage expression of suicidal thoughts. • Make a contract with patient that if he/she will have an urge to commit suicide, he/she will call for help. • Ask patient if he/she has any suicidal plan. • One to one observation. • Administer medications, as required. • Maintain a safe environment for patient. • Remove all sharp instruments from patient's reach.	• No suicidal attempts. • Patient's safety is ensured.
Low self-esteem related to poverty of positive ideas	• Accept the patient. • Convey a warm attitude. • Group therapy is instituted. • Encourage patient's participation. • Use therapeutic communication techniques. • Encourage the patient on a daily basis with every interaction.	Patient should accept oneself and feel positive about his/her identity and life.
Dysfunctional grieving related to actual or perceived loss	• Be empathetic to patient's situation. • Provide health education about normal grieving process and do encourage normality in dealing with grief. • Talk more about successes/gains and very less about failures/loses. • Give unconditional love and regard.	Patient will exhibit normal grieving process.

Nursing care plan for mania/manic phase of BPAD is depicted in Table 8.

Table 8: Nursing care plan for mania/manic phase of BPAD

Nursing diagnosis	Nursing interventions	Outcome criteria
Risk for injury related to psychomotor agitation (hyperactivity)	• Keep patient's environment safe and free from stimuli such as sharps, etc. • Keep room dim lighted. • Keep room noise free. • Encourage purposeful physical activities. • Be with patient. • Administer tranquilizers, as needed.	Patient's safety is ensured.
Imbalanced nutrition: Less than body requirements related to inability to sit still long enough to eat	• Provide finger food which can be eaten on the run. • Provide food with high calories, high protein. • Provide energy drinks. • Monitor weight. • Monitor intake and output. • Provide food in an attractive manner. • Sit with patient while eating. • Provide vitamins and minerals supplements.	Patient will maintain a normal weight.

Contd...

Nursing diagnosis	Nursing interventions	Outcome criteria
Risk for injury: Self-directed or other directed related to delusions and hallucinations	• Keep environment free from clutters. • Demonstrate staff strength. • Talk in a calm manner. • Convey an attitude of acceptance. • Involve patient in other physical activities to drain out the energy. • Encourage expression of emotions. • Set limits on patient's behavior. • Administer tranquilizers, as needed. • Restraint the patient as required as patients lose restraints at regular intervals.	No reported incidents of self or others injury.

5F: NEUROTIC DISORDERS

INTRODUCTION

Neurotic disorders are characterized with anxiety and lost touch with reality as main symptoms (Fig. 50). The main neurotic disorders are as follows:

- Phobia
- Anxiety disorders
- Obsessive compulsive disorders
- Depressive neurosis
- Conversion disorders
- Dissociative reaction
- Psychosomatic disorders
- Post-traumatic stress disorder

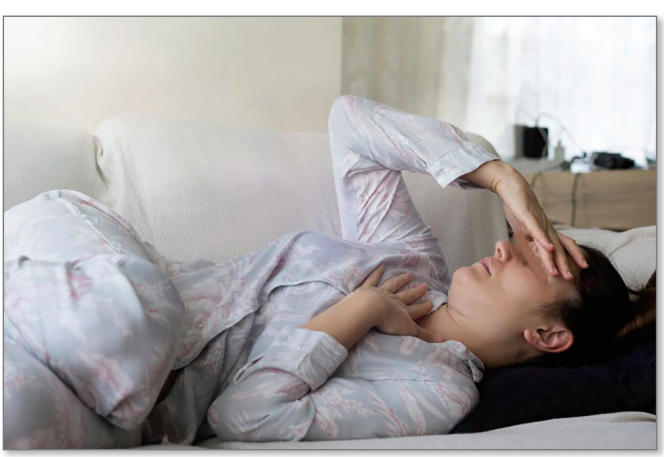


Fig. 50: Neurotic disorders: An illustration

PHOBIA

Definition

Phobia is a neurotic disorder in which a person has an irrational and excessive fear/anxiety toward an object, situation or a life event. It is also known as phobic neurosis.

Types of Phobias

Some types of phobias are shown in Figure 51.

- **Fear/anxiety in open spaces:** Agoraphobia
- **Fear/anxiety in closed spaces:** Claustrophobia
- **Fear/anxiety at heights:** Acrophobia
- **Fear/anxiety at sight of water:** Hydrophobia
- **Fear/anxiety with animals:** Zoophobia
- **Fear/anxiety with strangers:** Xenophobia

Fig. 51: Types of phobias

Prevalence of Phobias in World/India

Phobias are affecting nearly 3% of world's population. In India, the prevalence rate of phobia is 5.8% of total population.

Etiology

Every fear/anxiety is having a root in childhood. Although neurotic disorders like every other mental disorder are caused by multiple causes as given below:

- **Learning theory:** A child learns fear/anxiety as a natural behavior.
- **Psychoanalytical theory:** A child is having castration anxiety in phallic stage of psychosexual development. If oedipal complex is not resolved, this anxiety remains for a life time and may result in developing phobias later in life.
- **Genetic factors:** Some of the genes are responsible for an anxious/fearful behavior in the presence of stressful life events. Phobias may create family histories.
- **Stressors:** Strict and rigid parents (scolding, punishment)
  - Separation from parents at an early age (boarding school)
  - Sibling rivalry

Signs and Symptoms

- Fear/anxiety
- Avoidance of phobic object or situation
- Depression (sadness of mood)
- Fearful/anxious facial expression
- Substance use to overcome anxiety related to phobic object or situation
- Perspiration
- Dizziness
- Increased heart rate (palpitations)
- Syncope
- Tremors
- An urge to pass urine
- Shortness of breath (dyspnea)

Prognosis

Because of lack of research on prognosis of phobia, no definitive data is available regarding prognosis of phobia.

Medical/Psychological Management

There is no pharmacological treatment available for treating phobia. Instead, psychotherapies are of key importance in successful intervention of phobias.

- **Systematic desensitization:** Here, we reduce the sensitivity (reaction) toward phobic object or situation by a rhythmic (step by step) exposure by patient under supervision. The patient will be exposed to the phobic object or situation in succession.

- **Muscle relaxation and imagery:** Progressive muscle relaxation and imagery should be taught to the client. The client is instructed to use these techniques in the face of phobic stimuli.
- **Antianxiety drugs:** Benzodiazepines may also be used to relieve anxiety of the person with phobic neurosis.
- **Imaginal flooding:** This technique is only used under supervision of an expert psychiatrist. Here, patient is exposed to phobic stimulus as long as client can tolerate it. At the end, patient will reach a point where he/she will no longer feel anxiety toward phobic stimulus.
- **Virtual therapy:** In virtual therapy, there will a computer generated simulation of the phobic stimulus, e.g., dogs. The patient will be able to interact with phobic stimuli on the computer screen with less anxiety in comparison with actual interaction with phobic stimulus. In this way, patient's phobia will be reduced slowly to the point where they will no longer experience it.
- **Hypnosis:** Through hypnotic therapy, in which the patient will respond to suggestions of the therapist at a state of conscious where patient is not having voluntary control over action. Here, patient will be suggested to respond to the phobic stimulus in a less anxious manner. In this way, patient will learn to deal with the phobic stimulus in a real world.

ANXIETY DISORDERS

Everyone must have experienced anxiety during their lifetime. For example, before entering an examination hall, student may experience symptoms of anxiety such as palpitations, sweating, etc.

Anxiety is the fear of an unknown threat in future. Anxiety is based on pure assumption, i.e., a belief which may or may not be true. As for instance, here the student may have learned and prepared for the examination well enough, but a false belief that his exam may not go well brings a fear in his mind, which in turn produces anxiety.

Anxiety disorders are often chronic and are associated with great morbidity (disability) rate. Anxiety often comes with somatic symptoms such as headache, perspiration, palpitations, chest tightness, restlessness and stomach discomforts. Patients with anxiety disorders are often resistant to treatment. Anxiety disorders include following:

- Panic disorder
- Agoraphobia
- Specific Phobia
- Social anxiety disorder or phobia
- Generalized anxiety disorder

It is often stated that traumatic life events and stress are the main etiological factors of anxiety disorders. It is also known as anxiety neurosis.

Definition of Anxiety

Anxiety is an unpleasant emotional experience of apprehension (fear) related to an assumed danger in future. As we understand that anxiety disorders are having higher morbidity rate, patients are chronic and resistant to treatment (Fig. 52).

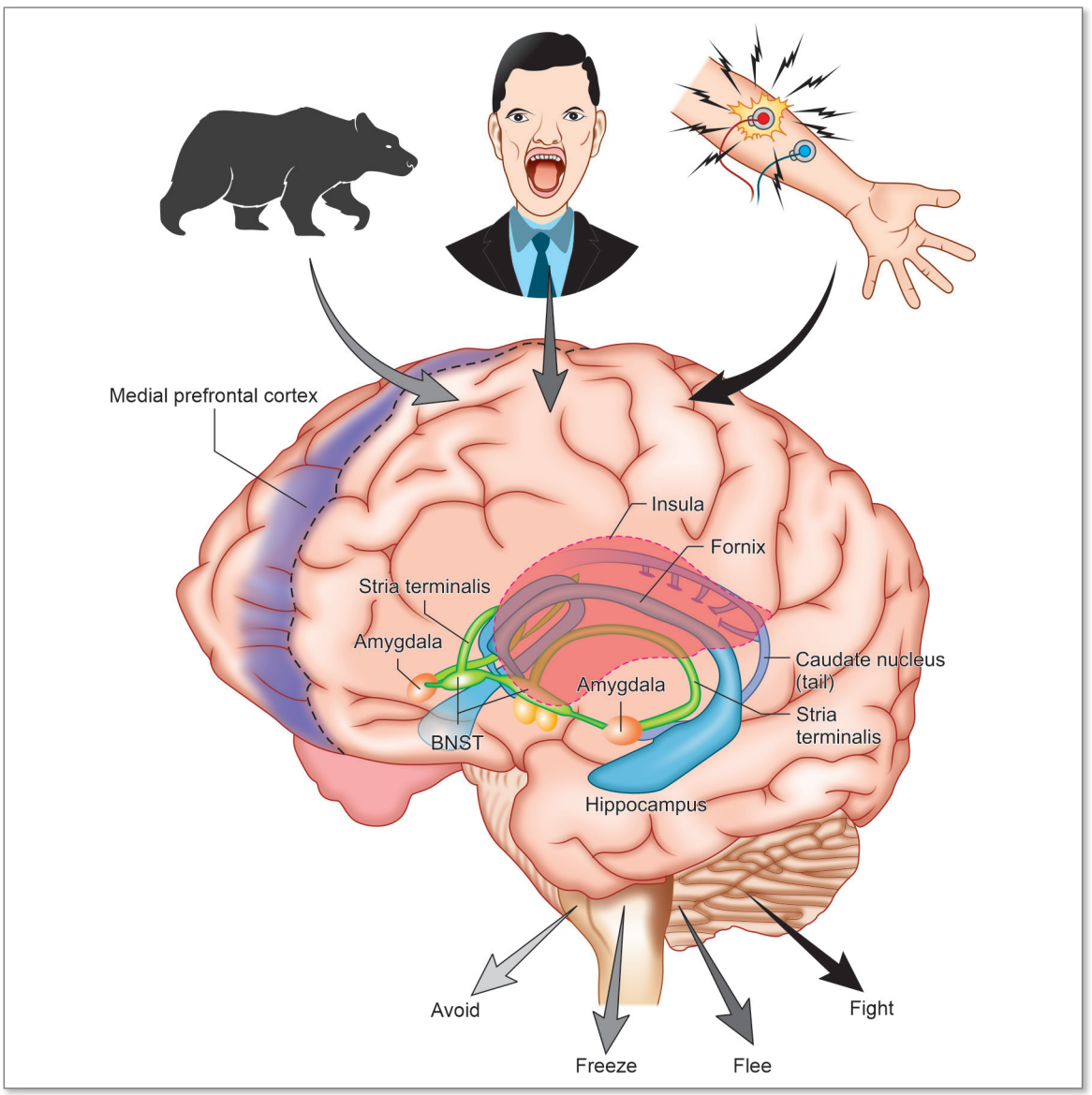


Fig. 52: Anxiety

Signs and Symptoms

- Diarrhea
- Dizziness/vertigo
- Lightheadedness (unpleasant sensation of dizziness or a feeling that one may faint)
- Hyperhidrosis (excessive sweating in the armpits, palms, soles of the feet, face, scalp and/or torso, i.e., trunk of human body)

- Hyperreflexia (overactive or over responsive reflexes)
- Palpitations
- Pupillary mydriasis (dilation of pupil)
- Restlessness
- Syncope
- Tachycardia
- Tingling in the extremities
- Tremors
- Upset stomach
- Urinary frequency, hesitancy, urgency

Prevalence

Anxiety is the hallmark symptom of every mental disorder. Therefore, we can well imagine that prevalence of anxiety disorders is possibly quite high. One out of four persons is suffering from anxiety disorders. In women, prevalence rate of anxiety disorders is 30.5% and in men, the prevalence rate of anxiety disorders is 19.2%.

It is important to note that anxiety disorders are less common in higher socioeconomic status and chances of anxiety disorder occurrence decreases with higher socioeconomic status.

Etiology

- **Psychoanalytical theory:** Anxiety is an embedded libido in the unconscious mind of the patient. This may have developed at any stage of development. The fear of an unknown danger in the environment gives an alarm to the individual in the form of anxiety.
  Anxiety often results from a psychological conflict in the brain. This conflict is often between id (pleasure) and super-ego (morality) or any external reality. In response to the internal psychological conflicts, external manifestations of anxiety appear in the form of somatic symptoms associated with anxiety.
- **Psychodynamics:** Anxiety is often an embedded psychological conflict which has its roots in childhood in any of its developmental stage. A child needs strong affirmation and validation from family and society. When he is faced with any kind of neglect or ignorance, this creates anxiety in the child.
  Previously this anxiety at that developmental stage is not so manifested in clinical features but gets stored in the unconscious mind of the patient as a defense mechanism, i.e., repression.
  Disapproval by parents also generates anxiety in the child.
  Oedipal complex in males and Electra complex in females are the original roots of anxiety in adults.
- **Oedipal complex:** A male child fears a male parent especially a strong aggressive figure and develops castration anxiety, i.e., fear of castration of penis by father.
- **Electra complex:** A female child is fearful of female parent and develops anxiety if a mother scolds her.
- **Behavioral theory:** A child may have learned to be anxious as a conditioned response to a stimulus in the environment such as an abusive parent, a loud cry/shout. As an adult, the individual responds to the stimulus by becoming anxious.
- **Existential theory:** Every individual tries to find meaning in their existence. One feels a void in oneself and always tries his best to fulfil that void by understanding his existence in a purposeless universe. This void creates anxiety in the person. This anxiety is developed in response to every unnatural stimulus in the universe. For example, War, Terrorism, Physical or Psychological Conflicts.

Biological Factors

- **Physiologic factors:** Symptoms of anxiety are manifested by autonomic nervous system such as tachycardia, headache, diarrhea, tachypnea, etc. All of these clinical features occur in an individual's autonomic nervous system response to any change in internal physiological or external environment.
- **Neurotransmitters:** Altered levels of Norepinephrine and GABA may produce anxiety in individuals. Any positive stimuli may reduce the anxiety and balance the neurotransmitters. On the other hand, any negative stimuli in the environment may alter the neurotransmitters to respond in the form of anxiety.
- **Norepinephrine:** Increased levels of norepinephrine can increase anxiety symptoms in individuals. Norepinephrine levels are altered in the nervous tissues of cerebral cortex, brainstem, limbic system and spinal cord.
- **HPA axis:** In stress, cortisol levels are increased in the body. The function of cortisol is to increase arousal, attention and memory and contributing to immune system. Increased levels of cortisol may result in increased BP, osteoporosis, immunosuppression, atherosclerosis and cardiovascular disorders. This is a negative feedback mechanism. Stress causes increased levels of Cortisol and increased levels of cortisol can cause stress.
- **Corticotrophin releasing hormone/CRH:** Increased levels of CRH results in responses such as decreased food intake, inhibited sexual activity, decreased growth and reproductive functions. Lasting stress leads to alterations in CRH levels and it then produces anxiety symptoms in individuals.
- **Serotonin:** Serotonin plays an important role in the causation of anxiety disorders. Acute stress often results in increased serotonin levels in the nervous tissues and produces anxiety symptoms in individuals. Increased levels of serotonin contribute to increased anxiety levels.
- **GABA:** GABA activity is also altered in anxiety disorders.
- **Galanin:** Galanin is a protein peptide which contains 30 amino acids. It has the functions such as learning, memory, pain control, food intake and cardiovascular health. Altered levels of galanin in the forebrain and midbrain structures can produce anxiety symptoms in individuals.
- **Structural changes in the brain:** Cerebral ventricles' size is increased in anxiety disorders. Any specific structural change in right temporal lobe, right hemisphere can contribute to anxiety symptoms in patients.

Genetic Factors

There has been found a strong correlation between anxiety disorders with genetic makeup of an individual. Heredity predisposes an individual to anxiety symptoms. There will always be a family history in at least one of the close relatives of the patient.

Limbic System

Limbic system is the emotional system of the human brain. Alterations in the emotional system can produce fear and anxiety in patients. The main areas involved are septo-hippocampal pathways where neuronal activity is increased.

Cerebral Cortex

As anatomically, frontal cerebral cortex is attached with hippocampal region. Any abnormalities in cingulated gyrus, temporal cortex or hypothalamus may lead to development of anxiety disorders.

Panic Disorder

Definition

It is an acute profound attack of anxiety accompanied by feelings of impending doom.

Impending doom may refer to a feeling that one is going to lose control or about to die.

Panic attack may occur as one episode in one day or several attacks in one day.

Panic attack is always with intense anxiety and feelings of impending doom suddenly (Fig. 53). Panic attack can occur as several attacks in one day or few attacks during a year. Agoraphobia is a common comorbidity with panic disorder. Agoraphobia is a phobia of those places from which escape might be difficult.

Panic attack is extreme fear lasting from minutes to hours. It is always sudden. It may occur in panic disorder as well as in specific phobias, post-traumatic stress disorder and social phobia.

Panic attacks can occur unexpectedly at any time. There is not always a presence of situation or stimulus.

Prevalence in World/India

Panic disorder accounts for 1.2% of the population worldwide. Every fifth person in India is suffering from anxiety disorder but the exact statistical information is not available.

The lifetime prevalence of panic disorder is in the 1–4% range, with 6-month prevalence approximately 0.5–1.0% and 3–5.6% for panic attacks.

Panic disorder is often chronic in nature and do have a variable course among patients.

Women are affected more with panic attack as compared to men. Panic attack is most commonly observed in social conditions such as divorce or separation. It is most commonly observed in young adults although panic attacks can affect any age group.

Panic disorder has usually its onset in early adulthood and at times during late adolescence, person can experience panic disorder for the first time.

The occurrence of psychological stressors is increased in case of panic disorder.

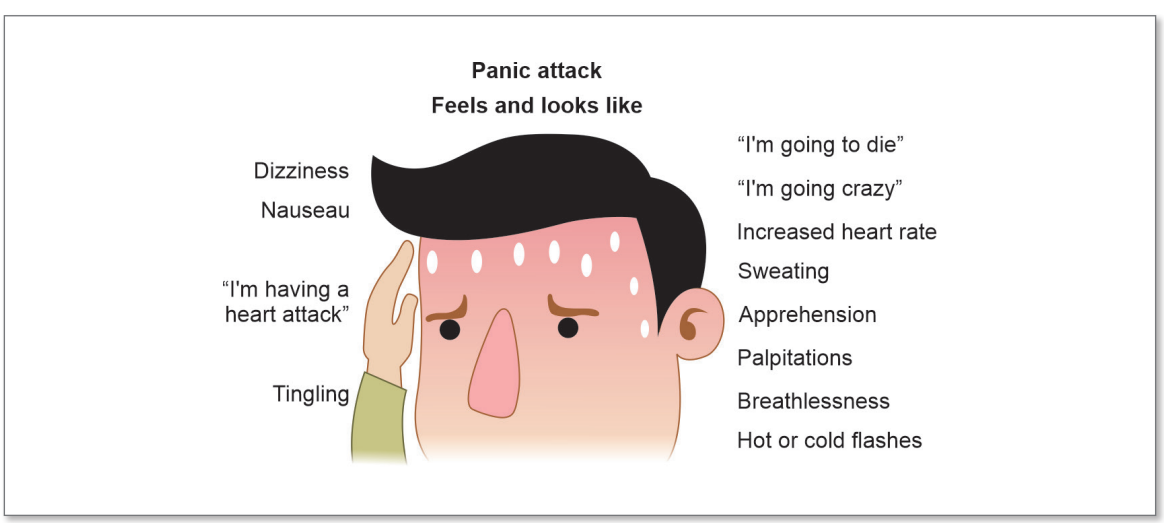


Fig. 53: Panic attack

Etiology of Panic Disorder

- **Biological factors:** Over active sympathetic system
  - Research suggests that there are structural and functional abnormalities in the patients with panic disorder.
  - There is abnormal regulation of brain noradrenergic system and both peripheral and central nervous system in patients with panic disorder.
  - There is increased sympathetic tone.
- **Neurotransmitters involved:** Norepinephrine, Serotonin, GABA
- **Dysfunctional brain areas:** Brainstem, limbic system, prefrontal cortex
  - Other areas involved as evidenced by brain imaging studies are temporal lobes, particularly the hippocampus and the amygdala. There may be cortical atrophy seen in the right temporal lobe of patients with panic disorder.
  - The functional problems are seen such as dysregulation of cerebral blood flow in patients with panic disorder.
  - Also panic attacks are characterized by cerebral vasoconstriction whereby CNS symptoms are observed in patients suffering from panic disorder such as dizziness.
  - These symptoms may be caused by a state known as hypocapnia, i.e., a state of reduced carbon dioxide in the blood. Hypocapnia is generally induced by hyperventilation in panic attacks.
- **Panicogens: They are panic inducing substances such as:** Carbon dioxide
  - Sodium lactate
  - Bicarbonate
  - Acid-base balance
  - These panic inducing substances stimulate respiratory system and cause a shift in the acid-base balance. This causes hyperventilation through a hypersensitive suffocation alarm system because of which there is increased partial pressure of carbon dioxide and increased brain lactate concentrations. This may result in asphyxia.
  - In addition to above Panicogens, others include yohimbine, i.e., an α-2 adrenergic receptor antagonist; m-caroline drugs, flumazenil, cholecystokinin and caffeine.
  - Isoprenaline or Isoproterenol is a medication used for the treatment of Bradycardia, heart block, and rarely for asthma. It can also act as a panic inducing substance.
- **Genetics:** Risk is four to eight fold in first degree relatives.
  - There is no clear evidence of any specific chromosomal location or mode of transmission through genes associated with the occurrence of panic disorder.
- **Psychosocial factors**
  - By psychodynamics, we understand that there is always a strong clear psychological trigger for the panic attack. This psychological trigger is usually related to any environmental or psychological factors. At times, social factors may also contribute to it.
  - **Psychoanalytical theories:** Panic attack occurs in those who are having unsuccessful defense mechanisms against anxiety. Over use of these unsuccessful defense mechanisms against anxiety provoking stimulants will lead to a failure of coping strategies which in turn results in panic disorder with a great deal of somatic complaints.
  - **Stressful life events (e.g., loss of loved one):** There is a higher incidence of stressful life events in the premorbid history of patients with panic disorder.

- Some people are more prone to experience a greater distress toward the same distressing element as compared with other people. Such people are more prone to develop panic disorder.
- **Childhood physical and sexual abuse:** Children who experience childhood physical and sexual abuse are at greater risk for developing panic disorder. Approximately 60% of the women suffering from panic disorders do have a premorbid history of childhood physical or sexual abuse.
- Separation from parents at a young age especially from mother is more likely to develop risk for panic disorder in later years of life.
- In cognitive therapy given to the patients with panic disorder, it is a clear observation that these people always do have a special unconscious meaning of the stressful events they address in life.
- **There are following features attached with the special unconscious play of the stress:**
  - Difficulty tolerating anger
  - Poor handling of the situations which demand increased work load/responsibilities
  - Controlling, frightening and demanding parents
  - Received critical evaluation from family, friends and society
  - Feelings of being trapped
  - Parents' rejection

Defense Mechanisms Used by a Patient Having Panic Disorder

- **Reaction formation** (in response to the emotion; expression of exact opposite behavior is done), e.g., disliking a person in personal and showing great admiration for the same person in public.
- **Undoing** (doing an action to compensate for one's wrong doing) e.g., a husband feeling guilty of being unfaithful brings flowers for wife.
- **Somatization** (expression of anxiety through bodily symptoms) e.g., headache, stress ulcers.
- **Externalization** (identifying one's personality characters in an external world) e.g., I feel like a torn cloth.

Diagnostic Criteria for Panic Disorder DSM-5

An individual can be diagnosed as having panic disorder only if he/she meets the diagnostic criteria for disorder. If the following conditions are not fulfilled, an individual cannot be diagnosed as having panic disorder.

- Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time four or more of the following symptoms occur:
  - Palpitations
  - Sweating
  - Trembling or shaking
  - Sensations of shortness of breath
  - Feelings of choking
  - Chest pain or discomfort
  - Nausea or abdominal distress
  - Feeling dizzy, unsteady, light-headed or faint
  - Chills or heat sensations
  - Numbness or tingling sensations
  - Derealization

  - Feeling of losing control or "going crazy"
  - Fear of dying
- At least one of the attacks has been followed by 1 month (or more) of one or both of the following
  - Persistent concern or worry about additional panic attacks and their consequences.
  - A significant maladaptive change in behavior related to the attacks (e.g., avoidance of exercise or unfamiliar situations)
- The disturbance is not attributable to the physiological effects of a substance or another medical condition.
- The disturbance is not better explained by another mental disorder.

Signs and Symptoms

- Profound anxiety of 10-minute period
- Extreme fear
- A sense of impending death or doom
- Confusion
- Difficulty in concentration
- Tachycardia
- Palpitations
- Dyspnea
- Sweating
- Impaired memory
- Stammering (difficulty speaking)
- Depression
- Derealization and/or depersonalization
- **Activities which may induce panic attacks include:**
  - Alcohol intake
  - Use of caffeine, nicotine, etc.
  - Disturbed sleep wake cycle
  - Unusual patterns of eating
- Anticipatory anxiety about having another attack
- Worry about death which they think can happen from the heart or respiratory problem that occurs during panic attacks.
- Syncope
- Somatic symptoms such as hyperventilation, respiratory alkalosis. In case of respiratory alkalosis, ask patient to breathe into a paper bag to relieve the symptom.
- Risk of suicide
- Depressive symptoms
- Obsessive compulsive symptoms
- Social symptoms such as interpersonal relationship problems, loss of work and substance use especially caffeine and nicotine can exacerbate the panic attack symptoms.
- After repeated attacks, patients may become unconcerned about their condition. At that stage, they keep their panic attack a secret and behave in a strange manner. This can cause fear and worry to the family and friends because of patient's unexplained weird conduct.

- It is interesting to note here that patients with panic disorder use the defense mechanism of avoidance and try their level best to appear as normal as general population by avoiding those situations and circumstances that can trigger a panic attack.
- They may long avoid certain specific settings such as using an elevator and/or speaking in public, avoidance of social gatherings, etc.

Prognosis

An acute panic attack is having a good prognosis and those with good premorbid functioning. Patients who are chronically ill are usually resistant.

If patients are taking long-term follow up, they may improve and have controlled effects of treatment. Symptoms are mild with treatment and patient may lead a normal life.

There are only 10–20% of the patients who are having a bad prognosis. The reason of bad prognosis could be an increased number of psychosocial stressors.

The prognosis of panic disorder can be worse with comorbidity especially a diagnosis of depression. Patients with panic disorder may never verbalize about suicidal ideation but they are at risk for committing suicide. In that case, the patient's history may reveal that he/she is having bad school or work performance.

Pharmacological Management

- **SSRIS (fluoxetine, sertraline, etc.)**
  - All kinds of selective serotonin reuptake inhibitors are effective to treat panic disorder symptoms. For immediate relief and **first line treatment**, Paroxetine is preferred drug over others.
  - **Second line treatment** includes citalopram, escitalopram, sertraline and fluvoxamine.
  - Initially start with smaller doses and slowly titrate to avoid side effects such as Sedation and tolerance, etc.
- **Tricyclic antidepressants (imipramine, desipramine, etc.) and tetracyclic antidepressants**
  - Although SSRIs are considered as the first line treatment for panic disorder, research evidenced that tricyclics such as Clomipramine and Imipramine have proved to be very effective in the treatment of panic disorder symptoms.
  - While using tricyclics and tetracyclic antidepressants, doses are started in smaller quantities first and then they are titrated upward slowly for the full clinical effectiveness.
  - Still tricyclics are used less widely in the treatment of panic disorders because they cause more severe adverse effects.
- **Benzodiazepines (clonazepam, diazepam, lorazepam, etc.)**
  - Benzodiazepines are used in the treatment of panic disorders because they have a rapid onset and are effective in providing immediate relief by inducing sleep at times.
  - They are used for a longer duration of treatment and chances of tolerance are less.
  - Alprazolam is listed as the most widely used benzodiazepines among antipanic drugs.
  - Some side-effects are observed in clinical settings such as dependence, cognitive decline and at times drug abuse by patients.
  - **Important health education while on benzodiazepines:** Patients must be instructed not to indulge oneself in those activities that require attention and alertness such as driving or operating any dangerous machinery. Patient must be given health education regarding precautions to be taken while taking CNS depressing drugs that they must refrain from alcohol intake and any other drug that will further cause CNS depression.
  - In case, patient develops addiction to these medications, they must go for a detoxification program.

- To avoid any untoward reactions, health care professionals need to taper drugs slowly. Give health education to patients on benzodiazepines about drugs' withdrawal effects.

- **MAOIS (phenelzine, tranylcypromine)**
  - Phenelzine and tranylcypromine are found to be effective in full doses for at least 8–12 weeks of treatment. But as we know, while on MAOIs, patients have to follow dietary restrictions and adverse reactions are also very dangerous. These drugs are not so popular among the treatment of panic disorder.
  - MAOIs are used as a last resort when other treatment modalities get failed.
- **Atypical antidepressants (venlafaxine)**
  - When there is no response with any one kind of treatment, there is a suggestion for trying a different pharmacological agent named venlafaxine which is research evidenced and has been proved to be effective.
- **Others (valproic acid)**
  - Even combination of drugs can be used. One that combination is SSRI/Tricyclic antidepressants plus Benzodiazepine.
  - Research also supports the use and effectiveness of carbamazepine, valproate and calcium channel blockers.
  - The aggressive treatment of panic disorder with use of pharmacological agents and psychotherapy may bring remarkable improvement in the panic disorder. Family therapy may also be executed.
  - Drugs named alprazolam and paroxetine are used effectively in the treatment of panic disorder.
  - Venlafaxine and Buspirone are found to produce addiction in some patients. Therefore, it is preferred to use SSRIs and Tricyclic antidepressants over other medications.
  - Following is a list of **anti-panic drugs** with their dosage summary.

Drug	Starting dose	Maintenance dose
SSRI		
• Paroxetine	5–10 mg	20–60 mg
• Fluoxetine	2–5 mg	20–60 mg
• Sertraline	12.5–25 mg	50–200 mg
• Fluvoxamine	12.5 mg	100–150 mg
• Citalopram	10 mg	20–40 mg
• Escitalopram	10 mg	20 mg
Tricyclic antidepressants		
• Clomipramine	5–12.5 mg	50–125 mg
• Imipramine	10–25 mg	150–500 mg
• Desipramine	10–25 mg	150–200 mg
MAO Inhibitors		
• Phenelzine	15 mg in 2 divided doses	15–45 mg in 2 divided doses
• Tranylcypromine	10 mg in 2 divided doses	10–30 mg in 2 divided doses
Benzodiazepines		
• Alprazolam	0.25–0.5 in 3 divided doses	0.5–2 in 3 divided doses
• Clonazepam	0.25–0.5 in 2 divided doses	0.5–2 in 2 divided doses
• Diazepam	2–5 mg in 2 divided doses	5–30 in 2 divided doses
• Lorazepam	0.25–0.5 in 2 divided doses	0.5–2 in 2 divided doses
Atypical antidepressants		
• Venlafaxine	6.25–25 mg	50–150 mg
Others		
• Valproic acid	125 mg in 2 divided doses	500–750 mg in 2 divided doses

Psychological Management

- Cognitive and behavior therapies are used in psychological management.
- It is suggested by research that if pharmacology and cognitive behavioral therapies are used in combination then there are very less chances of relapse or reoccurrence of symptoms.
- In many cases, Cognitive and behavior therapies have been proved to be far more high-ranking than pharmacology alone.
- Cognitive therapy focuses on gaining insight and understanding about panic disorder. Cognitive therapy in case of panic disorder is merely a health education in which patient is given insight about his false beliefs on panic attacks. He is provided with knowledge regarding panic attacks how they occur, what are the possible potential risk factors and how they can be treated.
- Gaining insight about the disorder relieves a whole lot of anxiety in patient which can further reduce the number of panic attacks.
- Patient is advised to keep a record of his panic attacks and instructed to interpret it with his knowledge. Then therapist helps patient to correct the misinterpretations of the patient such as considering mild bodily sensations as impending panic attacks, doom or death.
- Therapist helps patient understand that panic attacks have a limited duration, they cannot occur for more than a limited time and are never life-threatening.

Agoraphobia

Definition

Agoraphobia is the pathological fear of those places from where escape might be difficult.

Agoraphobia has higher morbidity rate. It may or may not occur as a complication of panic disorder.

Agoraphobia disables a person to work outside home and in social situations. Many of the times, it occurs as a complication of panic disorder meaning thereby a person is having a deep seated fear of having a panic attack in social situations or outside home and on the surface, he/she will avoid all the activities that require going outside home.

As a result, person will be having agoraphobia that is a pathological fear of those places from where escape might be difficult, e.g., a public place.

Still, we learn Agoraphobia as a separate disorder and not as a complication of panic disorder.

The term Agoraphobia is derived from two Greek words, *Agora* means market place and *Phobia* means fear.

Prevalence of Disorder in World/India

The prevalence of agoraphobia is 4.2% of the general population worldwide and in India, it is 1.7% among adults, which drops to a rate of 0.4% in elderly.

It is noteworthy that agoraphobia is more common in older adults above age 65 because they may have comorbidity such as cognitive decline, delirium and dementia. In many cases in clinical settings, patients who are having agoraphobia usually have a premorbid history of a traumatic event.

Etiology

The etiological factors of agoraphobia are similar to panic disorder, because in most of the cases, agoraphobia occurs followed by a panic attack. Agoraphobia is considered to be a complication of panic attack.

Signs and Symptoms

Below given are the signs and symptoms of Agoraphobia (Fig. 54).

Fig. 54: Signs and symptoms of agoraphobia

- Fear/anxiety of use of public transportation (buses, trains, planes and cars)
- Fear/anxiety of being in open spaces (parking lots, market places, shopping centers and parks, etc.)
- Fear/anxiety of being in enclosed spaces (shops, cinemas, stores, elevators and theaters, etc.)
- Fear/anxiety of standing in line or being in a crowd.
- Avoiding those places from where escape might be difficult.
- Avoiding all agoraphobic situations that may provoke anxiety or fear in patients.
- Active avoidance of phobic stimulus and if he has to face the phobic stimulus, he will do it with intense fear/anxiety.
- The individual with agoraphobia always demands company. He always requires the presence of a companion.
- The individual never goes alone outside the home.
- Patients with agoraphobia usually have marital fights because of their behavior. They will be having problems in their interpersonal relationships.

DSM-5 Diagnostic Criteria for Agoraphobia

- **Marked fear or anxiety about two or more of the following five situations:**
  - Using public transportation (buses, trains, planes)
  - Being in open spaces (parking lots, market places)
  - Being in enclosed spaces (shops, cinemas)
  - Standing in line or being in a crowd
- The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic like symptoms.
- The agoraphobic situations always provoke anxiety or fear.
- The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
- The fear or anxiety is proportionately higher than the actual danger posed by agoraphobic situations.
- The fear, anxiety or avoidance is persistent, typically last for 6 months or more.
- The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- If another medical condition is present, the fear, anxiety or avoidance is clearly excessive.
- The fear, anxiety or avoidance is not better explained by symptoms of another mental disorder.

Prognosis

Agoraphobia is a chronic illness and sometimes requires lifelong treatment. Thus, agoraphobia is having a poor prognosis.

As we know that at times, agoraphobia develops as a complication of panic disorder. Therefore, the prognosis of agoraphobia in that case depends upon the treatment of panic disorder. If panic disorder gets treated, then agoraphobia will be treated accordingly.

The prognosis of agoraphobia is very poor with comorbid conditions such as depression and alcohol dependence.

Pharmacological Management

- **Benzodiazepines**
  - Benzodiazepines are the most effective drugs in the treatment of agoraphobia. The most commonly used drugs are Alprazolam and Lorazepam. Research suggests that clonazepam is also equally effective against treating phobia.
  - The issues with use of benzodiazepines are risk of dependence, cognitive decline and abuse of drugs by patients if they are on long-term therapy.
  - The common but mild side-effects of benzodiazepines are dizziness and sedative effects. These symptoms get usually weaker or less effective with the passage of time.
  - The client must be provided health education regarding taking caution or avoiding operating dangerous machinery or any other heavy equipment, or any task which requires alertness such as driving, cooking, etc.
  - Alcohol is a CNS depression. Any patient taking benzodiazepines must not consume alcohol or any such substance which further depresses CNS activity.
- **Selective serotonin reuptake inhibitors**
  - SSRIs are although an antidepressant drugs but they have been proven to reduce all kinds/levels of anxiety especially agoraphobia.
  - Treatment of agoraphobia can be started with lower doses of SSRIs.
  - SSRIs are the safest and effective drugs against agoraphobia.
  - The side-effects of SSRIs are listed below:
    - Drowsiness
    - Dizziness
    - Sleep disturbances
    - Nausea
    - Diarrhea
    - Lightheadedness
    - Anxiety
    - Irritability
    - Tearfulness
    - Malaise
    - Difficulty in concentration

      These symptoms are always mild and with continued use of SSRIs, they are improved.

      The other symptom which is of concern to health care professionals is sexual dysfunction. It is manifested as decreased sexual urges in both genders, delayed orgasm in women and delayed ejaculation in men.

      These symptoms rarely improve with time. In that case, following strategies can be employed:
      - Discontinuation of the agent is the one resort which can help, if patient is so distressed with these symptoms.

- Other agents which can help are Bupropion (Wellbutrin) and Mirtazapine.
- Some practitioners make an adjunctive use of Viagra.

- **Tricyclic antidepressants**
  - Clomipramine and imipramine are effective to treat agoraphobia.
  - The full benefits of drugs will be observed in 8–12 weeks.
  - The side-effects of tricyclic antidepressants include reduction of seizure threshold which can be potentially dangerous.
  - In drug overdose, anticholinergic and harmful heart effects can also become a matter of concern. Therefore, drug monitoring is essential while using tricyclics to treat agoraphobia.

Psychological Management

- **Individual psychotherapy**
- **Cognitive therapy**
  - Cognitive therapy is based on changing the perception of the patient. An agoraphobic person usually perceives himself as a weak or powerless being in confrontation with the phobic stimulus.
  - This therapy is attempted to correct the distorted perceptions of the patient and to help patient gain an insight into this that how his perception has shaped his behavior.
  - In cognitive therapy, usually small interactive sessions are planned and homework in the form of tasks is given to the patient to perform in between the sessions.
  - The homework/assignments could be analyzing those situations that have caused anxiety and fear in the patient and then patient is given tasks to perform between sessions that would be confronting those situations.
- **Virtual therapy**
  - This therapy makes effective use of computer programs which allow patients with agoraphobia to see themselves as avatars who are visiting a supermarket, any open or closed spaces, any phobic place in accordance with patients' history.
  - Then patient visualizes himself in his mind in that phobic place and in computer generated avatars, these places seem less horrifying and more in control to the patient.
  - As we know that human behavior is a conditioned response as a result of learning. This learning can be unlearned through de-conditioning which happens in virtual therapy.
- **Behavior therapy**
  - Behavior therapy is focused on modification of behavior from old unhealthy patterns to healthy adaptive coping strategies. Following is a list of behavioral therapy techniques which are used to treat agoraphobia.
  - Positive/negative reinforcement
  - Systematic desensitization
  - Implosive therapy
  - Relaxation techniques
  - Flooding
  - Response prevention
  - Self-monitoring
  - Graded response
  - Thought stopping technique

- Panic control therapy
- Hypnosis

- **Insight oriented psychotherapy**
  - Any of the symptom which is apparently visible as a behavior pattern is actually a psychological conflict underneath.
  - As we already understand that every emotion on the surface is covered with another emotion in the mind. If we mend the psychological conflict of the mind and make patient gain an insight into the inner psychological discords, then patient may understand the cause of Agoraphobia and it can be easy for him to deal with it.
- **Supportive psychotherapy**
  - Supportive therapy is attempted to promote healthy coping strategies in the patient. Here healthy defense mechanisms in patient are encouraged and the use of unhealthy defense mechanisms is discouraged and attempted to disuse for a lifetime.
  - Some of the useful advices are given to the patient and the coping behavior of patient is encouraged and strengthened.

Phobic Neurosis

As we know that fear and phobia are two different terms. Fear of any object, circumstance or situation can have a strong basis at times. But phobia is an excessive and irrational fear of a specific object, circumstance, or a situation. It is also known as specific phobia.

Panic is the profound level of anxiety which happens when a person with a specific phobia is exposed to a feared object. Although this feared object is only a perceived feared object meaning thereby it is perceived by patient as a feared object and the actual fear experienced by the patient is out of the proportion.

This phobia is not to the actual occurrence sometimes but anticipation of the feared object such as being bitten by a dog/snake may ignite panic in the patient; another example is fear of using elevators because patient anticipates that after the doors of the elevators will be closed, he is sure to faint.

Definition

Phobia is an irrational, pathological fear toward an object or situation.

Persons who are having phobias are often in fear of being harmed by the phobic object or situation.

Specific phobia happens in a specific setting (e.g., a stage) and, therefore, patient tries his level best to avoid that particular situation.

Another peculiar feature of specific phobia is fear of speaking in public. It is important to note that person is having phobia of speaking in public but this cannot be considered as public speaking.

A–Z of Fear

Acrophobia: Fear of heights
Aerophobia: Fear of flying
Agoraphobia: Fear of public space
Ailurophobia: Fear of cats
Amathophobia: Fear of dust

Contd...

A–Z of Fear

Arachnophobia: Fear of spiders
Astrapophobia: Fear of lightning
Claustrophobia: Fear of closed-in spaces
Emetophobia: Fear of vomiting
Ereuthophobia: Fear of blushing
Genophobia: Fear of sex
Haematophobia: Fear of blood
Keraunophobia: Fear of thunder
Microphobia: Fear of germs/small things
Mysophobia: Fear of dirt
Nyctophobia: Fear of the dark
Ochlophobia: Fear of crowds
Ornithophobia: Fear of birds
Pathophobia: Fear of disease
Pnigophobia: Fear of choking
Pteronophobia: Fear of feathers
Pyrophobia: Fear of fire
Triskaedekaphobia: Fear of the number thirteen
Xenophobia: Fear of strangers
Zoophobia: Fear of animals

Types of Phobias

- **Glossophobia:** Fear of public performance; also known as stage phobia
- **Acrophobia:** Fear of heights
- **Claustrophobia:** Fear of closed spaces
- **Aviatophobia:** Fear of flying
- **Hemophobia:** Fear of blood or injury
- **Arachnophobia:** Fear of spiders
- **Cynophobia:** Fear of dogs
- **Ophidiophobia:** Fear of snakes
- **Nyctophobia:** Fear of night or darkness
- **Pyrophobia:** Fear of fire
- **Xenophobia:** Fear of strangers
- **Zoophobia:** Fear of animals
- **Mysophobia:** Fear of dirt and germs
- **Ailurophobia:** Fear of cats
- **Hydrophobia:** Fear of water

Prevalence of Disorder in World/India

The prevalence of phobias is 4–8% of the population worldwide and 4.2% of the population in India.

The lifetime prevalence of specific phobia is 10%. It is more prevalent in women (14–16%) among all other mental disorders as compared to men (5–7%) and in those who are having substance use disorders.

Almost all of the specific phobias usually develop at the age of 5–9 years in a natural setting/environment. On the other hand, situational types of phobias, e.g., fear of heights, etc. have their onset in the mid 20s.

Specific phobias are more commonly observed in persons who are also suffering with anxiety, mood and substance use disorders.

Etiology

Behavioral Factors

Anxiety is a normal response to an external stimulus. When a person overly reacts to the external stimulus, it leads to a state of profound anxiety, i.e., panic. An untreated panic may result in phobia. Phobia is not necessarily toward the real objects, e.g., dogs, cats, etc., but may have a psychological interconnection with another object, person or situation.

Example 1: A child, who is afraid of dogs, may have developed phobia because of his father shouting at him in childhood. The child has subconsciously symbolized shouting of father with barking dogs.
Example 2: A blind woman, who is having phobia of water, may have been raped when it was raining and she could only remember the feeling and sound of rain on that catastrophic day. The woman has subconsciously symbolized rain with rape and developed phobia of water, i.e., hydrophobia.

Classical Conditioning Theory

According to Sigmund Freud, phobic symptoms occur as a natural course of one's maturation. This is contrasted by John B. Watson who did some scientific experiments on a subject named "Little Albert" and made a conclusion that every phobia is a conditioned response which means that any person who is now having a specific phobia has learned to be afraid of the phobic stimuli as a result of his interaction with the environment.

Watson named it as 'Conditioned Emotional Reactions'. He concluded that phobias are induced conditioned responses meaning thereby one has learned to be scared of something.

An example could be; a mother says to a little child when he cries, "stop crying otherwise a ghost will be coming". Here, we can understand the source of anxiety by putting the same situation in the stimulus-response model of Pavlov experiment.

In present situation, a child does not even know who a Ghost is and what he can do to him. But seeing his mother's anxious facial expressions which is an inherently neutral stimulus will now be joined with the imaginary sight of Ghost. In this manner, he will learn to become phobic to the stimulus (ghost, cat, rat, lizard, insects, height, blood and the list goes on) and is now capable of arousing anxiety by itself.

The neutral stimulus thus has been converted to a conditioned stimulus for provoking anxiety and fear in a person.

It is interesting to note that the same phobic stimulus if not reinforced by repetitive exposure, human mind has a tendency to become less and less responsive and the potency to arouse a response is diminished.

Operant Conditioning Theory

Anxiety is a natural response of an individual like any other emotions such as love, hate, jealousy, etc. A mild level of anxiety is very beneficial for any person to perform better. When the level of anxiety increases, an individual would do anything possible to alleviate that anxiety.

Anxiety is an unpleasant response and causes significant distress in an individual. To get rid of this anxiety, an individual will examine himself and will make a list of things which provoke fear and anxiety in him/her. Then he/she starts avoidance mechanisms and do his/her level best to avoid any stimulus that is capable of producing anxiety and fear.

This is how certain things become phobic stimulus for an individual. In that case, avoidance gets stronger and stronger because it is so effective to protect the person from phobic anxiety.

Psychoanalytical Factors

Freud has hypothesized that phobia is due to the unresolved Oedipus- and Electra-complex in anal stage of psychosexual development. This leads to fixation of anal stage and resulting phobia.

According to the Sigmund Freud, anxiety is a signal response which is initiated in our mind by cognitively interpreting any stimulus as dangerous.

In accordance with psychoanalytical theory, the first anxiety response an individual initiates is a result of having Electra complex in females and Oedipus complex in males. When this anxiety is not get resolved in children, it is again manifested in adults as a result of psychological conflicts.

The main defense a child uses to deal with castration anxiety/fear of authority and power is **displacement.** A child displaces his/her anger toward those objects which are less threatening. This child when grows as an adult, uses the same pattern for dealing with anxiety.

For example, any anxiety posed by a Boss will be displaced and connected to barking dogs on the street and in this manner; a neutral stimulus will become a phobic stimulus to the person. Many of the sexual conflicts which invoke anxiety are displaced onto unimportant and irrelevant objects such as cats, lizards, etc.

Another defense mechanism used is **symbolization**. Every phobic stimulus is having a direct associative connection with the psychological conflict. For example, a loud and strict father with a loud barking dog; an abusive memory in the childhood which happened while raining may provoke an anxiety signal toward water resulting in Hydrophobia.

A human mind tends to forget painful memories using the defense of **repression.** Thus, an individual who is suffering from any specific phobia uses these three combined defenses and none among these is a healthy one but only for a temporary relief and alleviation of anxiety.

These defenses operate at an unconscious level and manifests psychological conflicts in the form of specific phobia.

Other Explanations for Phobias Include

- Separation anxiety
- Fear of red color is manifested as a fear of blushing and erythrophobia.
- Fear of being ashamed has its basis in conflicted super-ego.
- **Counter phobic attitude:** This is so interesting to learn and observe in persons who are having any specific phobia. In this attitude, an individual denies the presence of a phobic anxiety and rarely demonstrates that he/she is afraid of the phobic object or situation rather he adopts the role of the anxiety provoker. This is the active use of defense mechanism of **identification.**

  For example, a child who is afraid of injections when comes home and plays doctor with his dolls, he adopts the role of a doctor and injects injection to his doll and tries to actively confront and master the phobic stimulus.

  Persons who are counter phobic are high risk takers and actively participate in dreadful activities such as rock climbing, paragliding, reverse bungee, etc.

Genetic Factors

Temperament, personality and coping abilities of an individual are determined by genetic factors and the resulting adaptation/maladaptation in the face of stressors. Maladaptive stressful encounters may be responsible for developing phobia as a neurotic defense mechanism.

Certain individuals are born with such a temperament that they are more prone to develop any specific phobias. At times, it is in their genes that if grandmother is afraid of lizards then granddaughter will also be having phobia of lizards.

Even in the absence of sufficient genetic predisposition, chronic environmental stress may alter the biochemical levels of the individual and they develop phobia to any object, person or event.

Environmental Factors

- Death of a parent
- Separation from parent
- Criticism
- Humiliation
- Hostility and violence in the home
- Physical or sexual abuse in childhood

Psychodynamics

- Internal object relation is externally manifested in social situations. Every internal anxiety is manifested outwardly in behavioral patterns. This is the basis of Social Phobia.
- Anticipation of any shame, humiliation, and criticism can be projected to phobic stimulus in any form.
- Use of three main defense mechanisms: Displacement, projection and avoidance
- Chronic environmental stress exposure: Parental fights, Criticism by peer group, family, friends or teachers.
- A continuous emotional state of shame and embarrassment

Signs and Symptoms

- Profound anxiety
- Panic attack
- Avoidance of phobia object
- Confrontation of phobic object with great pain/endurance
- Depression
- Social withdrawal
- To avoid phobic object, an individual may go to great trouble. For example, who is afraid of airplane will reach the same destination by road by travelling 3–4 days where he can reach in an hour by air.
- When an individual cannot avoid the phobic object, he tries to confront it but when even confrontation is not possible for him then he tries to deal with the phobic stimulus by the use of substances particularly alcohol.

DSM-5 Diagnostic Criteria for Specific Phobia

- Marked fear or anxiety about a specific object or situation (e.g., flying, heights, and animals, receiving an injection, seeing blood).

- The phobic object or situation almost always provokes immediate fear or anxiety.
- The phobic situation or object is actively avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of the proportion to the actual danger posed by specific object or situation and to the sociocultural context.
- The fear, anxiety and avoidance are persistent, typically lasting for 6 months or more.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not better explained by symptoms of another medical disorder.

Prognosis

The prognosis of phobia is not well known because of lack of research evidences.

Many of the patients never seek treatment for the specific phobias. They deal with it by avoiding phobic stimulus. Moreover, specific phobias have different ages of onset. For example, in childhood, there are more chances of having animal phobia and blood-injection injury phobia. In adults, situational phobia is more common.

Specific phobia is having waxing and waning course, i.e., increase and decrease in strength and intensity from year to year.

Treatment

There is no pharmacological treatment available for treating phobia. Instead, psychotherapies are of key importance in successful intervention of phobias.

- **Systematic desensitization:** Here, we reduce the sensitivity (reaction) toward phobic object or situation by a rhythmic (step by step) exposure of patient under supervision. The patient will be exposed to the phobic object or situation in succession.
- **Muscle relaxation and imagery:** Progressive muscle relaxation and imagery should be taught to the client. The client is instructed to use these techniques in the face of phobic stimuli.
- **Antianxiety drugs:** Benzodiazepines may also be used to relieve anxiety of the person with phobic neurosis.
- **Imaginal flooding:** This technique is only used under supervision of an expert psychiatrist. Here, patient is exposed to phobic stimulus as long as client can tolerate it. At the end, patient will reach a point where he/she will no longer feel anxiety toward phobic stimulus.
  Imaginal flooding is also known as Implosion. It is only successful when patient experiences similar anxiety through exposure to the actual phobic stimulus.
- **Virtual therapy:** In virtual therapy, there will be a computer generated simulation of the phobic stimulus, e.g., dogs. The patient will be able to interact with phobic stimuli on the computer screen with less anxiety in comparison with actual interaction with phobic stimulus. In this way, patient's phobia will be reduced slowly to the point where he will no longer experience it.
  Virtual therapy has variable success rates among patients. But we can be sure of this that virtual therapy is the most recent, advanced stage in the development of treatment modalities of mental disorders.
- **Hypnosis:** Through hypnotic therapy, in which the patient will respond to suggestions of the therapist at a state of conscious where patient is not having voluntary control over action. Here, patient will be

suggested to respond to the phobic stimulus in a less anxious manner. In this way, patient will learn to deal with the phobic stimulus in a real world.

- **Behavioral therapy:** Behavioral therapy is employed for the patients having specific phobias. In behavioral therapy, the success of the treatment depends upon patient's commitment to treatment and a clear diagnosis of problems.

  A patient is always given an informed choice about all alternative strategies to deal with the phobic stimulus and associated feelings of fear and anxiety.

  The most commonly used technique in behavior therapy is systematic desensitization. Here, we reduce the sensitivity (reaction) toward phobic object or situation by a rhythmic (step by step) exposure by patient under supervision. The patient will be exposed to the phobic object or situation in succession.

  While patient is exposed to the phobic object or situation, he/she is given antianxiety drugs, hypnosis and instruction in muscle relaxation to successfully deal with anxiety provoking stimulus. This is being taught to the patient in successive sessions and once patient has mastered these techniques, patients are advised to use these coping strategies while dealing with the phobic stimulus in social situations.
- **Insight-oriented psychotherapy:** Previously analytical theory was considered the basis for treatment of phobias and resolving psychological conflicts were believed to resolve all problems of anxiety and fear associated with phobic stimulus. But clinical evidences report that patients still experience phobic symptoms even after successful completion of psychoanalysis.

  Instead by continuous avoidance of phobic stimulus, sometimes patients start developing anxiety from the therapeutic modalities. This has lead therapists to use Insight-oriented psychotherapy for treating phobias. In insight-oriented therapy, patient is made understand the source of the phobia and how it has influenced the patient's psyche for a secondary gain.

  Patient is also taught better coping strategies to deal with anxiety-provoking stimuli.
- **Supportive therapy:** Supportive therapy has also proved to help patients experiencing specific phobias. Many of the individuals can deal with their problems on their own; all they need is a support and presence of an individual who believes in their success.
- **Hypnosis:** Hypnosis may also be useful in the treatment of phobic disorders. In hypnosis, patient is suggested while he is in a deep sleep but in semiconscious mind. He/she is given suggestions that the phobic stimulus is not dangerous and he can deal with it without any amount of anxiety.

  Because patient is highly suggestible under the influence of hypnosis, his mind responds accordingly when he is exposed/confronted with a phobic stimulus.
- **Family therapy:** Family is an individual's own army to win any war/challenge/obstacle he faces in life. The support of the family and mere presence of a family member while confronting the phobic object can reduce a huge amount of anxiety in patient.

  Moreover, family therapy can help therapist understand the nature of the patient's problem.
- **Other treatment modalities**
  - **Exposure therapy:** Gradual, self-paced exposures to the phobic stimulus
  - **Relaxation breathing control**
  - **Cognitive approach:** It is characterized by reinforcement behavior by making realization that phobic stimulus is not dangerous but safe.

Social Anxiety Disorder

Figs 55A and B: Social anxiety disorder

Definition

Social anxiety disorder is characterized by fear of embarrassment in social situations or social contacts with known fellows or strangers. It is also known as social phobia (Figs 55A and B).

In social anxiety disorder, a person has fear or anxiety in social situations which demand careful examination, inspection or scan. One such situation is entering into a mall, scrutiny while travelling by air, etc. Any contact with strangers can invoke moderate to severe anxiety in persons having social phobia.

Here, in social anxiety disorder, individuals are anticipating their embarrassment/humiliation in social situations such as social gatherings, meeting new people or any oral presentation on stage.

In many cases, this social phobia is so specific and person is fearful of one particular activity which he/she is afraid of performing in public such as eating, speaking, dancing, etc. A person with social phobia is sure in his mind that he/she will not be able to perform right and that's why he/she is having a nonspecific fear/anxiety of embarrassing oneself in social gatherings.

Prevalence

The world's prevalence of social anxiety disorder is 3–13% of the total general population.

In India, 4.2% of the general population is suffering from social anxiety disorder.

On a general scale, we can say that among 100 people, 2 or 3 persons are suffering from social anxiety disorder.

Social anxiety disorder is more prevalent in females as compared to males.

The age onset of social anxiety disorder is from 5 to 35 years of age. The patients of social anxiety disorder are usually having a premorbid history of other anxiety disorders, mood disorders, eating disorders and/or substance use disorders.

Etiology

- Behavioral inhibition; many children are born with this trait which does not allow them rather inhibit them to interact socially.
- Children of parents who have panic disorder are more likely to develop social phobia.
- Less caring parents
- Overprotective parents
- **Neurochemical factors:** Increased levels of epinephrine and norepinephrine.
  - Biochemical studies reveal that people who are having performance phobias such as public speaking do have increased levels of epinephrine and norepinephrine serum levels as compared with those individuals who are not phobic persons.
  - The patients with social anxiety disorder are having significantly lower concentrations of Homovanillic acid, both centrally and peripherally.
  - Research suggested that there is some dopaminergic dysfunction in patients of social anxiety disorder. At biochemical level studies, it has been found that dopamine reuptake is reduced at dopamine receptor sites.
- Genetic Factors; first degree relatives and monozygotic twins are more prone to develop social phobia.
  - Genes are playing a significant role in the causation of social anxiety disorder. Twin studies give a strong evidence of genetic factors responsible for personality traits such as shyness, timid, downcast eyes, etc.
- The children who are born of parents with panic disorder exhibit severe shyness as they grow older.
- The patients suffering from social anxiety disorder usually have a premorbid history of social inhibition in childhood.
- Parents who demonstrate rejecting behavior with their children.
- In mental status examination of the person, we may observe that they are submissive and walk with their chins down to avoid eye contact in comparison with those individuals who are socially active and dominant; walk with their chin high and are not afraid to make eye contact.

Signs and Symptoms

- Anxious behavior in social situations
- Afraid of stage performances
- Feels awkward to talk with strangers
- Feels anxiety in front of others while eating, drinking, sitting, attending parties, etc.
- Aloof
- Avoids social gatherings
- Marked distress in social situations
- Feelings of shame and embarrassment
- Social anxiety/social consciousness
- Persons with social anxiety disorder reveal themselves that they are far more anxious than other people in the society.
- Severe social anxiety is demonstrated at the time of particular life stages such as during adolescence or any transitional phase of life such as marriage, job promotion, job transfer, etc.
- Social anxiety disorder patients do not participate in any such activity that requires social interaction.
- Any small social interaction at times can cause severe distress in persons with social anxiety disorder.
- Persons with social anxiety disorder usually have performance pressure and extreme social phobia (Fig. 56).

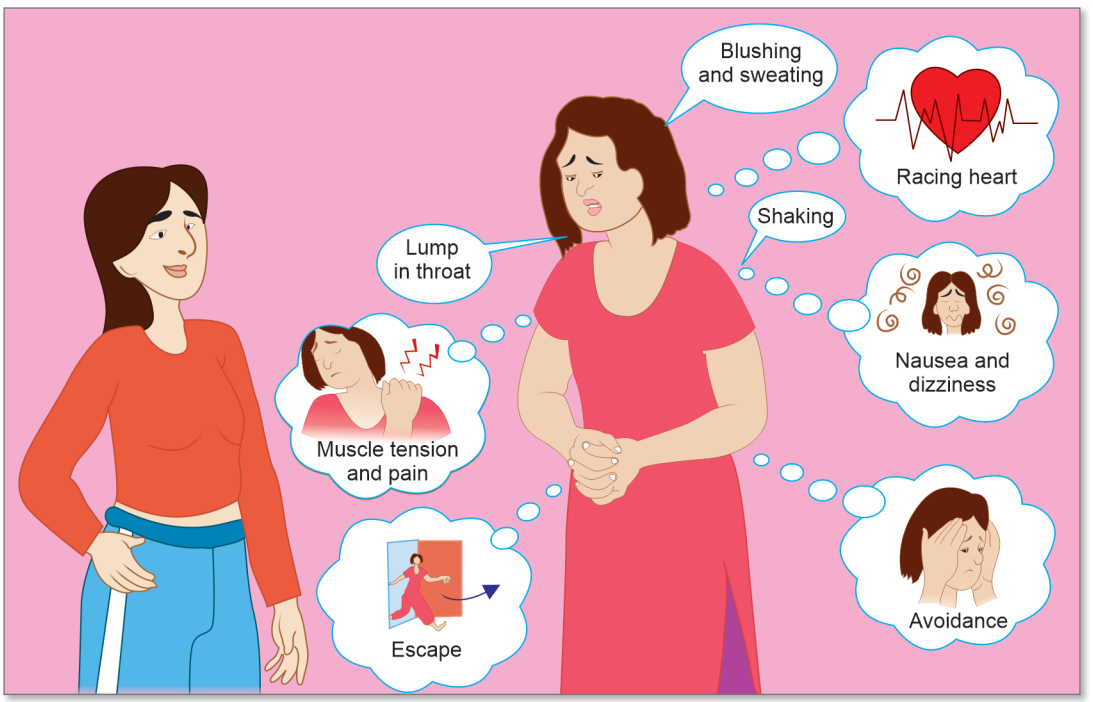


Fig. 56: Social anxiety disorder symptoms

DSM-5 Diagnostic Criteria for Social Anxiety Disorder

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.
- The individual fears that he/she will act in a way or show anxiety symptoms that will be negatively evaluated.
- The social situations almost always provoke fear or anxiety.
- The social situations are avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of the proportion to the actual threat posed by social situations and to the sociocultural context.
- The fear, anxiety or avoidance is persistent, typically lasting for 6 months or more.
- The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The fear, anxiety or avoidance is not attributable to the physiological effects of a substance or another medical condition.
- The fear, anxiety or avoidance is not better explained by the symptoms of another medical disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- If another medical condition is present, the fear, anxiety or avoidance is clearly unrelated or is excessive.

Prognosis

Social anxiety disorder is a chronic disease which tends to have more relapses.

As we know that social anxiety disorder symptoms become part of one's personality because these persons are living like that from a longer duration as this disorder has its onset in late childhood or early adolescence. This really makes the prognosis in a bad shape.

A person with social anxiety disorder has a disturbed life over many years and face significant social problems in school, work and interpersonal relationships.

This disorder never allows persons with social anxiety disorder to do their desired activities and is a hindrance in their academic and professional achievements.

Medical Management

- Combination of psychopharmacology and psychotherapy is more effective than a single treatment approach.
- Pharmacology
  - SSRIs
  - Venlafaxine
  - Benzodiazepines such as alprazolam and clonazepam both are effective against social anxiety disorder. Still physicians consider SSRIs as the best treatment and first line drugs in treating social anxiety disorder.
  - Buspirone when used in combination with SSRIs proves effective in the treatment of social anxiety disorder.
  - Phenelzine is also very effective in the therapeutic doses of 45–90 mg/day. The success rate of phenelzine is 50–70% among all patients with social anxiety disorder. The results of the treatment will prove to be effective in 5–6 weeks.
- Psychotherapy
  - Cognitive, behavioral and exposure techniques in treating performance phobia
  - Cognitive restraining
  - Systematic desensitization
  - Rehearsal of the session before hand
  - Homework/assignments

Treatment of Social Anxiety Disorder Associated with Performance Situations

- In performance situations, β-adrenergic receptor antagonists such as atenolol (50–100 mg) or propranolol (20–40 mg) are used.
- The individual who is having social anxiety disorder can take these drugs 1 hour before the stage performance.
- The other drugs which can help deal with performance anxiety are short/intermediate acting benzodiazepines such as lorazepam or alprazolam.
- **Other treatment modalities to deal with performance anxiety issues are:**
  - Cognitive therapy
  - Behavioral therapy
  - Exposure techniques

Generalized Anxiety Disorder (GAD)

Definition

Generalized anxiety disorder (GAD) is characterized by excessive worry and anxiety over several events for most of the days for at least 6 months of period.

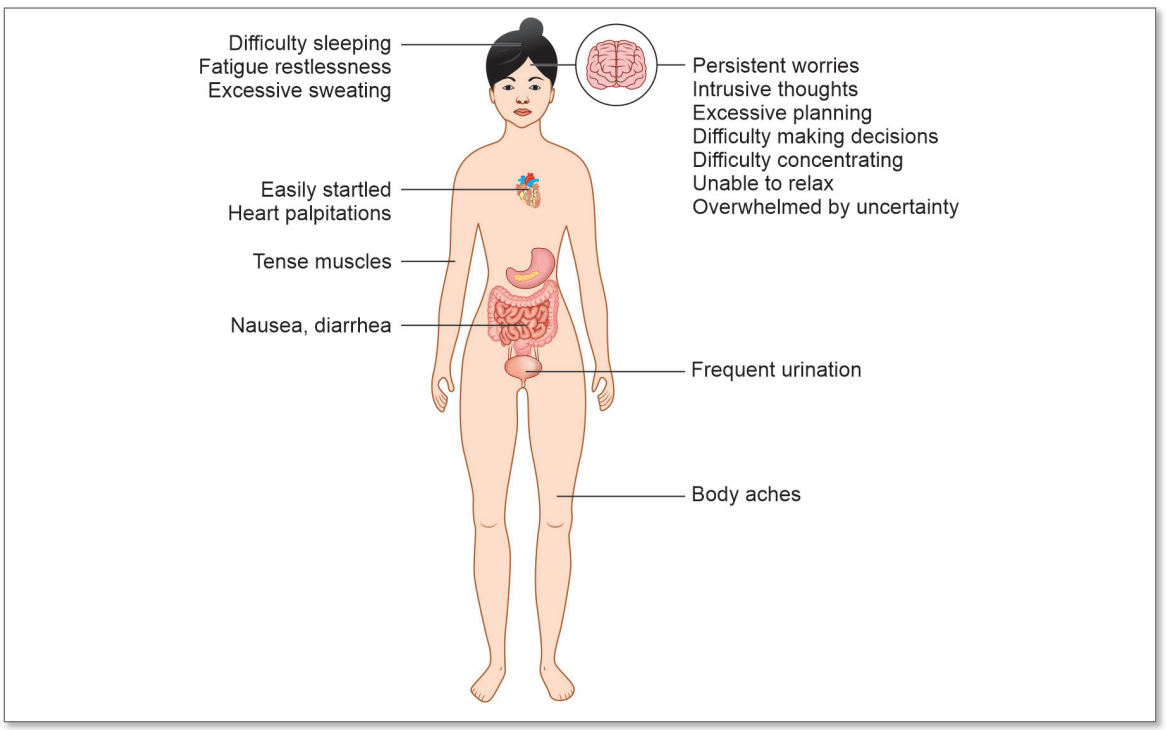


Fig. 57: Effects of generalized anxiety disorder on body

As we understand that mild level of anxiety is beneficial for better performance and anxiety is considered as a normal and adaptive response in case an individual feels threatened of any internal or external environment.

Anxiety is believed to prepare an individual for fight or flight response.

A chronic mild level of anxiety about everything and everyday matters of life is classified as generalized anxiety disorder. This kind of anxiety is associated with excessive worry regarding almost everything for a period of 6 months or more.

The individual suffering from generalized anxiety disorder is having bodily symptoms such as muscle tension, irritability, difficulty sleeping and restlessness. Generalized anxiety disorder is difficult to control and causes significant distress in personal, social and occupational functioning (Fig. 57).

Prevalence

Generalized anxiety disorder is more common in women than in men. The world's 3–8% of the population is suffering from generalized anxiety disorder. Among all clinical cases in India, 19% are with generalized anxiety disorder.

Generalized anxiety disorder is more in women as compared to men. In psychiatric settings, approximately 25% of the patients meet the criteria for generalized anxiety disorder.

Generalized anxiety disorder is usually first diagnosed in adolescent age or in early adulthood. It is research evidenced that approximately more than 80% of the patients having generalized anxiety disorder are also having some other mental disorders; among those, most common observation is panic disorder and depression.

Many of the patients who experience generalized anxiety disorder deal with it by using substances and then suffer with comorbidity of substance use disorders.

Etiology

The exact cause of generalized anxiety disorder is unknown. Because to differentiate between normal anxiety which is essential for better performance and pathological anxiety which makes you sick and distressed is a difficult task. Therefore, one can think of many things which may have caused any person to have generalized anxiety disorder.

Biological Factors

Altered levels of GABA, norepinephrine, glutamate and serotonin neurotransmitters, structural abnormalities in the following:

- Occipital lobe
- Basal ganglia
- Limbic system
- Frontal cortex

Some researchers suggested that there is abnormal regulation of serotonergic system in generalized anxiety disorder and other support the finding that there is an abnormal release of growth hormone in patients suffering from generalized anxiety disorder.

- **Brain imaging studies:** MRI of patients with generalized anxiety disorder demonstrates abnormalities in white matter and basal ganglia.
- **Genetic factors:** First degree relatives are more effected. There is 25% chance that siblings and children will suffer from generalized anxiety disorder. If the relative is a male, he is more prone to have alcohol use disorder.

Psychosocial Factors

- Inaccurate perception of danger in environment
- Over attention to the negative details of the situation
- Weak coping strategies
- Unresolved, unconscious conflicts

Patient with generalized anxiety disorder is not able to understand the life situations on an intellectual basis along with emotions. Most of the times, emotions take the lead and individual is not able to perceive the environment correctly.

His/her inaccurate perception of the environment puts him in perceived dangers in imagination. He/she is over attentive to the negative details of the environment. This makes a person less capable of dealing with stressful events.

Psychoanalytical Theory

According to Sigmund Freud, anxiety becomes a part of an individual's personality as a result of unresolved unconscious conflicts.

Signs and Symptoms

- Muscle tension

- Irritability
- Difficulty sleeping
- Restlessness
- Uncontrollable anxiety
- Easy fatigability
- Sleep disturbances
- Impaired attention and concentration
- Sustained and excessive anxiety
- Worry
- Restlessness
- Headaches
- Shakiness
- Frequent and persistent worry/anxiety out of the proportion to the actual danger or threat in the environment
- The only focus patient is having is to worry that causes bodily symptoms of anxiety further causing significant distress or impairment.
- Sustained anxiety/worry that is excessive and is accompanied with restlessness or motor tension.
- A patient with generalized anxiety disorder usually visits a physician's clinic for the treatment of bodily symptoms such as headaches, chronic diarrhea, chest pain, etc.

DSM-5 Diagnostic Criteria for Generalized Anxiety Disorder

- Excessive anxiety and worry, occurring more days than not for at least 6 months, about number of events or activities.
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with three (or more) of the following six symptoms:
  - Restlessness or feeling keyed up or an edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability
  - Muscle tension
  - Sleep disturbances
- The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational and other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance.
- The disturbance is not better explained by another medical disorder.

Prognosis

Because of the coexistence of other mental disorders, prognosis of GAD is difficult to predict.

Generalized anxiety disorder is chronic in nature and patients are suffering from its symptoms since a long time. They may have learned to live with it and adopted excessive worry and anxiety as their normal daily routine. That's why they are not so willing to seek treatment.

Only when they are so troubled with generalized anxiety disorder symptoms, they visit a therapist. This usually happens in early adulthood almost in their 20s. But to surprise, this clinical visit is to a general

practitioner in most of the cases and disorder is often misdiagnosed and it only worsens the already existing symptoms.

In this way, disorder prognosis becomes poor and difficult to predict when they finally get to know that their problem is psychological and they need a psychiatric evaluation.

Another reason for a poor prognosis could be the occurrence of several negative life events consequently which makes generalized anxiety disorder a chronic condition that can even happen for a lifetime.

Medical Management

Pharmacology

Antidepressants (fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram, venlafaxine, phenelzine)

Benzodiazepines (alprazolam, clonazepam, lorazepam, azapirone, buspirone)

Generalized anxiety disorder is a chronic disorder and its treatment with pharmacological agents should be carefully worked out because any of the prescribed drugs will be used for a long-term therapy (6–12 months of duration). Therefore, it is not advisable to start an antianxiety drug as soon as patient enters the clinic.

Following is a list of drugs used to treat generalized anxiety disorder with their dosages.

Name of the medication	Daily recommended doses
Antidepressants	
• Fluoxetine	20–80 mg/day
• Paroxetine	20–50 mg/day
• Sertraline	50–200 mg/day
• Citalopram	20–60 mg/day
• Escitalopram	10–30 mg/day
• Venlafaxine	75–225 mg/day
• Phenelzine	45–90 mg/day
Benzodiazepines	
• Alprazolam	0.25 mg in 3 divided doses
• Clonazepam	0.25 mg in 2 divided doses
• Lorazepam	0.5 mg in 3 divided doses
• Buspirone	7.5 mg in 2 divided doses

Benzodiazepines are considered as the treatment of choice for generalized anxiety disorder. They are available in short acting and long acting formulations and patients can have these medications as soon as they feel anxious.

The problems while on these medications are the risk of developing dependence and tolerance.

Psychotherapy

- Cognitive-behavioral approach (relaxation and biofeedback)
- Supportive therapy
- Insight oriented psychotherapy

The main treatment modalities for the treatment of generalized anxiety disorder are considered to be cognitive-behavioral, supportive and insight oriented psychotherapy.

Some individuals are more psychologically minded as compared to others and they are more motivated to understand the sources of anxiety. In that case, psychotherapy is the best treatment of choice.

- **Cognitive-behavioral therapy:** Among the three approaches of the psychotherapies, **Cognitive-behavioral therapy** has proven to be effective in both short-term and long-term use.

  The main mode of treatment of any disorder would be treating the underlying etiology. The etiological factor of generalized anxiety disorder is cognitive distortions because of which person is more attentive to negative details of the environment.

  In cognitive-behavioral therapy, a therapist attempts to correct cognitive distortions by using the behavioral techniques of relaxation and biofeedback.

  When cognitive and behavioral therapies are used in combination, they proved to be more effective than any other therapy used alone.
- **Supportive therapy:** Supportive therapy is given to the patients with generalized anxiety disorder to provide reassurance and comfort.

  It is the most assured therapy that anyone when provided with a conducive and trustworthy environment to discuss his/her difficulties, he/she will experience a huge lessening of the burdens and anxiety associated with it.

  While sitting with an empathetic and concerned therapist, an individual will be able to discover all the external situations which have had invoked anxiety in him/her. Then he/she will be able to change the environment and reduce the stressful provocations with the help of therapist and family members.

  When an individual's pressures and burdens are lessened, he/she is able to function at his/her best in the daily work activities, better able to maintain interpersonal relationships. This will increase the self-esteem of the patient and is found to be therapeutic.
- **Insight oriented psychotherapy:** Here, a therapist is focused to bring unconscious psychological conflicts on surface. Then he identifies the ego strengths, healthy defense mechanisms of the patients with generalized anxiety disorder and helps patient to adopt mature defense mechanisms to deal with anxiety provoking situations and to have a positive aspect of every stressful life event.

Psychodynamic Therapy

This therapy works on this principle that anxiety is a normal adaptive response of human beings. We must not work on reducing the level of anxiety rather increasing patient's anxiety tolerance.

Anxiety tolerance is an individual's capacity to experience anxiety without any need or compulsion to discharge it. Here, therapist is focused to make an individual experiencing generalized anxiety disorder to develop increased ego mastery.

Ego mastery signifies an individual's capability to use anxiety symptom as an alarm to work on his/her internal struggles and to increase one's understanding and insight into his/her problems and their origins. An individual after attaining ego mastery will be searching for his/her underlying fears invoking anxiety symptoms in him/her.

DEPRESSIVE NEUROSIS

Definition

Depressive neurosis/neurotic depression is a depressive episode resulting from other mental disorders which have already caused emotional disturbances in the person. It is also known as neurotic depression.

A mental illness characterized by a profound feeling of sadness or despair and a lack of interest in things that were once pleasurable is known as depressive neurosis.

In other words, neurotic depression is the depression which results from exogenous factors (factors external to the person) such as a medical disease, other mental disorder, stressful life-events, etc.

Prevalence

Overall 4% of the general population is affected by neurotic depression worldwide.

Etiology

- Genetic factors
- Psychosocial factors such as stress, social isolation, lack of social support
- Comorbidity of other mental disorders

Signs and Symptoms

- Low energy
- Low self-esteem
- Anhedonia
- Impairment in personal and social functioning
- Persistent sadness of mood

Prognosis

The prognosis of neurotic depression is good if the cause is exogenous. Its prognosis is poor, if there is comorbidity of other mental disorders.

Medical Treatment

- Antidepressants
- Psychotherapy
- Cognitive-behavioral therapy
- Interpersonal psychotherapy
- Group therapy
- Cognitive reconstructing

CONVERSION DISORDER

Definition

Conversion disorder is a disorder affecting voluntary, motor and sensory functions with no medical basis rather the cause is psychological.

In other words, conversion disorder is the manifestation of psychological conflicts physically.

In this disorder, psychological problems of an individual are converted into physical symptoms at an unconscious level.

In DSM-5, conversion disorder is now known as **Functional Neurological Symptom Disorder.** Conversion disorder is characterized by voluntary motor and sensory dysfunctions caused by psychological conflicts/stressors.

Conversion disorder is operating at an unconscious level meaning thereby its symptoms are not produced by patient with an intention but primarily for a psychological gain (Fig. 58).

Following are the sensory and motor abnormalities that occur in conversion disorder:

- **Sensory deficits**
  - Urinary retention
  - Diarrhea
  - Syncope
  - Psychogenic vomiting
  - Pseudocyesis
  - Blindness
  - Tunnel vision
  - Deafness
  - Anesthesia of extremities

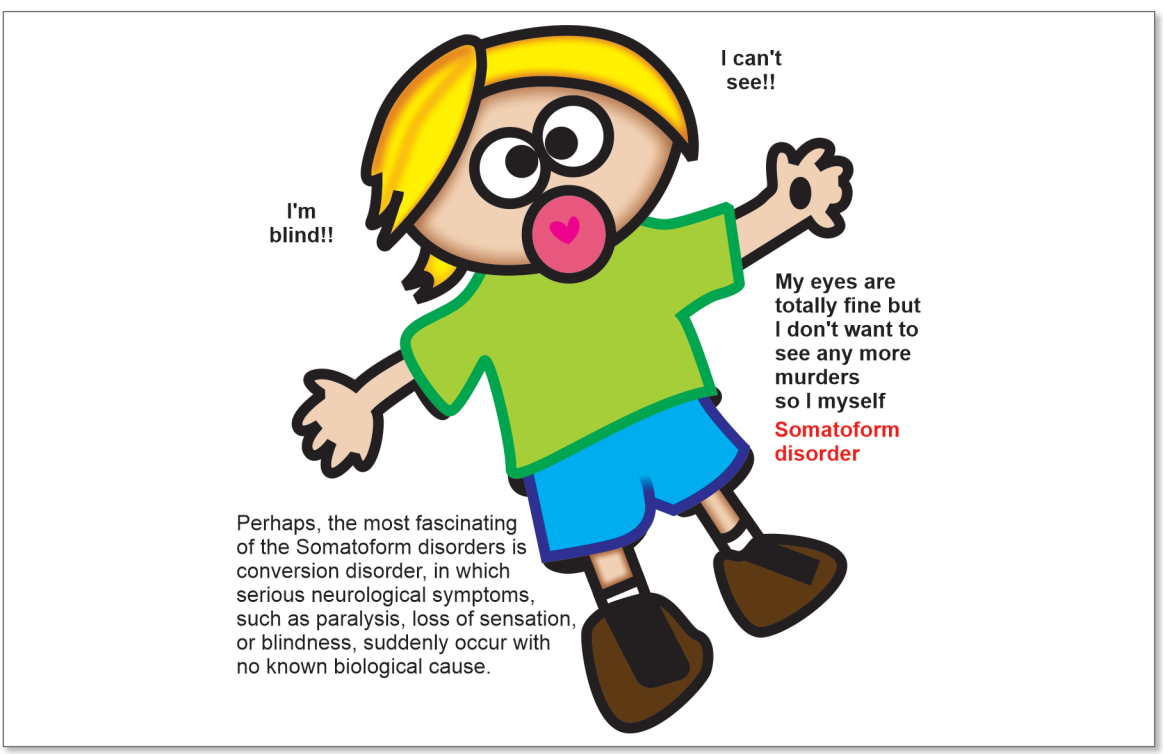


Fig. 58: Somatoform disorder

- **Motor dysfunctions**
  - Aphonic
  - Weakness
  - Paralysis
  - Abnormal gait
  - Astasia-abasia
  - Falling
  - Seizures
  - Tics
  - Involuntary movements

Many of the conversion disorders are not reported in psychiatric hospitals, but patients are admitted in general hospitals for clinical evaluation. Almost 5–15% of the patients in general hospitals are having conversion disorder worldwide.

Conversion disorder is more common occurrence in women as compared to men with a ratio of 10:1.

The symptoms of conversion disorder are mostly seen in the left side of the body more than the right side of the body in women.

Men with antisocial personality disorder are prone to develop conversion disorder.

Conversion disorder usually has its onset in childhood or early adulthood usually before age of 10 or after an individual 30s. In children, conversion disorder is usually manifested as abnormal gait or seizures.

Research suggested that conversion disorder is more among rural population and in those who are little educated and have lower IQ, lower socioeconomic status. It is also observed in military men who are exposed with dangerous situations.

Etiology

Psychoanalytical Factors

Repression (unconscious forgetting of painful memories) of psychological conflicts and converting the anxiety into physical symptom.

According to Sigmund Freud, every physical symptom of conversion disorder occurs by an underlying repression of unconscious psychological conflict. It is the anxiety and worry that has been converted into a physical symptom in conversion disorder.

The aggressive, sexual instincts of an individual produce desires and wishes for outward expression. When a person under social, moral and ethical standards is not able to express these emotions, they are unconsciously stored as intrapsychic conflicts in patient's mind.

Conversion is a means of expressing these instinctual impulses in a disguised form where patient partially expresses his/her emotions and gives a symbolic meaning to his/her hidden desires.

For example, an individual having great crush on someone becomes paralyzed by the limb where his/her crush touched unintentionally. The symptoms of the conversion disorder help patient express his/her unacceptable sexual wishes as well as serve as a means for dominating and manipulating others.

Biological Factors

Structural abnormalities of hemispheres of brain.

Research has been done at a molecular level to find out the cause for conversion disorder. It has revealed that there are metabolic abnormalities in patients' brains who have conversion disorder. There are

hypo metabolic reactions in the dominant hemisphere and hyper metabolic reactions in the nondominant hemisphere.

There is increased level of cortisol in patients with conversion disorder and this decreases the patient's awareness of the bodily sensation. This decrease of bodily sensations is manifested in sensory deficits of conversion disorder.

Personality Factors

Dependent, antisocial, histrionic personality disorder.

Learning Theory

According to classic conditioned theory, conversion symptom is a learned behavior of the patient in his childhood as a means of escaping otherwise impossible situations.

He/she may have observed his/her parents and significant others in the family using the conversion symptom as a means of coping with stressful life events.

Signs and Symptoms

- Paralysis
- Blindness
- Mutism
- Depression
- Anxiety
- Numbness and tingling sensation in extremities
- Pseudo-convulsions
- Deafness
- Tremors
- Gait abnormalities (ataxia)
- Self-mutilation
- Mostly seen in patients with passive-aggression, dependent, antisocial, histrionic personalities.
- Risk for potential harm (suicide, homicide, etc.)

Following are the mainly observed motor and sensory symptoms (Table 9).

Table 9: Motor and sensory symptoms of conversion disorders

Motor symptoms	Sensory symptoms
• Abnormal movements	• Anesthesia of extremities
• Gait disturbance	
• Weakness	• Hemi anesthesia along the midline
• Paralysis	
• Tremors	• Tunnel vision
• Tics	
• Jerks	• Patient may walk around without any injury

Contd...

Motor symptoms	Sensory symptoms
• Astasia-abasia, i.e., staggered gait accompanied by jerks and waving arm movements	
• A patient with conversion disorder rarely falls by any abnormal movements. Even if he/she falls, he/she will not be injured.	• Paresthesia of extremities
• Paralysis	
• Paresis	• Deafness
• Normal reflexes	
• No muscular destruction	• Blindness

Other Symptoms of Conversion Disorder

- **Pseudo seizures:** It is sometimes difficult to differentiate between actual seizure and pseudo seizure. Some patients may also have a comorbidity of epileptic disorder along with conversion disorder. Therefore, tongue biting, urinary incontinence and injury during seizure activity may happen in pseudo seizures also. But generally, there are not such symptoms present in pseudo seizures.
- **Psychological symptoms:**
  - **Primary gain:** There is no conscious awareness and confrontation with the psychological conflict. Internal psychological conflicts are expressed as physical symptoms which only have symbolic meaning and not a direct confrontation.
  - **Secondary gain:** Receiving sympathy and support from others. Exemptions from duties, work responsibilities and troubled life situations.
  - **La belle indifference:** Patient of conversion disorder do not seem to be concerned about any of the symptom of the disorder even if it is a major impairment such as deafness, blindness, paralysis, etc.

DSM-5 Diagnostic Criteria for Conversion Disorder

- One or more symptoms of altered voluntary motor or sensory function.
- Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
- The symptom or deficit is not better explained by another medical or mental disorder.
- The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Coding note: The ICD-9-CM code for conversion disorder is 300.11, which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see below).

Specify symptom type:

(F44.4) with weakness or paralysis
(F44.4) with abnormal movement (e.g., tremor, dystonia movement, myoclonus, gait disorder)
(F44.4) with swallowing symptoms
(F44.4) with speech symptom (e.g., dysphonia, slurred speech)
(F44.5) with attacks or seizures
(F44.6) with anesthesia or sensory loss

(F44.6) with special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
(F44.7) with mixed symptoms

Specify if:

- **Acute episode:** Symptoms present for less than 6 months.
- **Persistent:** Symptoms occurring for 6 months or more.

Specify if:
With psychological stressor *(specify stressor)*
Without psychological stressor

Prognosis

If the conversion disorder has an acute onset which lasts for less than 1 month, prognosis will be good. If conversion disorder is chronic, prognosis may be poor in 50% of the total clinical cases.

All that is needed by patients of conversion disorder is care, attention and active support by others. This will be accomplished in hospitalized clients and they can remit (without any symptoms of the disorder) within 2 weeks of hospitalization.

If the therapist can identify the stressors of the patient's life and address those efficiently then as soon as source of stress is gone, symptoms of conversion disorder disappear.

Prognosis of conversion disorder is different in terms of its symptoms also. For example, if patient is having paralysis, blindness and aphonia as symptoms of conversion disorder, prognosis is good. If the symptoms of conversion disorder are tremor and seizures, prognosis is poor.

Medical Treatment

- Insight oriented supportive therapy
- Behavioral therapy
- Hypnosis
- Anxiolytics
- Relaxation therapy
- Psychoanalysis
- The success of the treatment of the conversion disorder depends upon the caring and confident therapist. Psychotherapies should focus on identifying the sources of stress in patient and strengthening his/her healthy and effective coping strategies.
- Never argue with the patient on this that his symptoms are only imaginary and no such issues exist in reality. This can lead to a bad prognosis.
- Conversion disorder of chronic nature is difficult to treat.

DISSOCIATIVE REACTION

Definition

Dissociative reaction is a psychological *reaction* characterized by such behavior as amnesia, fugues, sleepwalking, and dream states.

Dissociation is an unhealthy defense mechanism that operates at unconscious level in which disturbances in the mental faculties occur such as in memory, perception, identity, consciousness and motor behavior.

Research evidenced that these disturbances are generally caused by psychological trauma and can occur suddenly or gradually. The use of the dissociative reaction by the person can be transient or chronic.

Dissociative reaction may have following manifestations:

- Dissociative amnesia
- Dissociative fugue
- Sleepwalking
- Dream states

Dissociative Amnesia

Dissociative amnesia is characterized by an inability to recall painful memories of traumatic or stressful life events.

Dissociative amnesia is different from normal amnesia in this manner that person is unable to recall important personal information regarding trauma or stress on a major level (Fig. 59).

Dissociative amnesia does not occur because of the use of a substance or any other medical or neurological disorder.

Types of Dissociative Amnesia

- **Localized amnesia:** It is characterized by an inability to recall events related to restricted period of time.
- **Selective amnesia:** It is characterized by recalling some of the information of a restricted period of time but not all.
- **Generalized amnesia:** It is characterized by inability to recall an individual's entire life.
- **Continuous amnesia:** It is characterized by failure to recall events following immediately one after the other.

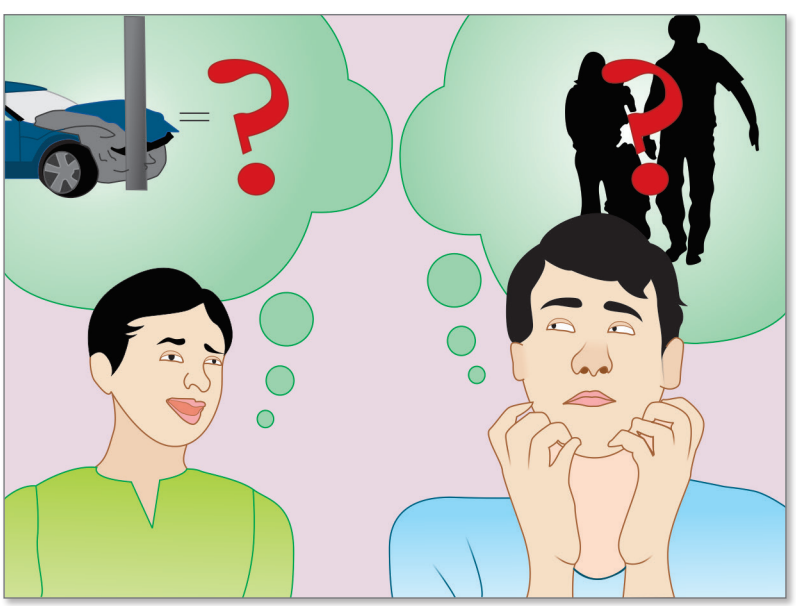


Fig. 59: Dissociative amnesia

- **Systematized amnesia:** This kind of amnesia occurs within the memory of a system. For example, forgetting the memory of one particular person, event or a year, etc.

Prevalence

The overall prevalence of the dissociative amnesia in general population is 2–6%. Men and women are equally affected by this disorder. The onset of the disorder is usually in late adolescence or adulthood.

Etiology

- Conflicting psychosocial environment
- Chronic shame
- Guilt feelings
- Despair
- Rage/aggression
- Intolerable desperation
- Psychological conflicts arise from social obligations over unacceptable sexual, suicidal or violent urges or impulses.
- Physical/sexual abuse
- Betrayal by a person who were trusted deeply; known as betrayal trauma

Signs and Symptoms

- Conversion symptoms
- Somatoform symptoms
- History of extreme acute trauma
- Profound anxiety/panic
- Heavy embedded emotional stress
- Profound intrapsychic conflict
- Alterations in consciousness
- Depersonalization
- Derealization
- Anterograde dissociative amnesia
- Regression, i.e., reverting back to previous developmental level
- Depression
- Suicidal ideation
- History of previous childhood or adult abuse/trauma
- Depression
- Mood swings
- Substance abuse
- Sleep disturbances
- Self-mutilation
- Violent outbursts
- Eating problems
- Flashbacks of traumatic experiences
- Problems with interpersonal relationships

DSM-5 Diagnostic Criteria of Dissociative Amnesia

- An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

  Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).
- The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Coding note: The code for dissociative amnesia without dissociative fugue is 300.12 (F44.0). The code for dissociative amnesia with dissociative fugue is 300.13 (F44.1).

Specify if; 300.13 (F44.1) with dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Prognosis

Lack of intensive research in clinical course of dissociative amnesia makes it difficult to predict prognosis. It is usually observed that as soon as traumatic events resolve and person is taken away from violent circumstances, he/she recovers spontaneously.

Family and friends should try to restore patient's lost memories as early as possible. In extreme cases, an individual with dissociative amnesia develops a chronic course of disorder and needs extensive social support and take care by family members.

Treatment

- **Cognitive therapy:** A traumatic experience results in cognitive distortions. Cognitive therapy may benefit individuals with traumatic experiences by correcting cognitive distortions.

  Therapist will identify cognitive distortions of the patient and will peep into the autobiographical memory of psychological trauma which has caused dissociative amnesia.

  Autobiographical memory is a memory system consisting of episodes recollected from an individual's life. By learning what has caused the disorder, therapist will be able to correct cognitive distortions.
- **Hypnosis:** Hypnotic therapy can also be employed with patients of dissociative amnesia. In hypnosis, we do not encourage intensifying recall of all the traumatic experiences rather it is a controlled recall of the memories so that patient does not collapse.

  Self-hypnosis can also be taught to the patient to deal with day to day life. Calming techniques can help deal with life stressors in an efficient manner. Patient will feel more in control of his/her life circumstances.
- **Pharmacological agents:** No specific drug is available for treating dissociative amnesia. Following are some of the drugs which may be used.
  - Sodium amobarbital
  - Thiopental

- Benzodiazepines
- Amphetamines

- **Group psychotherapy:** Group therapy is effective for patients experienced trauma because when they hear others experienced similar kind of traumatic experience and their stories of overcoming the same, they feel encouraged and motivated and it helps recover memories of amnesia phases. The kind courage and support of group members and psychotherapist can do wonders for the patient with dissociative amnesia.

Dissociative Fugue

Fugue means wandering. Because of amnesia of the past events and information, a person who is having dissociative fugue may leave home and reside at a new place with a new identity.

It is characterized sudden, unplanned and unexpected move away from home with being unable to recall his/her entire past or some part of it.

The individual will be confused about his personal identity and may assume a new identity with a new name and address. This disorder of dissociative fugue will cause significant distress in personal, social and occupational functioning of the patient (Fig. 60).

Prevalence

There is not much known about the prevalence of dissociative fugue except this that this disorder is mostly occurring in adults and more common in men as compared to women.

Etiology

- Traumatic experiences such as rape, recurrent sexual abuse, natural disasters, etc. An altered state of consciousness

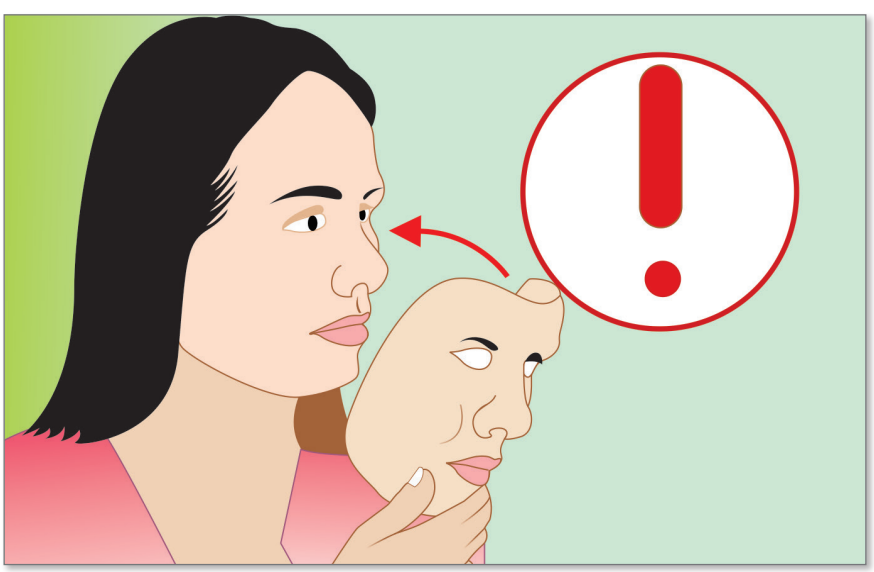


Fig. 60: Dissociative fugue

- A strong urge to flee
- External dangers and potential harm in an individual's life which may have invoked great distress in the individual.
- Psychological trauma/shock
- Extreme emotional attacks of guilt, shame, anger, sexual urges and suicidal ideations etc.)
- Intense fear/anxiety up till the level of panic.

Signs and Symptoms

The symptoms of dissociative fugue may last from minutes to months. Some individuals suffer from multiple fugues and disorder is of chronic in nature.

- Running away to another place outside home or moving to another part of the same house. This is usually with children and adolescents as they are afraid to travel to faraway places.
- When the episode of dissociative fugue ends, following signs and symptoms appear in the person with dissociative fugue:
  - Confusion
  - A state of feeling confused and worried because you can't understand what is happening or will happen known as perplexity.
  - A mental state in which individual do not notice what is going on around you. This is called Trance behavior.
  - Derealization
  - Depersonalization
  - Amnesia
  - Conversion symptoms
  - Mood disorder symptoms
  - Suicidal ideation/behavior
  - Anxiety disorder symptoms

Prognosis

In most cases, individuals with dissociative fugue recover spontaneously. The duration of the illness is short and lasts from hours to days only.

Treatment

- Psycho dynamically oriented psychotherapy
- Hypnotherapy
- Medical interventions for the injuries that happened during fugue state such as anemia, sleep alterations, starvation, etc.
- Initiate suicidal precautions
- Ensure safety of the individual
- Hospitalization, if required in patient interventions
- Family therapy in case of family problems
- Social service interventions

- Psychodynamic therapy focusing on merging the two identities of the individual, i.e., old identity and a new identity. This is employed where the past tragic experiences can bring worst in the patient if again feels an urge to comply the same.

Sleepwalking

Sleepwalking is a manifestation of dissociative reaction in which an individual walks and performs activities during sleep without conscious awareness of mind.

Dream State

A peak state during sleeping in which an individual may experience dreams and life in another imaginary world.

Prevalence

The world's 2–6% of general population is affected with dissociative reaction.

Etiology

- Psychological conflicts which are painful for conscious awareness
- Intolerable emotions such as fear, shame, guilt and despair
- Traumatic experiences such as physical/emotional/sexual abuse
- Betrayal by a trusted person in one's life

Prognosis

Not known exactly because of lack of research evidences.

Medical Treatment

- Cognitive therapy
- Hypnosis
- Group psychotherapy
- Pharmacology
  - Amobarbital
  - Diazepam
  - Thiopental
  - Oral benzodiazepines
  - Amphetamines

DEPERSONALIZATION/DEREALIZATION DISORDER

Definitions

Depersonalization is characterized by persistent and recurrent feeling of detachment from oneself. The individual feels like a moving mechanical device made in imitation of a human being. He/she assumes oneself in a movie (Fig. 61).

Fig. 61: Depersonalization

The individual experiencing derealization perceives his/her outside world as lacking emotional coloring and clarity (Fig. 62).

Prevalence

The overall prevalence of depersonalization/derealization is difficult to ascertain but it is found to be 19% in one survey study.

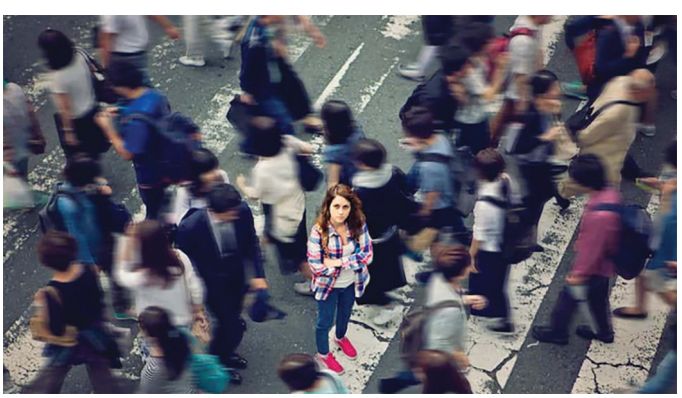


Fig. 62: Derealization

Many of the times, it is induced by certain medications such as marijuana, LSD and at times a side-effect of anticholinergic agents. The other causes may be head injury, deep hypnosis, etc.

It is more seen in women as compared to men.

Etiology

Psychodynamic Theory

Depersonalization is an ego defense mechanism against disintegration of ego. Any painful/stressful events can cause depersonalization/derealization disorder.

Traumatic Experiences

There is usually a premorbid history of traumatic experiences of patients with depersonalization/derealization disorder. Stress and fatigue can also lead to depersonalization/derealization experiences.

Signs and Symptoms

- Bodily change experiences
- Sense of duality of self-feeling, oneself watching and oneself playing the role
- Sense of being cut from others
- Sense of being detached from one's own emotions
- Can't express what they are feeling/experiencing. Usually expresses their emotions as subjective statements as, "nothing is real', "I feel like a dead person", "I am standing out of my body."
- Distress

DSM-5 Diagnostic Criteria for Depersonalization/Derealization Disorder

- **The presence of persistent or recurrent experiences of depersonalization, derealization, or both:**
  - **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).
- **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
  - During the depersonalization or derealization experiences, reality testing remains intact.
  - The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).
  - The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.

Prognosis

After resolving traumatic experiences and after stressful events, depersonalization/derealization resolves spontaneously.

Depersonalization/derealization causes severe impairment in personal, social and occupational functioning.

Treatment

- Pharmacological management
  - SSRI antidepressants, e.g., fluoxetine, sertraline, etc.
  - Mood stabilizers
  - Typical and atypical neuroleptics
  - Anticonvulsants
- Stress management strategies
- Cognitive-behavioral therapy
- Supportive therapy
- Relaxation therapy
- Distraction techniques/diversional therapy
- Physical exercise
- Hypnosis

DISSOCIATIVE IDENTITY DISORDER

Definition and Meaning

Dissociative identity disorder is also known as multiple personality disorder. It is characterized by presence of two or more distinct personalities in one individual.

Both or more personalities occur in one person and both personalities are unique, means the personalities do not complement one another rather one personality may be entirely different from the other personality existing in the same individual.

Each of the personality type will be having its own way of perception, thinking and judgment and operation of all other mental faculties.

An individual with dissociative identity disorder will be having all the manifestations of other dissociative reactions such as derealization, depersonalization, fugue, amnesia, sleep walking and dream state.

Prevalence

Dissociative identity disorder is more prevalent in women than in men. The overall prevalence of dissociative identity disorder in general population is not known.

Etiology

- Severe childhood trauma
- Neglect and maltreatment by parents, family members or others in the childhood
- Physical or sexual abuse
- Betrayal by someone trusted deeply
- Weak ego strengths and coping abilities to deal with life stressful events

Signs and Symptoms

The main feature of dissociative identity disorder is presence of two or more personality types in one individual. The other signs and symptoms are given as follows:

- Conversion symptoms
- Hyperarousal
- Numbness
- Pseudo-neurological symptoms
- Asthma and breathing difficulties
- Somatic symptoms
- Seizure episodes
- Headaches
- Pains such as abdominal, musculoskeletal or pelvic
- Menstrual problems
- Irritable bowel syndrome
- Depression symptoms
- Mood swings
- Suicidal ideation
- Self-mutilation
- Helplessness
- Hopelessness
- Obsessive-compulsive traits
- Memory and amnesia symptoms
- Sleep disturbances

DSM-5 Diagnostic Criteria for Dissociative Identity Disorder

- Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.
- Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events those are inconsistent with ordinary forgetting.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not a normal part of a broadly accepted cultural or religious practice.
  Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
- The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Prognosis

There is not much research available regarding the outcome of dissociative identity disorder. But we can calculate that prognosis will be poor with other coexisting mental disorders and if patient has antisocial and criminal personality traits.

Treatment

- Psychotherapies
  - Psychoanalytic psycho therapy
  - Cognitive therapy
  - Behavioral therapy
  - Hypnotherapy
  - Family therapy
  - Group therapy
  - Self-help groups
  - Occupational therapy
- Pharmacological management
  - SSRIs
  - Tricyclic antidepressants
  - MAOs Inhibitors
  - β-Blockers
  - Anticonvulsants
  - Benzodiazepines
  - Atypical neuroleptics such as risperidone, quetiapine, ziprasidone, olanzapine and clozapine, etc.
- Electroconvulsive therapy

PSYCHOSOMATIC DISORDER/SOMATIC SYMPTOM DISORDER/ HYPOCHONDRIASIS

New DSM-5 name: Somatic symptom disorder

Definition

Somatic symptom disorder is characterized by overly concern, worry and preoccupation with bodily health manifested by wrong exaggerated misinterpretation of bodily symptoms without any medical basis (Fig. 63).

This disorder grossly impairs social and personal functioning of the individual. The patient does not intend to manifest it in disorder's way but it happens at an unconscious level.

Somatic symptom disorder is also known as **hypochondriasis.**

This disorder is manifested as a person having nondelusional preoccupation of fears of having a serious illness which he bases upon the misinterpretation of the mild bodily symptoms such as headache is considered as a brain tumor, mouth ulcer as a benign tumor, etc. This should happen for

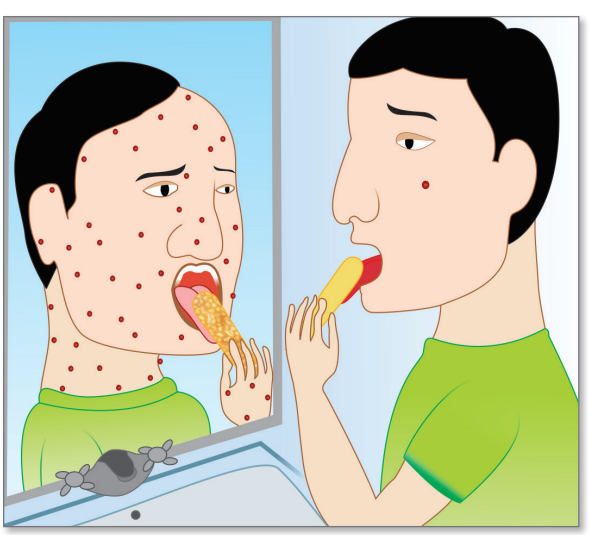


Fig. 63: Somatic symptom disorder

duration of 6 months or more to be considered as Hypochondriasis and must have caused significant distress and impairment in person's personal, social and occupational functioning.

Patients with somatic symptom disorder are having poor insight about having this illness.

Prevalence

The world's population incidence of somatic symptom disorder is 4–15%.

There are not any gender differences in occurrence of this disorder. This disorder is equally prevalent in men and women.

The disorder has its onset in 20 or 30 years of age.

This disorder can occur in any social class and equally affects married and unmarried, males and females, illiterate and literate, less qualified or more qualified.

Comorbidity is usually seen with somatic symptom disorder such as depression and other anxiety disorders. This may occur in 80% of the cases.

Etiology

- Low strengths and coping abilities to deal with discomfort.
- Faulty cognitive interpretation; a small blood loss may be misinterpreted as a hemorrhage.
- Sick role model; one may have learned or observed from family or significant others in life to interpret bodily symptoms in this way.
- For secondary gain; by assuming sick role, an individual may want relief from job responsibilities and obligations.
- Comorbidity with depressive or anxiety disorders.
- Unwanted desires to harm others may be converted into physical symptoms.
- Low self-esteem individuals are more prone to be affected with hypochondriasis.
- Faulty defense mechanisms such as somatization, undoing, etc.
- Basically, this disorder has its cause in false perception in the presence of a stimulus. This stimulus is although present, but is not great enough to be called what patient call and give meaning to it. For example, the normal abdominal pressure is perceived as abdominal pain.

The individuals with somatic symptom disorder exaggerate their bodily symptoms and pay great attention to mild bodily sensations.

Social Learning Theory

According to social learning theory, when an individual is not capable to solve his/her problems, he/she assumes a sick role to avoid the anxiety of being a failure. By assuming a sick role, first he is exempted to perform his duties and obligations and second everyone empathizes and allows a patient to avoid and postpone his tasks. This becomes his secondary gain.

Psychodynamic Theory

According to psychodynamic theory, an individual with somatic symptom disorder uses a defense mechanism of repression and displacement.

The individual is a passive aggressive and do not actively expresses his/her anger rather holds grudges for insults, ignorance, etc. Then, he converts these aggressive and hostile wishes which he has toward other significant members of his/her life into physical complaints.

All of an individual's past bad memories and impressions such as rejections, losses, disappointments remain in patient's mind as an unexpressed anger. This anger is expressed by the individual by asking for help and concern of those people whom he/she finds the cause of his/her losses, rejections and disappointments.

When those persons try to help the individual with somatic symptom disorder, he/she rejects all of their help and let them realize that all of their help and concern is ineffective. This mind play helps patient to take revenge for previous insults, rejections, losses and disappointments.

Other explanations for somatic symptom disorder include:

- Defense against guilt
- A significant sign expressing an individual's low self esteem
- A sign of over pampering of oneself and excessive self-concern.
- An innate mischievousness
- The person sees all of his/her bodily symptoms as a punishment which he/she thinks he deserves for his bad doings and suffering those bodily discomforts is a means of undoing and atonement for the past sins.

Signs and Symptoms

- Somatic complaints
- False beliefs, but not necessarily delusions that one has a serious illness
- Doctor shopping (visiting physicians again and again in spite of all medical reports found to be negative)
- Depression
- Anxiety
- It is interesting and noteworthy that an individual keeps on believing that he is constantly having a serious illness and illness is never cured. When the symptoms of one disease disappear or become mild, patient with somatic symptom disorder converts his/her belief of having a serious illness to another disease.
- All of the negative reports of laboratory tests cannot convince the individual that he/she does not have any particular serious illness.

DSM-5 Diagnostic Criteria for a Somatic Symptom Disorder

- One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- Excessive thoughts, feelings or behaviors related to somatic symptoms or associated health concerns as manifested by at least one of the following:
  - Disproportionate or persistent thoughts about the seriousness of one's symptoms.
  - Persistently high level of anxiety about health or symptoms.
  - Excessive time and energy devoted to these symptoms or health concerns.
- Although any one somatic symptom may not be continually present, the state of being symptomatic is persistent (typically more than 6 months).

Prognosis

Those patients who have a sudden onset of symptoms and good socioeconomic status are having good prognosis of hypochondriasis.

Research suggested that almost 50% of the patients with somatic symptom disorder improve and have a good prognosis.

Somatic symptom disorder is usually episodic and one episode of imaginary exaggerated illness may last for months to years and then patient may appear as normal as before illness. Any psychosocial stressor may again trigger the onset of the symptoms when an individual is not able to cope with life challenges and opportunities are taken as obstacles.

Basically somatic symptom disorder is because of faulty cognitive interpretation. Therefore, we can assume that as long as wrong learning patterns remain, disorder exists. If patient learns to do it in a healthy and acceptable manner, disorder can be cured as fast as learning can happen.

Any comorbidity may also be a reason for the bad prognosis of this disorder.

If the onset of the disorder is in childhood, by late adolescent or early adulthood, maturity will automatically enable an individual to deal with life stressors in a better way and disorder of somatic symptom disorder will have no basis for stay.

Medical Treatment

- Stress management
- Relaxation techniques
- Group psychotherapy
- Insight-oriented psychotherapy
- Behavior therapy
- Cognitive therapy
- Hypnosis

Patients usually do not accept treatment unless it is given in medical settings and not in psychiatric facilities or otherwise insight must be present to initiate the treatment.

Somatic symptom disorder is faulty cognition. Therefore, even if treating patient physically, our focus should remain on correcting the psyche of the patient.

It is advisable to schedule regular physical examinations so that patient believes that he/she is not being abandoned and is being taken care very well.

The patient with somatic symptom disorder must feel that his/her complaints are being taken very seriously. At times, physician may go for invasive diagnostic procedures to provide objective evidence for the patient's mind satisfaction.

Pharmacological Management

It is executed sometimes for a placebo effect. Placebo means a medicine or procedure prescribed for the psychological benefit to the patient rather than for any physiological effect.

Other times, pharmacology is initiated to treat comorbid disorder such as anxiety or depression.

- **Antianxiety drugs:** To treat anxiety symptoms
- **Antidepressant drugs:** To treat depressive symptoms

ILLNESS ANXIETY DISORDER

Definition

Illness anxiety disorder is a new diagnosis and it is only added in the recent DSM-5.

It is characterized by preoccupation with thoughts of being sick and thoughts of developing an illness of some kind.

Many of the times it is difficult to ascertain whether an individual is having somatic symptom disorder or illness anxiety disorder. The major distinctive features between two disorders are the presence of somatic complaints in case of somatic symptom disorder whereas in illness anxiety disorder there are no somatic complaints. Instead an individual is having a detailed thought layout of preoccupation of having or will be having a disease.

The major concern of people having illness anxiety disorder is this that they have only one idea that they are ill and this idea dominates all the thoughts of their mind.

This diagnosis can also be made for those persons who may have any medical illness but the anxiety related to that medical illness is out of the proportion to their actual illness and its prognosis.

Prevalence

The overall prevalence of illness anxiety disorder is 4–15% among general population. It is usually observed that generally people are worried about being sick even when they hear someone else suffering from any medical illness. They assume in their own mind what if I get the same disease.

Illness anxiety disorder is more common occurrence in older adults. Young people do not pay much attention to any of the details of normal signs and symptoms of any illness rather they always have this idea in their mind that they will never be sick and be like their grandparents or they will never be having any disease like their parents or grandparents are having even if they are having a family history.

Because this is a new diagnosis that's why not much research has been done about its prevalence among variables such as gender, socioeconomic status, marital status or educational level, etc.

Etiology

The exact etiological factors of illness anxiety disorder are not known.

Social Learning Model

The person with illness anxiety disorder may have learned that assuming a sick role is very bad thing and only those persons who want to escape their duties and obligations have this disorder.

In their home/society settings, no one is appreciated when being sick and disease is always seen as a huge burden/curse on other family members. This ignites the whole anxiety/worry habits related to idea of being sick.

If a person is having a faulty concept of being ill, then he/she will always be afraid of being sick and will perform his duties and obligations in spite of being sick.

Psychodynamic Model

When an individual is having extreme anger and annoyance toward some object, person or event and he is not able to express it, then these psychological anger spells are transferred into the fear of physical illness.

This anger may arise past childhood burdens, disappointments, rejections, losses, etc. The feared illness in patient's mind is viewed as a new burden, disappointment, rejection and a loss. Therefore, he/she is always worried and preoccupied with the fear of being sick.

Some past experiences also trigger the fear of illness in patient's mind such as death of a significant person from any medical illness, family history of any medical illness, potential risk factors associated with medical illness.

Diagnostic Criteria for Illness Anxiety Disorder

- Preoccupation with having or acquiring a serious illness.
- Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
- There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
- The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
- Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
- The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, and generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

- **Care-seeking type:** Medical care, including physician visits or undergoing tests and procedures, is frequently used.
- **Care-avoidant type:** Medical care is rarely used.

Signs and Symptoms

- Preoccupation with the idea that one is going to have a serious illness and fears associated with it.
- With the passage of time, fears related to the occurrence of one disease are transferred to another disease.
- The false beliefs and fears related to occurrence of disease persist despite negative reports of medical investigations.
- Significant impairment in individual's personal, social and occupational functioning.
- Over internet searches related to feared illness. For example, if they are feared about cancer, they will Google every detail about cancer, definition, meaning, causes, treatment, etc.
- They will take information available on internet as negative and make a worse interpretation out of it.

Prognosis

This disorder also occurs in episodes, therefore, it is unpredictable whether an individual will be having only one episode or have more episodes if any stressful psychosocial factors supported the disease.

There is a chance of good prognosis with high socioeconomic class and sudden onset of disease.

Prognosis will be bad in case of an individual having personality disorder.

Treatment

Treatment for illness anxiety disorder should be given in medical settings for increasing patient's comfort and confidence in the health care setting.

The treatment is focused on reducing stress by initiating stress management techniques.

Following are the treatment modalities used for treatment of illness anxiety disorder:

- **Group psychotherapy:** It is effective if all the members in the group therapy are suffering with the same disorder, i.e., illness anxiety disorder.
- Insight oriented psychotherapy
- Behavior therapy

- Cognitive therapy
- **Hypnosis:** It is to bring repressed unconscious psychological conflicts onto the surface and then by suggestion, correcting the maladaptive behavior.
- **Supportive therapy:** The patient is constantly assured that his/her complaints are being taken seriously and they do not have any serious illness from which they need to be afraid. Although they won't believe that they don't have serious illness but constant reassurance and objective evidence may help.
- **Antianxiety drugs:** To treat anxiety symptoms.

NURSING CARE PLANS

Nursing care plans for panic disorder, phobia, conversion disorder and hypochondriasis are given in Table 10 to 13 respectively.

Table 10: Nursing care plan for panic disorder/generalized anxiety disorder (GAD)

Nursing diagnosis	Nursing interventions	Outcome criteria
• Panic anxiety related to actual or perceived threat	• Be with patient. • Provide reassurance to the patient. • Keep calm, non-threatening environment. • Keep room lights dim. • Keep area noise free. • Talk in a clear and audible voice. • Do not shout on patient. • Talk with patient and allow patient to talk, rather encourage expression of emotions. • Administer tranquilizers, as needed.	• Patient will be calm and cooperate with staff to implement nursing interventions. • Patient was made calm with medications.
• Powerlessness related to fear of losing control	• Involve patient in decision making in nursing process. • Enforce independence as much as possible. • Help patient recognize his/her strengths and previous successes. • Remind patient about his previous capabilities in life situations. • Always set realistic goals. • Enforce positive coping strategies. • Provide patient with liberty to decide for him/her.	• Patient will demonstrate independence in decision making and explore/ implement his/her coping strategies to deal with problems.

Table 11: Nursing care plan for phobia

Nursing diagnosis	Nursing interventions	Outcome criteria
• Pathological fear related to phobic stimulus.	• Reassure the patient about his/her safety. • Be with patient. • Discuss with patient that his/her fear toward phobic stimulus is out of the proportion of the actual danger imposed. • Institute systematic desensitization. • Provide virtual therapy. • Help patient to confront the fear instead of avoiding them.	• Patient will be able to withstand phobic stimulus without anxiety.

Contd...

Nursing diagnosis	Nursing interventions	Outcome criteria
• Social isolation related to fear of those places from where escape is difficult.	• Accept the patient as he/she is. • Institute group therapy. • Encourage patient's interaction. • Talk with patient in a group and allow his/her expression also. • Convey a warm, compassionate attitude to the patient. • Positively reinforce for verbal expression. • Administer tranquilizers as required.	• Patient will be able to interact socially.

Table 12: **Nursing care plan for conversion disorder**

Nursing diagnosis	Nursing interventions	Outcome criteria
• Ineffective coping related to unresolved psychological conflicts	• Assess all coping strategies of patient. • Ask patient to tell all coping strategies which were previously used and their success. • Try all coping strategies and evaluate their success in effective coping. • Use all alternatives. • Make patient independent in decision making and help patient to take steps for effective coping strategies. • Encourage the patient. • Make patient understand that there are other coping methods instead of converting the psychological burdens into physical complaints. • Help patient understand that his/her physical complaints have no medical basis. • Educate patient about primary and secondary gains, he/she get benefited from adopting somatization as a defense mechanism.	• The patient will use different effective coping strategies instead of use of somatic complaints.
• Deficit knowledge related to effective coping strategies	• Provide health education about relationship between mental health and physical health. Educate patient that how poor mental health (psychological burdens) effects and cause physical complaints. • Report the findings of all lab investigations to the patient and explain the patient that his/her physical complaints have no medical basis. • Ask patient to keep a record (diary) for all physical complaints, their intensity and duration. • Teach relaxation therapy. • Teach about relaxation therapies. • Give assertive training. • Relax patient with guided imagery and teach the patient how to use it.	• The patient will understand conversion of psychological conflicts into physical symptoms.

Table 13: **Nursing care plan for hypochondriasis**

Nursing diagnosis	Nursing interventions	Outcome criteria
• Fear related to a serious physical threat/disease	• Assess patient's primary and secondary gains, which he/she gets from adopting such sick role behavior. • Be empathetic with patient. • Encourage expression of underlying fears and conflicts. • Teach relaxation therapy. • Institute guided imagery. • Maintain ward routine allowing physical activity. • Teach thought-stopping techniques. • Teach patient about somatic complaints with no medical basis. • Ignore the patient's symptom, but do not ignore the patient. • Role play/role reversal may be instituted for patient.	• The patient will verbalize his/her fears and perceptions about serious diseases.
• Low self-esteem related to unmet psychological needs	• Provide patient with unconditional love, care and acceptance. • Allow patient to express his/her heart in relation with psychological burdens; present and past. • Institute group therapy and promote patient's self-esteem by patient's participation as a leader or a significant member of the group. • Offer positive reinforcement. • Be non-judgmental. • Use therapeutic communication techniques. • Give feedback for every completed assignment such as words of praise, etc. • Teach assertive communication. • Educate patient about his human rights. • Encourage verbal catharsis.	• Patient acceptance of self will be demonstrated by expressing his/her as a person of worth.

5G: OBSESSIVE COMPULSIVE DISORDER (OCD)

DEFINITION

Obsessive: Compulsive disorder is characterized by intrusive thoughts, rituals, preoccupations and compulsions which cause severe distress to the individual and a significant impairment in social and personal functioning (Fig. 64).

Fig. 64: Obsessive-compulsive disorder: An illustration

Obsessions and compulsions are the reason for major distress of an individual's life because of its variety of symptoms, such as intrusive thoughts, rituals, preoccupations and compulsions, etc. These symptoms consume major portion of person's day to day life thus cause impairment in personal, social and occupational functioning.

Obsessive compulsive disorder includes presence of both obsessions and compulsions.

- **Obsession** is a repetitive thought, idea or feeling. An obsession is always recurrent and intrusive in nature; it is an activity of the mind and not inclusive of physical actions.
- **Compulsion** is a repetitive behavior in response to an obsession to relieve the anxiety. Compulsion is a physical action in response to the mind activity of obsession in order to avoid the unpleasant experience of anxiety. This recurrent compulsive act could be counting, checking or avoiding, etc.

A patient with obsessive compulsive disorder is aware of the fact that his/her behavior is not rational and is an unwanted behavior. This behavior is only carried out in an attempt to alleviate anxiety but at times even carrying out compulsive act does not eliminate the anxiety and this further increases the anxiety of the person.

PREVALENCE

About 2–3% of the general population of the world is affected with obsessive-compulsive disorder. Lifetime prevalence of OCD in Indian population is 0.6%.

Obsessive-compulsive disorder is the fourth most common mental sickness. The disorder is equally prevalent in men and women. The onset of the disorder is about 20 years of age and sometimes, it is firstly diagnosed in adolescents and in childhood.

The disorder is more common in single persons as compared to those who are married. Other coexisting disorders with OCD include alcohol use disorders, GAD, personality disorders, specific phobias, panic disorder and eating disorders.

The persons with obsessive compulsive personality traits such as an obsessive concern for details, perfectionism are more prone to develop obsessive compulsive disorder.

ETIOLOGY

Biological Factors

- **Altered levels of serotonin:** Serotonin can't be considered as the main responsible neurotransmitter for the causation of OCD. But serotonergic drugs have proved to be very effective in the treatment of OCD symptoms.
- **Streptococcal infection:** Group β-haemolytic streptococcal infection causes rheumatic fever which demonstrates a positive link between streptococcal infection and obsessive compulsive disorder.
- **Brain structural and functional abnormalities (frontal lobes, basal ganglia, cortex, and thalamus):** PET studies revealed that there is increased blood flow and metabolic rate in frontal lobes and basal ganglia of the patients with obsessive-compulsive disorder. In patients with obsessive-compulsive disorder, bilaterally there are smaller caudate nucleuses. The Caudate nucleus is a paired C-shaped sub-cortical structure near the thalamus and it lies deep inside the brain. The caudate nucleus plays higher neurological functions.
- **Noradrenaline:** There is not much research available about the role of noradrenaline in relation with obsessive compulsive disorder. But it has been studied at biochemical levels that if the amount of norepinephrine is increased at presynaptic terminals, obsessive compulsive disorder' symptoms occurs.
- **Sydenham chorea:** It is a rare neurological disorder characterized by chorea of an acute sudden onset with symptoms such as random-appearing, continuous involuntary movements affecting the entire body, especially face and tongue. Data revealed that approximately 30% of the patients with Sydenham chorea develop obsessive-compulsive symptoms.

Genetic Factors

First degree relatives have a three to five-fold risk of having OCD.

There is not any data available in relation to influence of culture and behavior on the risk of developing OCD. Comorbidity of other disorders such as eating disorders, hypochondriasis, generalized anxiety disorder, etc. do increase the chances of occurrence of obsessive compulsive disorder.

- **EEG changes:** There are EEG abnormalities found in the patients with obsessive compulsive disorder.
- **Personality factors:** Persons with obsessive-compulsive personality disorder are more prone to develop obsessive-compulsive disorder later in life.
  This is true only in case of 15–35% of the cases who do have premorbid compulsive symptoms that they will have obsessive compulsive disorder later in life.
- **Psychosocial factors:** Sociocultural influences such as relatives may involve child in ritualistic behaviors and OCD may become a learned behavior. Some people develop OCD because of gaining attention from other significant persons in their life. Strict toilet training may also contribute to behave in a rigid, over-disciplined manner.

  An insight into the psychodynamics of the OCD is so helpful to deal with the patient because every symptom of the disorder is having a psychological meaning attached to it. Sometimes, by adopting OCD symptoms, an individual gets some secondary gains which he/she never wants to give up at any cost and that's why he/she purposely loses the desire to lead a normal life.

  Another explanation for the obsessive compulsive traits is that whenever family is having poor functioning and a child is forced to learn some rituals as a tool for socialization, it unconsciously triggers an individual's mind to actively participate in rituals and modify his behavior to demonstrate perfectionism.

Example: When a child wants to express anger, parents do not allow him/her and ask him to adopt a sincere attitude toward all the insults and ignorance in any shape or form. This only brings REPRESSION which is an unhealthy defense mechanism of forgetting painful memories unconsciously.

Parents, relatives and society members and sometimes teachers also are major contributors of bringing ritual behavior in children and not a true expression of emotions. We do not allow anyone to truly express themselves. Love, hate, anger or jealously: Nothing is expressed openly and brings psychological conflicts.

Behavioral Factors

Behavioral factors contributing to development of obsessive-compulsive disorder can be understood by application of Pavlov's Classical Conditioning Theory. According to Classical Conditioning Theory, obsessions are conditioned stimuli and these behaviors of obsessions and compulsions are learned responses. When a neural stimulus is associated with fear and anxiety then the stimulus which was previously neutral, becomes capable of provoking anxiety and discomfort.

It is interesting to learn that how a person develops compulsive behavior:

When an obsessive thought that is so painful, intrusive to one person, he tries to do anything and everything possible to alleviate anxiety and when he/she learns a certain action capable of reducing anxiety provoked by an obsessional thought, an individual does those compulsive acts as a reflex in response to an obsession.

Case Study

An adult male of 20 years who have an obsession of having sexual imagery with his mother found himself in a very perplexed state where his superego was so punitive with guilt feelings of thoughts of having sex with his mother. He develops a compulsive act in the form of ritual that whenever he has had a thought of sex with his mother, he will touch his mother's feet as a compulsive act.

Psychoanalytical Theory

According to Sigmund Freud, regression in the oedipus complex in males and Electra complex in females is responsible for obsessive compulsive traits in individuals.

Other Factors

Environmental stressors during pregnancy, childbirth and parental care.

Signs and Symptoms

OCD has four main symptoms:

1. **Contamination:** Obsession of contamination may cause the patient to wash his hands repeatedly. The individual is so afraid of the contaminated object which he/she has assumed to be dirty so he/she would do anything to avoid this pre-assume contaminated object such as feces, urine, dust, germs, etc.

   The individual may literally rub his/her skin off his/her hands by washing hands time and again. Excessive hand washing may cause skin lacerations and other skin disorders but an individual will not be able to control his/her compulsive acts (Fig. 65).

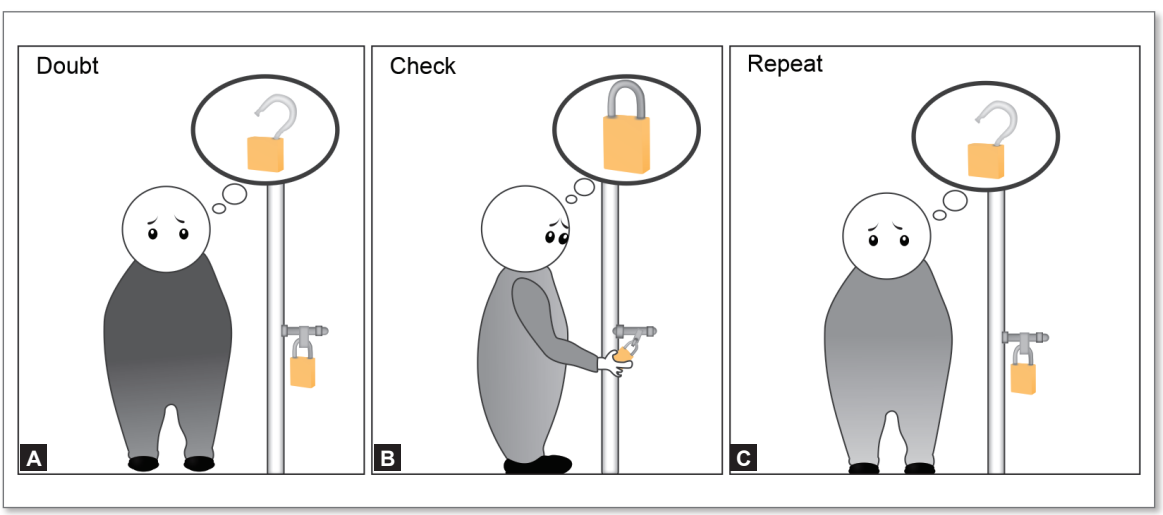
   This compulsive act is often accompanied by shame and disgust. The individual is having this belief in his/her mind that contamination can be spread by slightest contact with objects or persons.

Fig. 65: Obsession of contamination

2. **Pathological doubt:** Obsession of doubt may cause the patient to check again and again. For example, multiple visits in kitchen to check stoves (Figs 66A to C).

   An obsessive compulsive disorder with pathological doubt is having obsessional self-doubt and guilt of forgotten important things.

- **Intrusive thoughts:** It is obsession without compulsion, e.g. sexual fantasy. Intrusive thoughts are repetitive thoughts without any compulsive acts. These repetitive thoughts are usually of aggressive or sexual acts. Suicidal ideation is also a kind of obsession. They may confess their sexual fantasies to a priest and feel so sorry about having those thoughts (Fig. 67).



Figs 66A to C: Pathological doubts

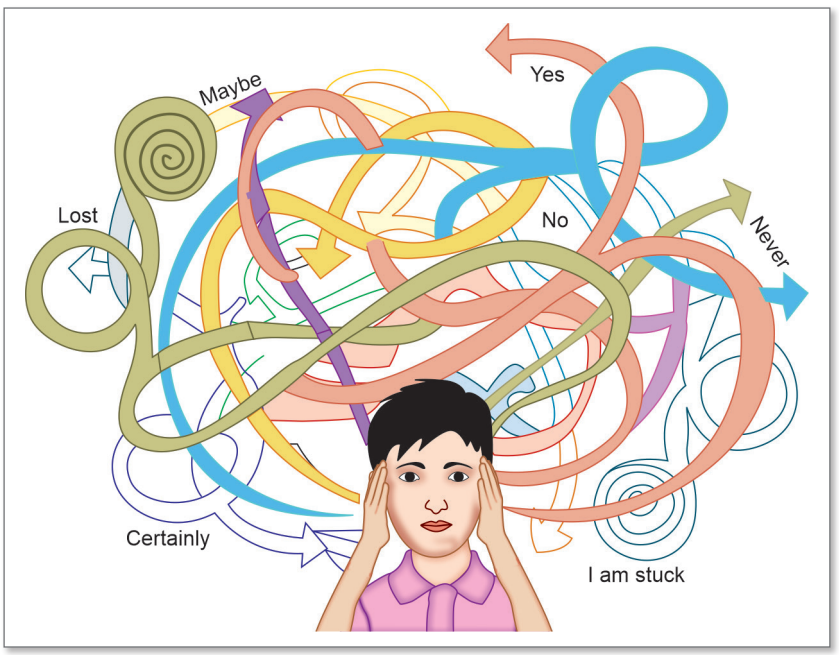


Fig. 67: Intrusive thoughts

- **Symmetry:** Compulsion for a symmetry in every pattern leads to slowing of work (Fig. 68).
  This is known as compulsive slowness. An individual with OCD of symmetry may take hours to finish one-time meal or doing a work such as shaving, bathing, cleaning, etc.

Patient with awareness about presence of obsessive compulsive disorder knows that his/her beliefs are not true. An example of an obsession about hurting a wife may be followed by a mental compulsion to repeat a prayer for her safety.

Fig. 68: Depiction of compulsion for a symmetry

Some patients are having obsessions only which are not followed by compulsive acts. For a disorder to be called obsessive compulsive disorder he/she should have both; obsessions and compulsions. In obsession, an intrusive and persistent impulsive thought enters into person's mind and causes significant stress and anxiety in person. Some typical obsessions are such as fear of contamination—my hands are dirty, pathological doubts such as, 'I forgot to turn off stove in kitchen'.

Severe anxiety can be caused by the obsessional thoughts and the compulsion is characterized by any action that is capable of reducing this anxiety in patient. The person with OCD recognizes his obsessions as absurd and irrational, and feels an urge to resist the compulsive acts.

Other Symptoms

- Religious obsessions
- Compulsive hoarding
- Compulsive hair pulling
- Compulsive nail biting
- Compulsive Masturbation

DSM-5 DIAGNOSTIC CRITERIA FOR OCD

- **Presence of obsessions, compulsions or both:**
  Obsessions are defined by (1) and (2)
  1. Recurrent and persistent thoughts, urges or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
  2. The individual attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)

  Compulsions are defined by:
  - Repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to the rules that must be applied rigidly.
  - The mental or behavioral acts are aimed at preventing or reducing anxiety or distress, preventing some dreadful events or situations; however these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent and are clearly excessive.
- The obsessions or compulsions are time-consuming or clinically significant distress or impairment in social, occupational and other important areas of functioning.
- The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance.
- The disturbance is not better explained by another medical disorder.

PROGNOSIS

The OCD is having a good prognosis in the presence of good social and occupational support.

Some patients do have a fluctuating course of obsessive compulsive disorder. When life is consequently faced with stressors, the prognosis of OCD will be bad. A coexisting disorder, especially personality disorder, will also make prognosis worse.

If the repressed emotions are worked out through psychoanalysis, then there are chances of a good prognosis. Noncompliance with pharmacological agents can also be responsible for a lifelong illness with poor prognosis.

MEDICAL MANAGEMENT

Psychopharmacology

- Selective serotonin reuptake (SSRIs) inhibitors are the best therapeutic antidepressants for obsessive-compulsive symptoms. But it can cause side-effects such as nausea and diarrhea, sleep disturbances, anxiety, headache and restlessness. Still, we can say that its benefits outweigh its side-effects.
- **Clomipramine:** It is the most effective drug among all tricyclic and tetracyclic antidepressants. The dose of clomipramine should be titrated upward over a period of 2–3 weeks. It will help dealing with adverse reactions, such as GI upset, orthostatic hypotension, dry mouth, constipation, etc.
- Other drugs, such as Valproate, lithium, carbamazepine
- Research evidenced that in the treatment of OCD, venlafaxine and MAO inhibitors are also proved to be effective. Phenelzine is the drug of choice among these categories.
- If a patient is unresponsive with all other pharmacological agents, then buspirone and clonazepam can be tried to combat OCD symptoms.
- At times, physician may use an atypical antipsychotic such as Risperidone in the treatment of obsessive compulsive disorder.
- Although OCD is a neurotic disorder and neurosis is characterized by presence of insight, in many cases, patient with obsessive compulsive symptoms are not aware of their symptoms and it can cause noncompliance with the treatment. Patient in that case refuses medications and other treatment modalities.
- A combination of pharmacological agents plus behavioral therapy is more effective in the treatment of obsessive compulsive disorder.

Behavior Therapy

The therapeutic effects of behavioral therapy are much lasting and effective as compared with pharmacological agents. In many psychiatric settings, behavioral therapy is the treatment of choice for OCD patients.

Techniques Used in Behavioral Therapy

- Desensitization
- Thought stopping
- Flooding
- Exposure therapy
- Implosion therapy
- Aversive therapy

Psychotherapy

- Individual psychotherapy
- Supportive psychotherapy

This therapy is so effective in those patients who are having insight about their mental illness and are trying their level best to work and make social adjustments. By motivation and encouragement in patient, a therapist

may help the patient with obsessive compulsive disorder. This therapy helps alleviate anxiety to a greater extent. Absence of psychosocial stressors can also make a big difference in the patient with obsessive compulsive disorder by reducing stress levels.

A little emotional support, reassurance and explanation can do wonders in the life of the patient with obsessive compulsive disorder.

- **Family therapy:** Family therapy is helpful in reducing the interpersonal relationship conflicts.
- **Group therapy:** It also serves as a support system for the patient who is experiencing obsessive compulsive symptoms.
- **Insight oriented psychotherapy:** It may help making visible symptomatic improvement in patients with obsessive compulsive disorder.
- **Electroconvulsive therapy:** For those patients who do not respond to any other treatment modalities, electro-convulsive therapy is the last resort to deal with obsessive compulsive disorder.

Nursing care plan for obsessive-compulsive disorder is depicted in Table 14.

Table 14: Nursing care plan for obsessive-compulsive disorder

Nursing diagnosis	Nursing interventions	Outcome criteria
Ineffective coping related to dysfunctional ego/disease psychopathology	• Help the patient in understanding disease psychopathology. Educate him/her. • Make patient realize and make out, which situations are responsible for increasing his/her anxiety. • Be educative/supportive to patient. Make a strict ward routine so that patient does not feel free to have obsessions and compulsive acts. Keep patient busy in purposeful activities. • Teach thought stopping technique. • Teach relaxation therapy. • Promote physical exercise to help patient have a normal routine activity. • Be non-judgmental and allow patient to express his/her heart.	Lesser reported/observed compulsive acts. Patient will verbalize that he/she is able to control obsessions through thought stopping techniques/ relaxation techniques, etc.
Dysfunctional role performance related to compulsive need to perform rituals.	• Allow patient to express his/her previous roles and responsibilities in family, society Encourage patient to express his/her ideas about role expectations. • Role play/role-reversal is the therapy which may be instituted for patient. • Family therapy and family cooperation in making patient understand his/her roles and helping him/her in performance of those roles is really helpful. • When patient starts playing his/her roles efficiently, provide patient with positive reinforcement.	Patient will be able to perform his/her roles with low reported incidents of obsessions and compulsions.

5H: TRAUMA AND STRESS-RELATED DISORDERS

INTRODUCTION

Trauma and stress-related disorders mainly include following two disorders:

- Acute stress disorder (ASD)
- Post-traumatic stress disorder (PTSD) (Fig. 69)

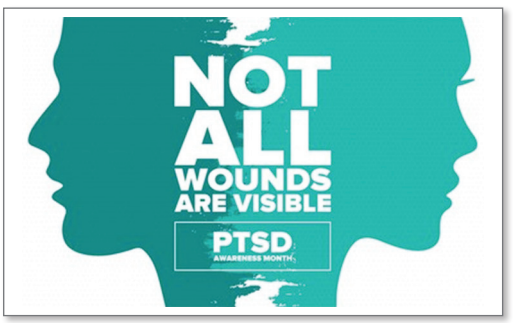


Fig. 69: Post-traumatic stress disorder: An illustration

These disorders are characterized by increased stress and anxiety after exposure to a stressful event. Life is so hard on some persons and when anyone faces trails and turmoil consequently, his/her ability to deal with stress sometimes diminishes or gets weakened. Other times the stressful event is so big that an individual is not efficient enough to deal with it.

Whatever may be the case, the individual then experiences marked stress and anxiety after being exposed to stressors. The following are some of the stressors that may invoke anxiety and stress in the person after being confronted by it:

- Violence
- Accident
- Involvement in crime
- Assault
- Being kidnapped
- Natural disasters
- Life-threatening illness
- Physical abuse
- Sexual abuse
- War
- Rape
- Catastrophic events

Any of the events will bring an emotional reaction to it. The person may manifest stress in the form of fear, anxiety, helplessness and hopelessness, depression and cognitive decline, etc. Because person will want to undo the event and being failed at it will bring back all the painful memories in the form of flashbacks.

Flashbacks can occur in dreams or while awake in the thoughts and mind of the person. A person usually uses the defense mechanism of avoidance and actively avoids anything/person who will remind him/her of the traumatic experience. Individuals with trauma and stress- related disorders also experience numbing of responsiveness plus a state of hyperarousal.

DEFINITIONS

- **ASD** is characterized by an acute short-lived marked stress and anxiety reaction occurred in the response of a traumatic event.
- **PTSD** is manifested by an increased stress and anxiety after exposure to a traumatic event, which was seemingly stressful.

PREVALENCE

The lifetime prevalence of PTSD is approximately 9–15%.

It is estimated that almost 8% of the general population is affected by PTSD. PTSD is more prevalent in women as compared to men. It is observed that soldiers after war are more of a candidate of ASD and PTSD.

PTSD is more prevalent in young adults as this age is more exposed to risk behavior and precipitating situations.

Traumatic events are different for men and women as society demands different obligations from both genders. Women's traumas are usually in the form of assault or rape.

ASD and PTSD is more prevalent in single, divorced, widowed, socially withdrawn or in those with a low socioeconomic status. It does not mean that people who are married, socially active and those having a high social class will not be affected with ASD or PTSD. Anyone can be affected and no one is immune to stress and trauma-related disorders.

Stress and trauma-related disorders is having at times coexisting disorders such as depression or other mood disorders, substance-related disorders, anxiety disorders, etc. Any comorbidity makes an individual more prone to develop stress and trauma-related disorders.

ETIOLOGY

Biological Factors

- Neurotransmitters alterations (norepinephrine, dopamine, endorphins)
- Dysfunctional Hypothalamus-pituitary-adrenal (HPA) axis
- Cardiovascular disorders
- Increased responsiveness of autonomic nervous system
- Abnormal sleep architecture
- Tachycardia
- Increased blood pressure
- **Noradrenergic system:** The presence of autonomic nervous system symptoms in PTSD such as nervousness, increased blood pressure and heart rate, palpitations, flushing, sweating and tremors, etc. shows that there is role of noradrenergic system in the causation of post-traumatic stress disorder. In patients with post-traumatic stress disorder, there are increased 24-hour urine epinephrine concentrations.

In sexually abused girls, there is increased urine catecholamine concentration in 24-hour studies.

- Abnormality in opioid system (low plasma β-endorphin concentrations).
- Low plasma and urinary free cortisol concentrations in PTSD
- Cortisol hyper-suppression
- Hyper regulation of the HPA axis
- Structural changes in hippocampus
- **Structural changes in amygdala:** Amygdala is an area of brain associated with fear.

Cognitive-behavioral Factors

Cognition implies almost every mental faculty of thinking, memory and judgment, etc. When an individual fails to cognitively explain and rationalize the traumatic experience, then he/she tries to minimize the anxiety associated with trauma by an attempt to avoid feeling it through avoidance defense mechanisms.

This we can understand through the application of theory of classical conditioning.

- Unconditioned stimulus-traumatic experience
- Unconditioned response-fear, anxiety and distress

Conditioned stimulus: Physical or mental reminders of the trauma, flashbacks and revival of the traumatic experience by sights, smells and sounds or by any sort of memories of the trauma.

Conditioned response-fear, anxiety and distress

It is noteworthy that many individuals continue experiencing PTSD symptoms because of receiving of secondary gains after the traumatic experience. The secondary gains are in the form of monetary compensation, increased attention or sympathy and the satisfaction of dependency needs.

Psychosocial Factors

- Faulty defense mechanisms to deal with life-stressors (denial, minimization, splitting, dissociation, delusion of guilt)
- Misinterpretation of the traumatic event
- Childhood traumas
- Increased responsiveness to sympathy and attention
- **Splitting of consciousness:** According to Freud, in PTSD, there is splitting of consciousness. An individual who has previously experienced any childhood assault, physical or sexual trauma have a psychological conflict embedded in his memory. This psychological conflict is symbolically gets aroused after exposure to a new traumatic event. In that case, ventilation of emotions is very important and with people who are unable to verbalize their emotions are not able to calm themselves under stress.

According to Psychoanalytical Theory, PTSD occurs as a response to an unresolved psychological conflict. PTSD is having the main characteristic symptom of Revival of the trauma in the form of flashbacks. Any revival, be it a childhood trauma or recent exposure to any stressful event will ignite the defense mechanism of regression, i.e., reverting back to previous stage of development. Other defenses used will be undoing, reaction formation, repression and denial.

- **Denial:** An individual forces his/her psyche to not believe that any such bad experience had ever happened with him/her.
- **Undoing:** At any cost, person with PTSD wants to undo the experience of traumatic event. This is most common in victims of Rape and Assault. They want to undo the event already happened but flashbacks and memories bring back those things again and again which makes it so painful to deal with the stressor.
- **Repression:** An individual unconsciously forgets the painful memory of traumatic experience.
- **Reaction formation:** It is the exact opposite behavior to the actual emotion. For example, after a breakup, going for a party or parlor to enjoy the dining and hair services, etc.

Personality Factors

Certain personalities are more prone to experience PTSD such as borderline, paranoid, dependent and/or antisocial personality.

Life Stressors

Life stressors may be physical trauma (accidents), psychological trauma (rape), natural disasters (tsunami, earthquake, volcano eruptions, cyclones, etc.)

As the name suggests, ASD and PTSD means it is so obvious that the main cause for these disorders is a stressor. A stressor is any stimuli in the shape of traumatic event capable of causing severe distress in the individual.

The intensity of the stressor is not the case always; it depends on the preexisting biological and psychosocial factors that are there before the occurrence of the traumatic event. What does that mean is that many individuals who lived through a traumatic experience at times become so strong that they lead better lives after that. Other individuals who have weak biology and psychology fail to cope with the stressors and become distressed.

Everyone interprets stressor from his/her own point of view and perception. For one individual, a challenge may be taken as an opportunity to grow and the same challenge may be taken as a stressor and a cause for distress. Meaning thereby is this that the subjective meaning of the person of a stressor is also very important.

POST-TRAUMATIC STRESS DISORDER

These risk factors predisposes an individual to experience PTSD.

- Female gender
- Recent stressful life changes
- Genetic factors
- Perception and subjective meaning of the stressor
- History of substance use
- History of childhood trauma or abuse (physical or sexual)
- Certain personality traits such as borderline, paranoid, dependent and antisocial personality traits.
- Dysfunctional family relations
- Inadequate social support

Signs and Symptoms

The signs and symptoms of PTSD are given in Figures 70 and 71.

- Re-experiencing traumatic events time and again in the mind (Fig. 71)
- Flashbacks
- Psychological distress
- Anhedonia
- Derealization
- Detachment from reality
- Insomnia
- Irritability

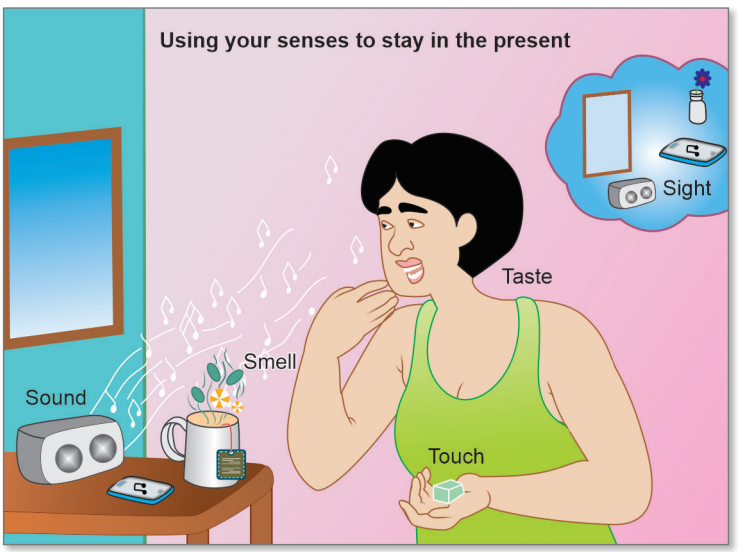


Fig. 70: Signs and symptoms of PTSD

Various post-traumatic stress disorders are depicted in Figure 71.

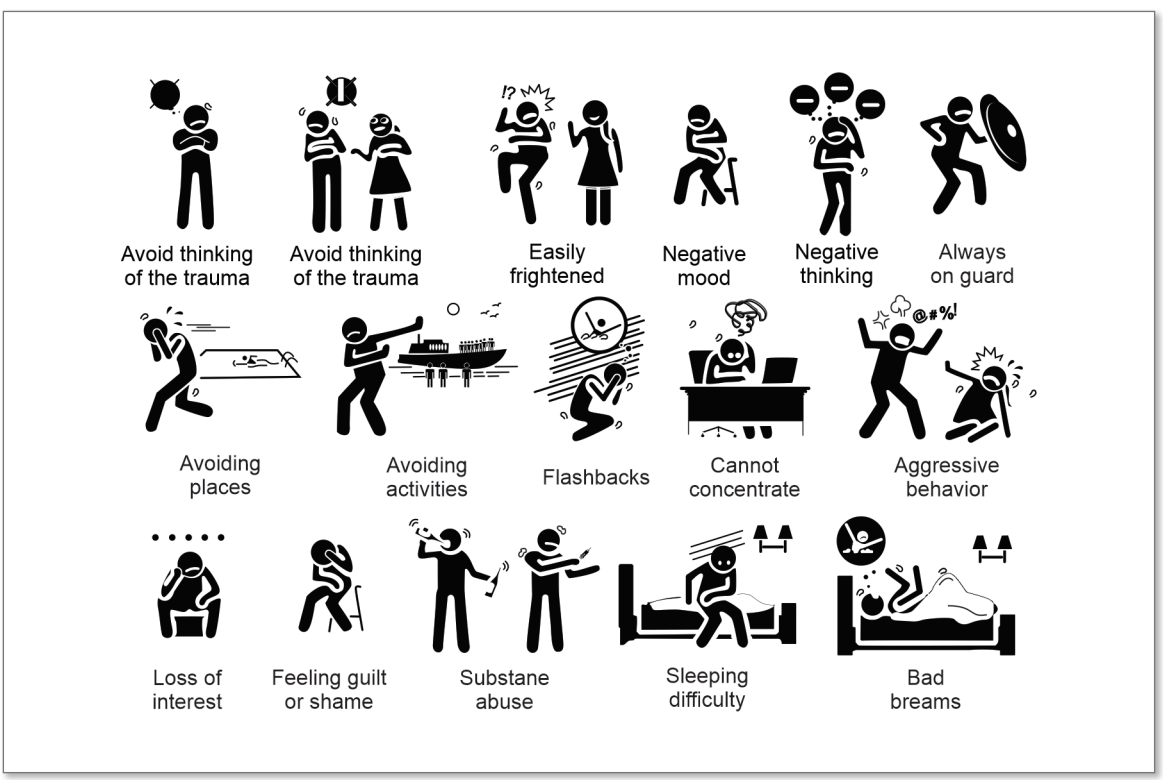


Fig. 71: Various symptoms depiction of post-traumatic stress disorder

The symptoms of PTSD can be classified into three categories.

- **Intrusion symptoms:** These are the symptoms which occur immediately after the occurrence of trauma:
  - Enhanced startle reflex
  - Increased autonomic arousal
  - Flashbacks—a classic intrusion symptom
  - Distressing recollections
  - Distressing dreams
  - Physiological symptoms such as sweating, tremors, perspiration etc.
  - Psychological symptoms such as crying, anger, irritability
- **Symptoms of avoidance**
  - Anhedonia
  - Reduced ability to remember traumatic events
  - Blunted affect
  - Feelings of detachment (depersonalization or depersonalization)
- **Symptoms of increased arousal**
  - Insomnia
  - Irritability
  - Hypervigilance
  - Exaggerated startle
  - Migraine headaches
  - Digestive problems
  - Skin rash
  - Hair loss
  - Forgetfulness
  - Difficulty in concentration
  - These symptoms are called
  - Gulf war syndrome

DSM Diagnostic Criteria

Intrusion Symptoms

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
  Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s).
  Note: In children, there may be frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event (s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).
  Note: In children, trauma-specific re-enactment may occur in play.
- Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

Persistent inability to experience positive emotions, (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

- An altered sense of the reality of one's surroundings or oneself, (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
- Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

- Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

- Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- Hypervigilance.
- Problems with concentration.
- Exaggerated startle response.
- Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
  Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

DSM-5 Diagnostic Criteria for ASD

- Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
  - Directly experiencing the traumatic event(s).
  - Witnessing, in person, the event(s) as it occurred to others.
  - Learning that the event(s) occurred to a close family member or close friend.
    Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).
    Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
- Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

DSM-5 Diagnostic Criteria for PTSD

- Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - Directly experiencing the traumatic event(s).
  - Witnessing, in person, the event(s) as it occurred to others.
  - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: Police officers repeatedly exposed to details of child abuse).
- Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
  - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
    Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
  - Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
    Note: In children, there may be frightening dreams without recognizable content.
  - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
    Note: In children, trauma-specific re-enactment may occur in play.
  - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic events.
- Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
  - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
  - Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - Inability to remember an important aspect of the traumatic event (s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
  - Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," 'The world is completely dangerous," "My whole nervous system is permanently ruined.") Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
  - Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
  - Markedly diminished interest or participation in significant activities.
  - Feelings of detachment or estrangement from others.

  - Persistent inability to experience positive emotions, (e.g., inability to experience happiness, satisfaction, or loving feelings).
- Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  - Reckless or self-destructive behavior. Hyper-vigilance.
  - Exaggerated startle response.
  - Problems with concentration.
  - Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- Duration of the disturbance (criteria B, C, D, and E) is more than 1 month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

PROGNOSIS

Prognosis of PTSD can be good if premorbid functioning is good and there is no comorbidity of other mental disorders.

The symptoms of the PTSD and ASD can fluctuate over time and during the period of stress, these symptoms get worsen. Within one year of traumatic experience, 50% of the patients will recover spontaneously. Prognosis is good if the symptoms have a rapid onset.

Prognosis will be good in those patients who have adequate social support of family, friends and peer group and in those who don't have coexisting mental disorders.

MEDICAL TREATMENT

The treatment of the patient with traumatic experience includes support and encouragement mainly along with the psycho-education about coping strategies.

- First, encourage patient to talk about his bad experiences and help him/her ventilate and express through emotional discharge.
- Do not force expression of thoughts but let patient take his/her time to talk as he/she wants to convey.
- If patient refuses to talk about such traumatic experiences, respect client's decision and privacy. Any forceful expression will never be helpful to decrease PTSD symptoms rather will increase anxiety and fear in the patient. The therapist can make use of sedatives and hypnotics in such cases.
- Encourage ventilation/catharsis/abreaction (emotional discharge)
- Ask patient to express his/her feelings.
- Use of sedatives and hypnotics to encourage expression of emotions.

Psychopharmacology

- **Selective serotonin reuptake inhibitors (SSRIs)**
  - Sertraline
  - Paroxetine

- **Antidepressants**
  - Imipramine
  - Amitriptyline
    - Antidepressants are used to treat PTSD symptoms such as avoidance, denial and emotional numbing etc.
- **MAO inhibitors**
  - Phenelzine
  - Trazodone
- **Anticonvulsants**
  - Carbamazepine
  - Valproate
- **Antiadrenergic agents**
  - Clonidine
  - Propranolol
  - Buspirone
- **Antipsychotic drugs**
  - Haloperidol

Psychotherapy

- Individual psychotherapy
- Group psychotherapy
  Group therapy is so helpful for patients with post-traumatic stress disorder as it helps the individual to share his/her traumatic experiences and support from other group members motivate the victim to deal with the traumatic events more efficiently.
- Family therapy
  Family therapy is helpful to endure times of intense intrusive symptoms. If patient has a risk of suicide or other directed violence, then hospitalization is mandatory.
  Psychodynamic psychotherapy: This is executed through abreaction and catharsis in a therapeutic manner. In this way, the therapist reconstructs traumatic events. The results of the psychodynamic therapy vary because of individual differences.
- Behavioral therapy
- Cognitive therapy
- Hypnosis
- Crisis intervention
- Psychoeducation
- Individual psychotherapy to develop coping mechanisms
- **Exposure therapy:** In exposure therapy, patient will be re-experiencing traumatic event through imagery or in artificial set up. The exposure can be intense or graded.
- Stress management such as relaxation therapy or other cognitive approaches.
- While providing any psychotherapy to the patients with PTSD, one must take care of time. Psychotherapy must be short with time limits because re-experiencing the traumatic events at times overwhelms some patients. This is helpful in providing support and safety security needs.
  In psychotherapy sessions, the patient must remove himself from the source of stress and the therapist should help him to identify that source of stress.

- Use sleep and medication whenever and wherever is necessary.
- Social support can do wonders for the patient with post-traumatic stress disorder.
- **Eye movement desensitization and reprocessing (EMDR):** In this psychotherapeutic technique, patient is asked to focus on the lateral movement of the finger of the therapist but have to maintain a mental image of the trauma experience.

The idea behind EMDR is that when patient re-experiences the traumatic event in a state of deep relaxation, then the symptoms will automatically be minimized.

Table 15 explains the nursing care plan for post-traumatic stress disorder

Table 15: Nursing care plan for post-traumatic stress disorder

Nursing diagnosis	Nursing interventions	Outcome criteria
Post-trauma syndrome related to traumatic experience	• Be with patient. Merely presence of a supportive person may help patient feel a sense of security and comfort. • Be supportive when patient experiences flashbacks, nightmares in relation with traumatic events. • Catharsis must be allowed. • Help patient express his/her perception about traumatic events. • Be consistent in your treatment approach. • Make same staff available as possible. Change of person may increase patient's anxiety unnecessary. • Give unconditional regard and love to the patient's expression of thoughts and ideas. • Provide calm, non-threatening environment. • Help patient understand the traumatic event and its effects on him/her. • Ask patient about previously used coping strategies and their success. Try all alternatives and help patient to achieve success in effective coping.	The patient will understand traumatic effects and will use coping strategies effectively to lead a new purposeful life.
Dysfunctional grieving related to actual or potential loss	• Encourage expression of feelings related to guilt or self-blaming. • Assess the patient in which phase of grief he/she is: (a) Denial, (b) Aggression, (c) Bargaining, (d) Depression, and (e) Acceptance. ▪ Help patient move successfully through these stages towards acceptance of reality. ▪ Observe keenly; one to one relationship. ▪ Assess for self-mutilating behavior. ▪ Be supportive to patient. ▪ Have a consistent approach.	Patient will make use of effective coping-strategies.

5I: SUBSTANCE USE AND DE-ADDICTION: ALCOHOL, TOBACCO AND OTHER PSYCHOACTIVE SUBSTANCE

TERMINOLOGIES RELATED TO SUBSTANCE USE

- **Dependence:** Means the habitual use of substance for physical, psychological and behavioral benefits. Dependence is of two kinds:
  1. **Physical dependence:** Pathological usage of substance for physiological effects such as calming the mind, as a CNS stimulant, mood elevation, etc.
  2. **Psychological dependence:** It is also known as habituation. It is the habitual use of substance to have a psychological calming effect.
- **Codependency:** When one member of family is taking a substance and another is influenced in a negative way.
  Codependency is also known as co-addiction or codependence.
- **Tolerance:** An increased amount of substance is required to produce the same desired effects.
- **Addiction:** Use of substance repeatedly and subsequently in an increased dose.
- **Intoxication:** When the usage of substance is causing toxic effects on mind faculties.
- **Withdrawal:** Collection of the symptoms which occur after sudden stoppage of substance use.
- **Enabling:** Enabling refers to the feelings of the family members in relation with codependency or co-addiction. The family members think that they have no control/power over the enabling actions. It may occur because family members are often struggling with social pressures for protection and support of their family member who is substance abused.
  The family members who are even trying to help patient often feel overwhelmed and pressurized. Many of them are not willing to accept addiction as a disorder. For example, In Punjab, social drinking does not carry a negative attitude among many people.
  On the other hand, what is happening within the drug addict is also destructive because they feel any substance (alcohol) is much more important than a family member. The resulting emotions are anger, guilt and depression.
- **Denial:** The family members believe the notion that substance use is not an actual problem and is not at all a disorder. There may be many reasons for such denial but most commonly family members deny the problem because they don't want to take guilt of patient's disorder and do not believe that they are in any ways responsible for drug addiction.
- **Abuse:** Use of any drug that is not appropriate and is not approved by social or medical patterns.
- **Misuse:** Misuse is similar like abuse but it only includes those drugs which are prescribed by physicians and are used improperly.
- **Cross-tolerance:** It is characterized by ability of one drug that can be substituted for another drug for the same physiological and psychological effects.

TYPES OF SUBSTANCE USE

- Alcohol
- Caffeine
- Cannabis
- Opioid

- Tobacco
- Sedative-hypnotics

Alcoholism + Tobacco + Cannabis + Caffeine

PREVALENCE

The world's prevalence of alcoholism is increasing day by day. It is acceptable in some societies to drink. In other situations, it is mandatory in some cultures such as marriage, party functions, etc. Not everyone who drinks is an alcoholic. But life stresses may provoke an occasional drinker to be an alcoholic and many other neuro-biochemical factors also contribute to its usage. But the exact number and figures of its prevalence are difficult to assess. It would be shocking to know that almost 60–70% of the world's populations are current drinkers. They may or may not have an addiction.

ETIOLOGY

- Peer pressure
- Antisocial personality disorder is more prone
- Family/societal pressure
- Psychological effects of alcohol on brain, i.e., calming effects, it relieves tensions and worries which may be the reason for initiating drinking.
- Physiological effects of other substances
- Self-punitive harsh superego may be the reason. The people who can't handle guilt may adopt drinking as a resolution method.
- Genetic factors and family history may also contribute to etiology of alcohol usage.
- We can conclude that substance use disorder is the result of many causative factors collectively interacting to produce drug-using behavior. The drug addict actually loses his judgment in relation to the decisions he/she has to make about use of a drug.

It is surprising to note that not everyone is affected or motivated by the same reasons for becoming dependent on the same drug. Some of the common factors that may have contributed in the etiology of drug addiction are as follows:

- Drug availability
- Social acceptability
- Peer pressures
- Personality factors
- Individual biological factors
- Social media
- Specific actions of the drug (sleeping pills, tranquilizers)
- Changes in the structure and neurochemistry of the brain of the drug user
- Drug-using behavior in response to positive re-enforcers
- Drug using behavior
- Immediate social and psychological situations
- Drug addicts' premorbid history

- In the first place, use of drug seems rewarding to the drug user and the desire to produce the same rewarding effect again results in more likelihood that drug-using behavior will be repeated.
- Internal and external motivation for use or rejection of a drug

Psychodynamic Factors

Masturbatory equivalent: It has been reported by heroin users that initial rush of heroine is as a prolonged sexual orgasm for them.

For other people, it is like a defense against anxious impulses. Whenever they feel like anxious and nervous, they would use substance to deal with it.

Another explanation says, it is dependency as a result of oral regression. Meaning thereby the individual is having fixation at the oral stage of psychosexual development.

Many of the people are using drugs because they want to escape the real-life situations and they are having disturbed ego functions, i.e., inability to deal with reality.

Self-medication: Many people use alcohol as a medicine to control panic attacks. Opioids are used for anger management. Amphetamines are used by many people as a measure to decrease depressive symptoms.

Alexithymia: Some addicts are unable to find words to explain their inner world; they cannot put their feelings in words. This is known as alexithymia. These drug addicts use substances to recognize their inner emotional states. For example, it is commonly heard that a person expresses him/her under the effect of drug, especially alcohol. The physiological effect of drug is CNS depression.

Learning and conditioning: Twin brothers; one among them was a drug addict and other who never used any substance was asked question in relation to drug use as follows:

- The one who was a drug addict was asked that why do you use drugs? He replied that I have seen my father.
- Another was asked who never used a substance that why you never used a drug? He replied that I have seen my father.

Therefore, we can conclude that same environment can condition individuals differently as a result of learning. Drug use can be reinforcing if it is a symbolic presentation of some special status or for the approval of friends, etc.

Drugs are used by drug addicts as they are believed by drug addicts to terminate noxious and unpleasant feelings such as pain, anxiety and depression. Every time use of the drug invokes a positive reinforcement in patient's behavior to use it again for the results such as euphoric state, diminished disturbed emotions, diminished withdrawal symptoms, etc.

Drugs (cocaine, opioids, and cigarettes) alter the brain activity in limbic (emotional) regions such as amygdala and anterior cingulate gyrus. These regions are the regions which are activated by sexual stimuli and use of these substances may be a result of their learning therefore.

Craving of a substance is at times initiated by its availability and use. When a drug addict sees another person using heroin, lighting a cigarette or if he is being invited to use the substance, he/she is more likely to lose control.

Genetic Factors

Research suggested that there is some genetic predisposition in the addiction of substances such as alcohol abuse.

Neurochemical Factors

Research in the field has suggested that specific neurotransmitters are involved in substance abuse. For example, Opioids act on Opioid receptors. A person whose serum concentrations of endorphins are low or an endogenous Opioid antagonist is working more than usual; he/she is more prone to use Opioid and develops dependence.

Neurotransmitters

The neurotransmitters involved in substance abuse are opioid, catecholamine, dopamine and Gamma aminobutyric acid (GABA) receptors.

COMORBIDITY

The persons with substance use disorder often demonstrate a comorbid psychiatric disorder. Many of the substance users also meet the criteria for an antisocial personality disorder or they may have a premorbid history of antisocial behavior. It has been observed that those who are having impulsive, isolated, antisocial personality are more likely to use illegal drugs. They often meet the criteria for depression also.

CLASSIFICATION OF SUBSTANCE USE DISORDERS

According to DSM-5, there are mainly four categories in relation with substance use which are as follows:

Substance Use Disorder

Substance use disorder is the diagnostic term applied to the specific substance abused (e.g., alcohol use disorder, opioid use disorder) that results from the prolonged use of the substance. The following points should be considered in making this diagnosis. These criteria apply to all substances of abuse.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
- Recurrent substance-use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - Markedly diminished effect with continued use of the same amount of the substance

- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance
  - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
- Important social, occupational, or recreational activities are given up or reducedbecause of substance use
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- Craving or a strong desire or urge to use a specific substance.

Substance Intoxication

Substance intoxication refers to a syndrome characterized by peculiar clinical manifestations resulting from recent ingestion and exposure to the substance, e.g., alcohol intoxication.

Substance Withdrawal

Substance withdrawal refers to a clinical diagnosis which describes a syndrome that results from the abrupt stoppage of the ingestion of heavy and prolonged use of a substance, for example, opioid withdrawal.

Substance Induced Mental Disorder

The substance/medication-induced mental disorders are potentially severe, usually temporary, but sometimes persisting central nervous system (CNS) syndromes that develop in the context of the effects of substances of abuse, medications, or several toxins. They are distinguished from the substance use disorders, in which a cluster of cognitive, behavioral, and physiological symptoms contributes to the continued use of a substance despite significant substance-related problems.

All substance/medication-induced disorders share common characteristics. It is important to recognize these common features to aid in the detection of these disorders. These features are described as follows:

- The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder.
- There is evidence from the history, physical examination, or laboratory findings of both of the following:
  - The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
  - The involved substance/medication is capable of producing the mental disorder.
  - The disorder is not better explained by an independent mental disorder (i.e., one that is not substance or medication-induced). Such evidence of an independent mental disorder could include the following:
    - The disorder preceded the onset of severe intoxication or withdrawal or exposure to the medication; or
    - The full mental disorder persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication.

This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

- The disorder does not occur exclusively during the course of a delirium.
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

ALCOHOL USE DISORDERS

Alcohol use disorders are the commonest among all substance use disorders. Many of the road-side accidents are contributed by the consumption of alcohol.

The consumption of alcohol is much more in comparison with other substances because alcohol is a very powerful drug capable of causing sudden and chronic changes in the physiology of human body. Although anyone would be initiating its use to combat stress or depression, the matter of the fact is this that alcohol can rather cause such psychological symptoms, i.e., depression, anxiety and psychosis.

Chronic use of alcohol can produce serious physiological disturbances such as tolerance, i.e., need of a higher dose to produce the same desired effects.

Alcohol withdrawal is also not easy path; it is always marked by insomnia, anxiety and hyperactivity of autonomic nervous system.

Prevalence

Alcohol use is prevalent both in urban and rural settings of India. The prevalence rate is variable among males that are from 23% to 74% in general population. In females, although alcohol consumption is not that common still the prevalence rate is 24–48% in certain sections and communities.

Uttar Pradesh is among the highest consumer of alcohol in India followed by West Bengal in second position.

As per the results of a large scale survey conducted across India in 2020, majority of the people from Pune consumed the most alcohol. Among the cities surveyed, metros contributed significantly to alcohol consumption.

According to TRIBUNE findings; at the national level, about 2.7 percent of population (2.9 crores individuals) has alcohol dependence. States with the highest prevalence of alcohol dependence are Tripura (13.7%), Arunachal Pradesh (7.2%) and Punjab (6%).

Current Users

Alcohol: India 14.6%; Chhattisgarh 35.6%; Tripura 34.7%; Punjab 28.5%

It has been observed that men and women with higher education and with higher income are more likely to consume alcohol but are among the lowest rates of alcohol dependence. It may be because of this that they usually consume alcohol when they have to imbibe among social settings only.

Drinking alcohol is generally considered an acceptable habit in many communities. For instance; in Punjab, social drinking is an acceptable norm among males.

Etiology

The etiology of alcohol consumption is multi-faceted. Not a single factor contributes to alcohol consumption in life. But it is largely contributed by social, religious and psychological factors plus genetic makeup also.

Psychological Factors

The major notions which you might hear about alcohol consumption are use of alcohol to relieve tension and/or to increase feelings of power and to decrease the effects of psychological pain of any kind.

Alcohol causes CNS depression therefore people with alcohol-use problems often state that alcohol decreases their nervousness and anxiety and help them cope with day to day stresses of life.

Many people consume low doses of alcohol in tense social settings, like before handling a stage, etc. to have an enhanced self-esteem and to have improved and at ease social interactions.

It is important to note that these kind of relaxing effects are only there when alcohol is consumed in mild to moderate levels. At high doses, muscle tension, anxiety and nervousness are increased instead.

Psychodynamic Factors

It is hypothetically stated that some people use alcohol to help them deal with their self-punitive harsh superego. For example, Devdas started drinking because he ditched Paro, his childhood love. Unconsciously alcohol intake helps decrease stress levels.

Psychoanalytical theory believes that alcohol intake happens as a result of fixation at the oral stage of psychosexual development. Therefore, these individuals use alcohol to inhibit their frustrations by taking substance by mouth.

Behavioral Factors

Some individuals drink alcohol because they cognitively appraise the benefits of consuming alcohol. They believe that alcohol consumption is so rewarding. Their first experience with alcohol reinforces their decision to drink again. Tolerance is developed and makes it difficult to deal with physical and psychological dependence even in the presence of health issues.

Sociocultural Factors

It is surprising to note that ethnic groups who introduce alcohol to their children in moderate levels have very low rate of alcoholism.

Alcohol consumption is common in those communities where social drinking is an acceptable norm. It is estimated that 40% of the alcohol consumption is influenced and triggered by cultural factors. Cultural attitude and beliefs about alcohol consumption often hit the psychology of a person and make his attitude toward a substance.

Genetic Factors

Research evidenced that the risk of alcohol-related disorders is three to fourfold greater among those who are having close alcoholic relatives. The risk and prevalence of alcohol problems increases with the number of alcoholic relatives. There is increased risk for alcoholism in the offspring of alcoholic parents.

Effects of Alcohol

- Often makers and distributors of alcohol publicize the beneficial effects of alcohol consumption. One epidemiological study revealed that one or two glasses of red wine each day lower the incidence of cardiovascular diseases. However, these findings are controversial.

- **Absorption of alcohol:** Only 10% of the alcohol is absorbed from stomach and remaining 90% is absorbed from the small intestine. The peak level of alcohol in blood reaches within 30–90 minutes. Alcohol absorption is enhanced without food and with food, its absorption is delayed.
  If alcohol is consumed slowly, time for peak concentration reduces and if alcohol is consumed rapidly, peak concentration is slowed down.
- **Pylorospasm:** Pylorospasm, i.e., closing of the pyloric valve is a protective defense mechanism of the body in case of excessive alcohol consumption in short periods of time. When a person consumes alcohol in excess, then mucus is secreted in the stomach and pyloric valve is closed which may also cause nausea and vomiting. By this, body slows down the absorption of alcohol because it does not allow alcohol to pass into small intestine where 90% of the alcohol will be absorbed and unabsorbed alcohol remains in stomach only for hours.
- **Metabolism of alcohol:** Alcohol is oxidized in the liver (approximately 90%) and 10% is excreted through kidneys and lungs. It is interesting to note that excessive alcohol consumption can itself upregulate the necessary enzymes needed for its absorption which is the reason for rapid alcohol metabolism in chronic drinkers. Meaning thereby alcohol itself can make enzymes for its metabolism. The enzymes responsible for metabolism of alcohol are alcohol dehydrogenase (ADH) and aldehyde dehydrogenase.
  ADH converts alcohol into acetaldehyde which is a toxic compound and aldehyde dehydrogenase converts alcohol into acetic acid. It is important to note that disulfiram is capable of inhibiting aldehyde dehydrogenase and can be used as an antabuse.
- **Effect on behavior:** Alcohol is a CNS depressant; therefore, it affects an individual's thought judgment and memory faculties of brain. Voluntary motor activities become clumsy; often manifest as staggered gait. Emotional control is also lessened in alcohol toxic levels. The person may become confused and stupor. At extreme levels, individual can go into come also.
- **Effect on sleep:** Alcohol consumed in evening times can help get sleep.
- **Effect on liver:** Alcohol consumption at higher levels is capable of liver damage adversely. The first symptom will be an accumulation of fats and proteins in the liver which will be clinically diagnosed as fatty liver. The end results can be alcoholic hepatitis and/or hepatic cirrhosis.
- **Effect on gastrointestinal system:** Chronic alcohol consumption can result in esophagitis, gastritis, achlorhydria and gastric ulcers. The other major disorders that may occur because of heavy alcohol consumption are pancreatitis, pancreatic insufficiency or pancreatic cancer. Alcohol intake can interfere with intestine' absorption capacity of vitamins and amino-acids which can result in deficiency disorders.
- Increased blood pressure
- Increased risk of heart attack and other cardiovascular diseases
- **Hypoglycemia in case of acute intoxication:** It may cause sudden death.
- **Muscle weakness**

DSM-5 Criteria for Alcohol Use

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol-use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- **Tolerance, as defined by either of the following:** (A) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. (B) A markedly diminished effect with continued use of the same amount of alcohol.
- **Withdrawal, as manifested by either of the following:**
  - The characteristic withdrawal syndrome for alcohol
  - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Clinical Manifestations of Alcohol Use Disorders

- Inadequate daily functioning
- A regular pattern of heavy drinking which is sometimes limited to weekends
- Binges of heavy alcohol
- **Associated behavioral patterns:**
  - Inability to cut down or stop drinking
  - Repeated efforts to control drinking
  - Periods of temporary abstinence
  - Restricting alcohol to certain times of the day
  - Binges-remains intoxicated throughout day
  - Amnestic periods
  - Blackouts
  - Continuation of drinking despite a serious physical disorder
  - Impaired social and occupational functioning
  - Violence is demonstrated by alcohol users
  - Job loss
  - Absenteeism from work
  - Arrest for intoxicated behavior
  - Arguments or difficulties with family members
  - Regular fights with significant others
- **Alcohol intoxication:** It is also called simple drunkenness. It is characterized by recent ingestion of heavy alcohol, maladaptive behavior and physiological manifestations of alcohol intoxication. The other associated symptoms are as follows:
  - Impaired coordination and judgment
  - Ataxia

- Slurred speech
- Dizziness
- Unsteady gait
- Nystagmus
- Double vision
- Cognitive deterioration
- Severe nausea and vomiting
  - Anterograde amnesia
- Alcoholic blackouts
- Heavy alcohol consumption can also result in first level of anesthesia, respiratory failure, coma or death.

- **Alcohol withdrawal:** It is characterized by cessation of heavy and prolonged alcohol use. It can cause seizures and autonomic hyperactivity.
  The peculiar feature of alcohol withdrawal is tremulousness, i.e., shaking slightly because you are nervous. The associated symptoms are delusions and hallucinations.
- **Delirium tremens:** It is also called Alcohol delirium. It is fatal emergency. It may start usually two to five days after the last drink. Severe alcohol withdrawal symptoms such as shaking, confusion, seizures and hallucinations are included in alcohol delirium.
  The tremors of alcohol withdrawal are similar to the physiological tremor but are of greater intensity. The other associated symptoms are nausea and vomiting, irritability, anxiety, sweating, facial flushing, mydriasis, tachycardia and mild hypertension.
  - **Withdrawal seizures:** Withdrawal seizures can be generalized tonic-clonic seizures.

Treatment

Treatment for alcohol withdrawal symptoms: The main treatment for controlling alcohol withdrawal symptoms are benzodiazepines. Benzodiazepines can help control the withdrawal symptoms including seizures.

All of the benzodiazepines can be given through oral or parenteral route except diazepam and chlordiazepoxide (librium) which should be administered by oral route only.

Benzodiazepines need to be used with caution as they can cause dependency. Therefore, start with a high dose and lower/taper the dose as patient recovers. Sometimes, benzodiazepines are used to keep patient calm and sedated.

The alternative treatment for alcohol withdrawal is carbamazepine in daily doses of 800 mg. β-blockers and clonidine can be used to treat sympathetic nervous system hyperactivity.

Treatment for alcohol withdrawal delirium: It is also known as DTs. Treat alcohol withdrawal delirium as a medical emergency because it can lead to major morbidity and mortality.

The patient with alcohol withdrawal delirium is a potential threat for himself as well as for others. He/she may be assaultive or suicidal because of experiencing delusions and hallucinations. The clinical manifestations include tachycardia, diaphoresis, anxiety, insomnia and increased blood pressure. The condition will be worse if the patient is already having a pre-existing physical illness such as hepatitis or pancreatitis. Therefore, the best treatment for alcohol withdrawal delirium will be prevention. When patient is withdrawing alcohol, he/she should be administered benzodiazepine. The commonly used medicine is chlordiazepoxide in the doses of 25–50 mg every 2–4 hours until patient is out of danger and coping well.

For prevention, the doses are 25–50 mg of chlordiazepoxide. But if delirium occurs, then the doses will be 50–100 mg of chlordiazepoxide every 4 hourly by oral route. Alternatively, lorazepam can be used by Intravenous route.

It is important to consider that patient must take a high-calorie, high-carbohydrate diet supplemented by multivitamins.

In case, patient is a danger for himself and others; use of seclusion room is recommended in contrast use of physical restraints.

For patients suffering with dehydration, fever and diaphoresis; use fluids by oral route or intravenously.

Do not use antipsychotic medications for patients with DTs as they can reduce seizure threshold in patient.

The other treatment modalities that can be used are supportive psychotherapy and skillful verbal support.

- **Treatment for blackouts:** Blackouts are discrete episodes of transient global amnesia because of alcohol intoxication. The individual experiencing blackouts feels distressed because he fears that he/she has unknowingly harmed someone or misbehaved with someone.
- **Treatment for fetal alcohol syndrome:** Women who are pregnant or breastfeeding their child must not consume alcohol as it may result in fetal alcohol syndrome which is characterized by intellectual disability, microcephaly, craniofacial malformations, limb and heart defects. The child with fetal alcohol syndrome is likely to have short adult stature and maladaptive behaviors.

Prognosis of Alcohol Use Disorders

The following conditions favor a positive prognosis:

- Absence of pre-existing antisocial personality disorder
- Absence of other substance abuse or dependence
- Stable life with a job
- Family support with close family contacts
- Absence of legal problems
- If patient stays for full course of initial rehabilitation, prognosis is good.

If all of the above conditions are favorable in a patient with alcohol use disorders, then the chances of abstinence are 60% and one year of abstinence brings a good chance over another years of life.

Other factors that favor abstinence are an individual's motivational level and quality of patient's social support system.

Treatment and Rehabilitation of Alcohol Use Disorders

Treatment and rehabilitation of a patient with alcohol use disorders involves the following three approaches:

Intervention

The intervention phase is also known as confrontation. Alcohol use disorder patients very often use the defense mechanism of denial; so we need to break these feelings of denial and let patient face the reality and give health education about the ill effects of alcohol use and the consequences he will face, if the disorder is not treated.

We certainly do every effort to motivate patient and maximize abstinence. The therapist will make patient focus on the adverse effects which alcohol use is bringing in patient's life such as life impairments, insomnia, difficulties with sexual performance, depression, anxiety or psychotic symptoms.

Detoxification

It is clinically common observation that patients with alcohol use disorder have mild physical and psychological symptoms when they quit drinking. The significant good health of the patient will serve as a boon and patient will not be having severe symptoms of alcohol withdrawal.

The first step in detoxification is to rule out any comorbidity such as medical disorder or other substance abuse, etc.

The second step is to ensure adequate rest, good nutrition with multivitamins with special consideration to thiamine.

For mild to moderate withdrawal: Alcohol is a CNS depressant and when patient' brain is physically dependent on it, it is unable to function adequately without alcohol therefore withdrawal develops. Therefore, the first thing to do is to replace alcohol (CNS depressant) with another brain depressant such as barbiturates or benzodiazepines etc. On first day, give sufficient brain depressant and then over the next 5 days wean the patient from the drug. Drugs that can be used are short-acting drugs such as Lorazepam or long-acting drugs such as chlordiazepoxide and diazepam, etc.

For severe withdrawal: The severe withdrawal symptoms are seen in those patients with alcohol use disorder who exhibit delirium tremens, extreme agitation, confusion and severe dysfunction of the autonomic nervous system. In case of severe withdrawal, benzodiazepines in high doses are recommended. Alternatively, antipsychotic drug such as haloperidol can be used. As in case with mild to moderate withdrawal, same approach is used for severe withdrawal; first and second doses are used to control behavior and patient's doses are tapered around the fifth day.

If patient is experiencing grand mal convulsion, a rarest complication of withdrawal only in 1 percent of the patients, then the first thing to do is neurological examination and then if a seizure disorder is evidenced, then administers anticonvulsant drugs.

Rehabilitation

The treatment of alcohol use disorders is based on holistic approach meaning thereby one must take all the possible efforts to optimize physical and mental health of the patient with alcohol use disorders.

The patient with alcohol use disorders with suicidal ideation needs hospitalization and one to one observation. In the same way, if any person is having physical problems such as liver cirrhosis/cardiomyopathy, etc. along with alcohol use disorders, then his physiological problems also needs to be addressed with the conventional treatment of alcohol use disorders.

In rehabilitation, the following measures are taken on a constant basis:

- High level motivational therapy for consistent abstinence
- Help patient positive adaptation to a lifestyle free from alcoholism
- Prevention of relapse
- Strengthen the social support system
- Teach and help patient execute healthy coping strategies
- Treat the underlying psychopathology such as depression, anxiety, life stress, etc.

- Optimize physical and psychological functioning
- Family therapy
- Individual and group counseling
- Involve patient in self-help groups such as AA, i.e., alcohol anonymous

Counselling

Counseling is given to help patient deal with day-to-day life issues without use of alcohol. While counseling, it is advised to use behavioral or psychotherapeutic approach to optimize motivation for abstinence from alcohol as a resort to deal with life problems.

In counseling, explore the bad consequences of drinking alcohol and positive outcome of quitting alcohol. Help patient to lead a life free from alcohol.

Medications

Benzodiazepines are used to treat insomnia and anxiety, if patient is really on abstinence.

Disulfiram is alcohol sensitizing agent which is given in daily doses of 250 mg. However, disulfiram should not be given to those patients who have preexisting heart disease, cerebral thrombosis or diabetes because an alcohol reaction to disulfiram could be fatal.

Another drug that can be used is opioid antagonist naltrexone, which is used by clinicians to decrease the craving for alcohol and to dull the rewarding effects of drinking.

Another alternative medication is acamprosate (campral) which is available in India as Acamprosate 333 mg and is used to treat patients with alcohol use disorders.

One more drug has been tried in the treatment of alcoholism is non-benzodiazepine antianxiety drug, i.e., buspirone.

Alcoholics Anonymous

This is a self-help group known as AA. The members of this self-help group are having an access to help which will be available 24/7. In this group, members are encouraged to lead a sober life without alcohol consumption. Group members need to be convinced that it is possible to have social interactions without alcohol consumption.

Kinds of groups of AA:

- Only men
- Only women
- Mixed group including both men and women
- Group which includes only professionals
- Groups composed mostly of blue-collar men and women, i.e., those people who are engaged in hard manual labor such as construction, mining, or maintenance.

The therapist must help select patient his/her suitable group. Some groups use religious emphasis to treat alcoholism, others may use other motivations. Still, AA groups are proved to be benefitted millions with alcohol use disorders.

CAFFEINE-RELATED DISORDERS

Caffeine is very commonly used psychoactive substance not only in India but throughout the world. The reason of such wider consumption is that psychoactive substance, i.e., caffeine is found in huge number of plant species.

Caffeine is an alkaloid of methylxanthine class which affects neurobiological and physiological systems and produces psychological effects.

Caffeine use is not fatal or put any person in the danger of death but its consumption can cause psychiatric disorders. Because caffeine is widely accepted ingredient in social settings, people often devalue its harmful benefits on body.

Types of Caffeine-related Disorders

- Caffeine use disorder
- Caffeine intoxication
- Caffeine withdrawal
- Caffeine induced anxiety disorder
- Caffeine induced sleep disorder

Prevalence of Caffeine-related Disorders

Caffeine is easily available and legally salable substance. Therefore, it is a constituent of many drinks and foods. Coca Cola, Energy drinks and Coffee are most commonly consumed caffeine products.

One cup of coffee is having up to 150 mg of caffeine and one cup of tea is having up to 50 mg of caffeine. Other substances available in the market which contain enough caffeine are chocolates, cocoa and cold drinks.

Etiology of Caffeine-related Disorders

Once an individual experiences the desired effects of caffeine, he/she can be influenced to have a daily consumption of caffeine because of any one or combination of following factors:

Personal Factors

Some individuals find consuming caffeine so pleasurable. For example, many of the college students develop habit of drinking coke with every meal just because they find it a pleasurable activity and are unaware of the long-term consequences of consuming caffeine.

Other individuals consume caffeine for energy purposes, enhancing concentration and motivation for doing day-to-day activities.

College students also consume excess amounts of coffee during exam days for keeping themselves alert and awake. But it is a common observation that excessive amount of caffeine then produces unpleasant experiences of anxiety and nervousness.

Genetic Factors

Research evidenced that there might be some genetic predisposition in caffeine use disorders.

Age Factors

It is a common observation that middle-aged people are more likely to consume more caffeine.

Gender Factors

There is no clear difference among men and women regarding use of caffeine.

Personality Factors

Caffeine use is not an accent of a particular personality type.

Other Factors

It is seen that people who are cigarette smokers tend to consume more caffeine than those who are not smoking cigarettes. It is also the case with alcoholics and non-alcoholics. People who consume alcohol are more prone to caffeine use disorders.

Research evidenced that prisoners consume more caffeine as compared to general population.

DSM-5 Criteria for Caffeine Use

- Recent consumption of caffeine (typically a high dose well in excess of 250 mg). Five (or more) of the following signs or symptoms developing during, or shortly after, caffeine use:
  - Restlessness
  - Nervousness
  - Excitement
  - Insomnia
  - Flushed face
  - Diuresis
  - Gastrointestinal disturbance
  - Muscle twitching
  - Rambling flow of thought and speech
  - Tachycardia or cardiac arrhythmia
  - Periods of inexhaustibility
  - Psychomotor agitation
- The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance

Signs and Symptoms of Caffeine Use Disorders

- Restlessness
- Nervousness
- Excitement
- Insomnia
- Flushed face
- Diuresis

- Gastrointestinal disturbance
- Muscle twitching
- Rambling flow of thought and speech
- Tachycardia or cardiac arrhythmia
- Periods of inexhaustibility
- Psychomotor agitation

Whenever an individual consumes more than usual intake of caffeine, e.g., 4–5 cups of brewed coffee, the individual experiences more alertness and an improved sense of well-being plus a finer verbal and motor activity.
The other associated factors are as follows:

- Increased urination
- Increased rate of peristalsis
- Stimulation of cardiac muscles
- Hypertension
- Increased production of gastric acid

Treatment of Caffeine Use Disorders

If the individual tries to leave the substance, he/she experiences withdrawal symptoms such as muscle aches plus headache. In case of withdrawal symptoms, give symptomatic treatment such as pain killers for pain relief.

Keep a record of caffeine intake. Keep a list of all the food stuffs patient consumes which contains caffeine, e.g., coffee, beverages, etc.

Keeping a record will help you cut down caffeine intake even in smaller doses. Cut down slowly as it will help deal with withdrawal symptoms of caffeine use.

CANNABIS USE DISORDERS

Cannabis stands at number four among all the substances which are abused with first place of caffeine followed by alcohol then nicotine. Cannabis is the illegal drug used and abused worldwide in developed, developing as well as underdeveloped communities.

Cannabis is a drug that can be extracted from the plant cannabis sativa. This plant does have medicinal properties and is commonly used in India. Other than medicinal value, cannabis has psychoactive effects.

How Cannabis is Used as a Psychoactive Substance

The leaves of cannabis plant are dried and out of it, a black-brown substance is extracted which is called HASHISH.

Another way to use cannabis is to role it into cigarettes and smoke. It is also a very harmful way and can cause lung cancer.
Other forms of cannabis are:

- Marijuana
- Weed
- Tea
- Charas

- Bhang
- Ganja

In India, Cannabis is even given as a *Prasad* in temples on some special occasions.

DSM-5 Criteria for Cannabis Use

- A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
  - Cannabis is often taken in larger amounts or over a longer period than was intended.
  - There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
  - A great deal of time is spent in activities necessary to obtain cannabis, use cannabis or recover from its effects.
  - Craving, or a strong desire or urge to use cannabis.
  - Recurrent cannabis use resulting in a failure to fulfil major role obligations at work, school, or home.
  - Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
  - Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
  - Recurrent cannabis-use in situations in which it is physically hazardous.
  - Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
  - Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of cannabis to achieve intoxication or desired effect
    - Markedly diminished effect with continued use of the same amount of cannabis
  - Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for cannabis
    - Cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Signs and Symptoms of Cannabis Use

- **Increased appetite:** An individual who is having cannabis-use disorder will eat more than usual.
- Red eyes
- Orthostatic hypotension
- Tachycardia
- **Dry mouth:** A sign of cannabis intoxication
- Cannabis used as an inhalant can cause respiratory distress and in worst cases, lung cancer.

In Heavy Doses and Chronic Consumption

- Cerebral atrophy
- Weak immune system
- Reduction of seizure threshold
- Altered levels of testosterone
- Irregular menstrual cycles
- Cognitive decline
- Flashbacks

Treatment of Cannabis Use Disorder

Treatment modalities of cannabis use include the following:

- **Abstinence:** Have one to one observation in case with chronic heavy abuse. Hospitalize if you find it necessary to ensure abstinence. Daily urine testing should be done to monitor drug levels in body.
- Supportive therapy
- Family therapy
- Individual therapy
- Group psychotherapy
- Motivational psychotherapy
- Antianxiety drugs to manage withdrawal symptoms
- Treat any underlying pathology or comorbid disorder, if any.

Nursing management of substance use disorders is depicted in Table 16.

Table 16: Nursing management of substance use disorders

Nursing diagnosis	Nursing interventions	Outcome criteria
Ineffective denial related to use of faulty ego defense mechanisms	• Establish a trustworthy nurse patient relationship. • Accept the patient as he is. • Correct patient's interpretation of denial and explain about healthy defense mechanisms usage to deal with life stressors. • Provide health education about ill effects of substance use. • Do not allow patient to use faulty defense mechanisms such as denial, rationalization and projection. • Administer antidepressants and benzodiazepines as prescribed.	• The patient will understand usage of faulty defense mechanisms. • The patient will verbalize the ill effects of substance use on body.
Imbalanced nutrition: Less than body requirements related to loss of appetite for food	• Administer IV fluids in case patient does not eat orally. • Do not allow patient to drink alcohol or smoke. • Maintain the nutritional status of patient. • Monitor patient weight. • Maintain intake and output chart. • Ensure adequate protein intake. • Provide small frequent meals.	The patient will be able to maintain an ideal body weight.
Ineffective coping related to weak ego defense system	• Explain to the patient that there are other methods to deal with stress other than substance use. • Maintain adequate nutritional support to boost up the immune system which in turn will support ego defense mechanisms. • Provide encouragement for abstain from substance use. • Individual psychotherapy. • Alcohol anonymous group therapy is beneficial. • Be supportive.	The patient will be able to use other coping strategies instead of substance use.

5J: SLEEP DISORDERS

Sleep is a normal physiological function of the body to promote rest. If anyone does not experience sound sleep, he/she may have sleep disorders. Sleep disorders are p otentially dangerous for the one who is suffering and for others who are accompanying the sufferer. Sleep disorders are expensive to treat also.

One third of a human life is being spent in sleeping. Sleeping is universal i.e., there is no one who has ever conquered his/her sleep. Sleep is a human behavior that is part and parcel of human life.

One's brain will function properly if his/her sleep will be sound. A sound sleep helps you to make good/right decisions because then the brain functioning is proper. If any person is being deprived from normal sleep, then he/she may suffer physical or cognitive impairment.

It is surprising to note that prolonged sleep deprivation may lead to death eventually. We always assume that when we sleep, brain is resting but this is not the case. When an individual sleeps, his/her brain is highly activated and functioning.

CHARACTERISTICS OF SLEEP

- Quantity
- Quality
- Functional importance
- Regulatory mechanisms

If a person is being deprived of his/her normal sound sleep which has the above given characteristics, then it would not only lack only sleep but all the functional and regulatory mechanisms which he does during sleep. Sleep alterations are common in every kind of mental disorders.

Sigmund Freud has given sleep an important place in an individual' mind. He exclaimed that while sleeping, an individual's unconscious mind is working more efficiently and in active form. According to him, "dreams are the royal road to the unconscious of the individual."

Dreams are playing an important role in the Psychoanalysis of the patient.

STAGES OF SLEEP

- Wakefulness
- Non-rapid eye movement (NREM)
- Stage-I (low voltage), mixed frequency activity
- Stage-II (low voltage), mixed frequency background
- Stage-III (high amplitude), slow waves
- Stage-IV (high amplitude), slow waves
- Rapid eye movement (REM)

PHYSIOLOGY OF SLEEP

The physiology of the sleep is divided into two physiological states:

Non-rapid Eye Movement (NREM)

In NREM phase, the physiological functions of the individual are lower than in wakefulness in a very obvious and noticeable way. NREM phase starts after 90 minutes of sleep onset. It is a peaceful state in comparison to waking. The pulse rate, respiratory rate and blood pressure is typically slow but regular.

In NREM phase, involuntary body movements happen episodically. In men, sometimes, penile erections occur. The blood flow is also slightly reduced in NREM phase of the sleep.

If in the deepest stages of NREM sleep, an individual gets aroused usually after 30 minutes to 1 hour after sleep onset, he/she is disoriented and has disorganized thinking. Any disturbances at this stage of disorganized thinking may results in sleep problems such as enuresis, night mares and night terrors etc.

Rapid Eye Movement (REM)

In quality terms, REM sleep is different from NREM sleep. In REM phase, the physiological activities of the individual are at the same pace as these were when the individual is awake. But the main essence of this sleep is this that in REM, there is high level of brain activity. REM is followed by NREM and is usually of 90 minutes. Any disturbances in the REM phase will result in sleep disorders such as narcolepsy or depression etc.

The most characteristic feature of REM sleep is dreaming.

The sleep patterns are similar to that of awaken person in the REM stage and even pulse, respiration and blood pressure is also higher than that is observed in NREM stage and during waking. That's why REM sleep is also named as paradoxical sleep.

The oxygen consumption is also increased during REM phase of sleep.

There are alterations in thermoregulation during REM phase of sleep. This could be the reason for failure to respond to changes in surrounding temperature with physiological compensatory mechanisms of shivering and sweating.

In almost every phase of REM sleep, there is partial or full penile erection.

It is interesting and noteworthy that it is during REM phase of sleep where almost entire paralysis of the skeletal muscles occurs.

Sleep patterns are changed over individual's lifespan. The typical adult distribution of sleep during different stages is as follows:

- NREM (75%)
- Stage-I (5%)
- Stage-II (45%)
- Stage-III (12%)
- Stage-IV (13%)
- REM-(25%)

The electrophysiology of the sleep can be assessed by the following three variables:

1. **Electroencephalogram (EEG)**
   EEG helps to recognize features of the sleep state such as no or few rapid eye movements in NREM phase.
2. **Electrooculogram (EOG)**
3. **Electromyogram (EMG)**
   It is depicting the noticeable reduction in the muscle tone during sleep.

REGULATION OF SLEEP

- There are a number of interconnecting systems mainly in the brainstem, which are regulating the sleep by either activating or inhibiting one another.
- If there is reduced serotonin level in the nervous tissue either because of reduced serotonin synthesis or destruction of the nucleus (raphe) that contains serotonergic cell bodies may cause insomnia, nocturnal awakenings.
- The cell bodies of neurons, which contain norepinephrine also help regulating normal sleep patterns.
- Drugs capable of increasing noradrenergic neuronal firing can also cause insomnia because it increases wakefulness.
- Acetylcholine is helpful in inducing REM sleep.
- There is also altered cholinergic activity in sleep disorders.
- Melatonin is helpful in inducing sleep. Low concentrations of melatonin decrease sleep.
- Increase in dopamine concentrations in nervous tissue produce alertness and wakefulness. Dopamine blockers increase the sleep time.

FUNCTIONS OF SLEEP

- Restoration
- Hemostasis
- Thermoregulation
- Energy conservation

NORMAL SLEEP REQUIREMENTS

The normal sleep of different individuals varies accordingly. It is given as follows:

- **Short sleepers:** Need fewer than 6 hours of sleep every night to function adequately. These individuals are efficient, socially adequate and efficient workers.
- **Long sleepers:** Need more than 9 hours of sleep every night to function adequately. Long sleep has more REM phases in one-night sleep. These individuals are candidates for mild depression, anxious and socially withdrawn.
- At some periods of time, the sleep requirements are more such as during physical work, exercise, illness, pregnancy, stress, etc.

CLASSIFICATION OF SLEEP DISORDERS

According to DSM-5

- Insomnia disorder
- Hyper somnolence disorder
- Narcolepsy
- Breathing-related sleep disorders
  - Obstructive sleep apnea Hypopnea
  - Central sleep apnea
    - Idiopathic central sleep apnea

    - Cheyne-Stokes breathing
    - Central sleep apnea comorbid with opioid use
    - Sleep-related hypoventilation
- Circadian rhythm sleep-wake disorders:
    - Delayed sleep phase type
    - Advanced sleep phase type
    - Irregular sleep-wake type
    - Non-24-hour sleep-wake type
    - Shift work type
    - Unspecified type
- Parasomnias
- Non-rapid eye movement sleep arousal disorders:
    - Sleepwalking type
    - Sleep terror type
- Nightmare disorder
- Rapid eye movement sleep behavior disorder
- Restless legs syndrome
- Substance/medication-induced sleep disorder

Insomnia Disorder

Definition

Insomnia refers to difficulty in initiating or maintaining sleep with associated symptoms such as early morning awakening, problems in returning to sleep after awakening, etc.

Insomnia is the most common sleep complaint.

Insomnia can be transient or persistent.

DSM Definition of Insomnia

Insomnia disorder is defined as dissatisfaction with sleep quantity or quality associated with one or more of the following symptoms:

- Difficulty in initiating sleep
- Difficulty in maintaining sleep with frequent awakenings
- Problems returning to sleep
- Early morning awakening with inability to return to sleep

Types of Insomnia

On the Basis of Duration

- Transient
- Short duration
- Long duration

Another Classification

- Sleep-onset insomnia
- Sleep-maintenance insomnia
- Early-morning awakening

Prevalence

The insomnia disorder is prevalent in 30–45% of adults at some or other time of the life.

DSM-5 Diagnostic Criteria for Insomnia

Signs and Symptoms

- Predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:
  - Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.)
  - Difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings. (In children, this may manifest as difficulty returning to sleep without caregiver intervention.)
  - Early-morning awakening with inability to return to sleep.
- The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- The sleep difficulty occurs at least 3 nights per week.
- The sleep difficulty is present for at least 3 months.
- The sleep difficulty occurs despite adequate opportunity for sleep.
- The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., narcolepsy, a breathing-related sleep disorder, a circadian rhythm sleep-wake disorder, a Parasomnia).
- The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.

Medical Management

Pharmacological Treatment

- Benzodiazepines
  - Zolpidem
  - Eszopiclone
  - Zaleplon
  - **Primary insomnia:** Primary insomnia is not caused by lifestyle habits or any other psychiatric cause and it is t by decreased ability to fall asleep/stay asleep with resulting daytime effects of sleep deprivation such as fatigue, dozing off and irritability.

  - To treat primary insomnia, the psychiatrist can use benzodiazepines such as zolpidem, eszopiclone, zaleplon and hypnotics.
  - The major problem with the use of sedatives and hypnotics is that patients develop tolerance and withdrawal. Therefore, these medications should not be prescribed for more than 2 weeks.
- Hypnotics
- Long acting sleep medications
  - Flurazepam
  - Quazepam
  - Triazolam
  - Long-acting sleep medications are used to treat middle of the night insomnia.
- Short-acting drugs
  - Zolpidem
  - Triazolam
  - These are best drugs for individuals who have difficulty falling sleep.
- Over-the-counter medications
- L-tryptophan
- Melatonin receptor agonist
- Rozerem
- This is used for treating sleep onset insomnia.
- Sedating anti-Hypertensive
  - Trazodone
- Self-administered food additives
  - Melatonin

Cognitive-behavioral Therapy

Cognitive-behavioral therapy (CBT) is employed in patients experiencing sleep disorders to treat dysfunctional sleep behaviors and distorted thinking patterns during sleep.
The behavioral techniques used in CBT are:

- Universal sleep hygiene
- Stimulus control therapy
  This therapy is a de-conditioning program in which cycle of problems in relation with difficulty initiating sleep is broken. This therapy is executed in the following steps:
  - Go to sleep only when feel sleepy
  - Use bed only for sleeping. Do not watch television in bed, do not read or eat in bed and not even talk on phone in bed.
  - Do not become frustrated if you are unable to sleep on bed. After sometime watching clock, don't stay there. Get up and go to another room and keep yourself awake until sleep returns.
  - Rule no. C should be repeated as and when required.
  - Be awake at the same time every morning irrespective of late night sleep, total sleeping hours).
  - Avoid daytime napping.
- Sleep restriction therapy
  - This therapy is based to decrease the time spent awake while lying in bed.

- If the patient only sleeps for 6 hours, ask patient to stay there only for 6 hours and not to just lying down in the bed without sleep.
- You can reduce time in bed up till 5 hours but not less than 4 hours per night.
- Avoid daytime sleeping in adults although elderly can take nap of 30 minutes in a daytime.

Relaxation Therapies

- Self-hypnosis
- Progressive relaxation
- Guided imagery
- Deep breathing exercises

Biofeedback

Biofeedback increases an individual's awareness. Here, we use a machine which will measure muscle tension in the forehead and/or finger temperature.

Muscle tension is decreased when the patient is relaxed.

Finger temperature is increased when the patient is relaxed.

It takes time and patience to learn and apply biofeedback and relaxation techniques by patient itself.

Although medications are there for providing improvement in sleep disorders but the effects of the cognitive behavioral therapy are long lasting. With treatment by the use of insomnia, insomnia relapses after cessation of drug therapy therefore use of CBT is found to be more efficient in treating insomnia.

The limitations of CBT are also there. First, it takes longer than usual to have benefits of CBT may be more than several weeks after which therapy will provide relief in insomnia. For patients, who want quick fix of their problems, CBT will not be a treatment of choice. CBT requires commitment to attend multiple sessions.

Sleep Hygiene Practices

- Maintain regular timings for sleep and awakening.
- Eat bedtime light snacks.
- Drink a glass of milk before going to sleep.
- Maintain cool environment in bedroom.
- Keep bedroom noise free.
- Exercise in the evening to make you tried to get a sound sleep.
- Watch television while lying down in bed.
- Eat on bed.
- Keep talking in bed with someone lying next to you or on telephone.
- Drink coffee in afternoon.
- Read yourself in bed; a good story book/novel.
- If you are worrying about anything, write it down and ask yourself that you will work on this problem tomorrow morning.
- Give yourself an hour before you go to sleep to wind down.
- Talk on phone in bed.

- Exercise in bed
- Eat in bed
- Read in bed when you can't sleep
- Use alcohol to help get you sleep when it is so distorting and disturbing cognition.
- Keep the bedroom dark. Keep all curtains on.
- Maintain a quiet bedroom.
- Watch the clock continuously to unconsciously telling yourself that how bad your insomnia is.
- Eat a heavy meal before bed if it helps you to get sleep.

Hypersomnolence Disorder

Another name: Excessive sleepiness

Definition

Hypersomnolence is characterized by sleeping in excess which is potentially life-threatening and affects individual and others in a negative way.

In literal meaning, hypersomnolence is excessive sleeping. It is a serious disorder affecting personal, social and occupational functioning of the individual.

The possible causative factors of excessive sleepiness are:

- Insufficient sleep
- Neurologic dysfunction
- Disturbed sleeping patterns

The person feels like a debt of not sleeping adequately and then he compensates and pays this debt by excessive sleeping.

Sleepiness can be in the form of sleep attacks. The person who didn't sleep his/her set hours at time lapse into sleep in daytime and sleep in excess.

Hypersomnolence disturbs an individual's attention, concentration, memory and other cognitive functions adversely. It affects individual's personal, social and occupational functioning.

Therefore, it affects school performance, work performance, etc. in a bad shape. The individuals with hypersomnolence are prone to motor bike accidents and accidents caused by operating dangerous machinery.

Some individuals have normally adopted the habit of being long sleepers. Their sleep physiology is normal in that respect and in terms of sleep efficiency and sleep-wake schedule.

Types of Hypersomnia

- **Kleine-Levin syndrome:** It is characterized by recurrent periods of prolonged sleep. During these hypersomnia periods, individuals will withdraw him/her from social contacts and will be searching for an opportunity to fall asleep as soon as he/she finds one.

  It is more common in males as compared to women in adulthood. This syndrome is having other symptoms such as hyper-sexuality, disinhibition and eating large amounts of food.
- **Menstrual-related hypersomnia:** This is hyper-somnolence that occurs before the onset of menstrual cycle. These symptoms usually occur for duration of one week and it is resolved with menstruation. The cause for menstrual-related hypersomnia may be endocrinal disorder.

- **Idiopathic hypersomnia:** It is characterized by excessive sleepiness without any additional symptoms. As name suggests, the etiology of the idiopathic hypersomnia is unknown. The onset of disorder is adolescents and in adulthood.
  The other symptoms include naps, difficulty awakening, migraine headaches, syncope, orthostatic hypotension and sleep drunkenness. idiopathic hypersomnia is having its onset usually before 25 years of age.
- **Insufficient sleep syndrome:** If a person does not keep sleep-wake schedule properly then he/she is a potential candidate for insufficient sleep syndrome. This kind of sleepiness is patient caused and he/she is confident to handle it. When a person does not keep a schedule of sufficient amount of sleep, he feels a debt for less sleep and it is paid as daytime sleepiness, fatigue, moodiness, and irritability and concentration lack with impaired memory.
- Hypersomnia due to a medical condition
- Hypersomnia due to drug and substance use

DSM-5 Diagnostic Criteria for Hypersomnolence Disorder

Signs and Symptoms

- Self-reported excessive sleepiness (hypersomnolence) despite a main sleep period lasting at least 7 hours, with at least one of the following symptoms:
  - Recurrent periods of sleep or lapses into sleep within the same day.
  - A prolonged main sleep episode of more than 9 hrs/day that is nonrestorative (i.e., unrefreshing).
  - Difficulty being fully awake after abrupt awakening.
- The hypersomnolence occurs at least three times per week, for at least 3 months.
- The hypersomnolence is accompanied by significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.
- The hyper-somnolence is not better explained by and does not occur exclusively during the course of another sleep disorder (e.g., narcolepsy, breathing-related sleep disorder, circadian rhythm sleep-wake disorder, or a parasomnia).
- The hypersomnolence is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- Coexisting mental and medical disorders do not adequately explain the predominant complaint of hypersomnolence.

Medical Treatment

Maintain scheduled sleeping and awakening.

Pharmacology

- Modafinil
- Amphetamines
- Antidepressants
- SSRIs

Psychotherapy

Counseling

Narcolepsy

Definition

Narcolepsy is characterized by sleep attacks during day times, frequent naps for ten to twenty minutes of sleeping.

The sleep attacks of narcolepsy constitute irresistible sleepiness which includes 10–20 minutes of sleep for temporary refreshment.

Narcolepsy occurs at inappropriate times such as while an individual is eating, talking, or driving and during sex. This is really dangerous as it can cause automobile and other accidents.

The usual onset of narcolepsy is in adolescents or in young adulthood. In narcolepsy, patient cannot avoid sleep. The other associated symptoms are cataplexy, i.e., sudden loss of muscle tone, jaw drop, head drop, weakness of knees and paralysis of all skeletal muscles.

Within 1 or 2 minutes, they return to normal awake state after sleep attack.

Narcolepsy with cataplexy is having following symptoms:

- Excessive daytime sleepiness
- **Cataplexy:** In individuals with long-standing disease, brief (seconds to minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that is precipitated by laughter or joking.
- In children or in individuals within 6 months of onset, spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.
- **Sleep paralysis:** Sudden paralysis usually numbness while sleeping. The person is unable to move yet he feels conscious.
- **Hypnagogic hallucinations:** Hypnagogic means a state immediately before falling asleep. These are vivid dreams that occur while patient is still conscious.

Cataplexy is activated by strong emotions such as laughter and anger. It may occur from several seconds to minutes. The other associated symptoms are social isolation, difficulty with school and work performance.

DSM-5 Diagnostic Criteria for Narcolepsy

Signs and Symptoms

- Recurrent periods of an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day. These must have been occurring at least three times per week over the past 3 months.
- The presence of at least one of the following:
  - Episodes of cataplexy, defined as either (a) or (b), occurring at least a few times per month:
    - In individuals with long-standing disease, brief (seconds to minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that is precipitated by laughter or joking.
    - In children or in individuals within 6 months of onset, spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.

- Hypocretin deficiency, as measured using cerebrospinal fluid (CSF) hypocretin-1 immunoreactivity values (less than or equal to one-third of values obtained in healthy subjects tested using the same assay, or less than or equal to 110 pg/mL). Low CSF levels of hypocretin-1 must not be observed in the context of acute brain injury, inflammation, or infection.
- Nocturnal sleep Polysomnography showing rapid eye movement (REM) sleep latency less than or equal to 15 minutes, or a multiple sleep latency test showing a mean sleep latency less than or equal to 8 minutes and two or more sleep-onset REM periods.

Medical Treatment

Pharmacology

- Maintain strict sleep hygiene. Do not allow the patient to take naps during day time.
- Modafinil
- SSRIs (Fluoxetine)
- Imipramine
- Counselling sessions

Nursing care plan for sleep disorders is depicted in Table 17.

Table 17: Nursing care plan for sleep disorders

Nursing diagnosis	Nursing interventions	Outcome criteria
Insomnia		
Disturbed sleep pattern related to medical/ psychological disease	• Institute sleep hygiene methods. ▪ Maintain regular timings for sleep and awakening. ▪ Eat bedtime light snacks. ▪ Drink a glass of milk before going to sleep. ▪ Maintain cool environment in bedroom. ▪ Keep bedroom noise free. ▪ Exercise in the evening to make you tried to get a sound sleep. ▪ Watch television while lying down in bed. ▪ Eat on bed. ▪ Keep talking in bed with someone lying next to you or on telephone. ▪ Drink coffee in afternoon. ▪ Read yourself in bed; a good story book/novel. ▪ If you are worrying about anything, write it down and ask yourself that you will work on this problem tomorrow morning. • Relaxation therapy • Administer sedatives/hypnotics as prescribed.	• No reported early morning awakening, insomnia. • Normal sleep pattern.
Hypersomnia		
Risk for injury related to aspiration, sleep-walking	• Maintain scheduled sleeping and awakening. • Keep side-rails raised and bed in a low position. • Keep night bulb on. • Ensure patient safety. • Remove all clutters from the pathway. • Keep a bell near patient's bed.	No reported incidents of injury.

5K: EATING DISORDERS

ANOREXIA NERVOSA

Definition

Anorexia nervosa is characterized by compulsive starvation, persistent fear of getting fat and physical manifestations of starvation such as malnutrition, underweight, nutritional deficiencies, etc.

The term anorexia nervosa is derived from the Greek language and is the same term which is used for loss of appetite. An individual is believed to suffer from anorexia nervosa if he fulfils the criteria of the three features as follows:

- Self-induced starvation (behavior component)
- Undying urge for thinness and pathological fear of being fat (psychopathology component)
- Presence of physiological signs and symptoms caused by starvation (physiological component)

Fig. 72: Anorexia nervosa

Anorexia nervosa is often associated with disturbed body image and a delusion that a person's body is fat as compared to others in spite of extreme starvation (Fig. 72).

Sub-types of Anorexia Nervosa

- Restricting type of anorexia nervosa
- Binge/purge type of anorexia nervosa
  - The individual in both types suffers from low self-esteem related to body weight. The individual's mind is always preoccupied with the thoughts of shape and size of the body affecting his/her mood and behavior.
  - 50% of all individuals suffering with anorexia nervosa will reduce their total food intake and their weight will be reduced drastically.
  - Remaining 50% will also engage themselves in binge eating followed by purging behaviors.
  - Anorexia nervosa is usually considered as an eating disorder of females but that does not mean that it is not affecting males. The matter of the fact is that it is more prevalent in females as compared to males; it may be due to more societal pressure on female gender to adopt a certain ideal beauty.
  - The disorder has its onset usually in adolescence, i.e., a transition period from girlhood to woman-hood.
  - Adolescents are extremely preoccupied with weight, food and body shape.

Prevalence

The overall prevalence of anorexia nervosa is 0.5–5% among adolescents and young women.

This disorder is more prevalent in pre-pubertal girls and boys. Many of them are having the onset of disorder in their early 20s. This disorder is more prevalent in upper class.

The disorder is most commonly seen in developed countries in comparison with developing countries. This disorder is also most common in those professions that demand thinness such as modelling and ballet.

Anorexia nervosa is having comorbidity with depression, social phobia and obsessive-compulsive disorders.

Etiology

In the etiology of anorexia nervosa, biological, social and psychological factors are employed.

- **Biological factors:**
  - Increased level of endorphins (endogenous opioids). Endogenous opioids may have ignited the response of denial of hunger in patients suffering with anorexia nervosa.
  - Enlarged CSF spaces
  - Enlarged Sulci and ventricles
  - Higher caudate nucleus metabolism
  - Dysfunction in serotonin, dopamine and norepinephrine
  - Altered humoral factors of CRF, i.e., corticotropin-releasing factor, gonadotropin releasing hormone and thyroid stimulating hormone
- **Neuroendocrine changes:**
  The alterations are found in the following hormones/neurotransmitters:
  - Corticotrophin releasing hormone (CRH)
  - Plasma cortisol levels
  - Diurnal cortisol difference
  - Luteinizing hormone (LH)
  - Follicle-stimulating hormone (FSH)
  - Growth hormone (GH)
  - Somatomedin C
  - Thyroxine (T4)
  - Triiodothyronine (T3)
  - Thyrotropin stimulating hormone (TSH)
  - Insulin
  - Vasopressin
  - Serotonin
  - Norepinephrine
  - Dopamine
- **Social factors:**
  - Societal impression of beauty as thinness and slim built
  - Stressful relationship with family members
  - Peer pressure
  - Close but troubled relationships
  - High levels of hostility in family
  - Chaos and isolation in family relationships
  - Low levels of nurturance and empathy
  - Strained marital relationships
  - Vocational interests (Ballet or Modeling)
  - A man with gay orientation would also like to follow norms for slimness

- **Psychosocial factors:**
  - Obsessions with being thin
  - Unhealthy defense mechanisms
  - Lack of autonomy
  - Obsession with perfection in terms of body image
  - As an effort to gain validation as a unique and special person
  - Acts of extraordinary self-discipline
  - To develop a sense of autonomy and selfhood
- **Psychoanalytical theory:**
  - Anorexia nervosa is usually seen in those individuals who may have an intrusive and unempathetic mother.
  - Young people who are unable to separate themselves from their mothers psychologically.
  - Psychological conflicts and use of unhealthy defense mechanisms such as projection of unacceptable desires.

Signs and Symptoms

- Starvation
- Fear of being fat
- Amenorrhea
- Bradycardia
- Malnutrition
- Nutritional deficiencies
- Refusal to eat more frequently
- Anorexia
- Self-induced vomiting
- Ritualistic exercising
- An intense fear of becoming obese
- Patients with anorexia nervosa often refuse to eat with their families, friends or in public places
- Patients with anorexia nervosa lose weight by drastically reducing their total food intake.
- Patient will actively reduce intake of high-carbohydrate and fatty foods.

The term 'anorexia' is a name that is wrong and inappropriate because this symptom is usually rare until the disorder enters in its late stage. This means that although patients do have appetite and want to eat food but they refuse themselves eating anything because they are too afraid to gain weight.

This will be demonstrated by patient in this way that they will be constantly thinking about food which will be verbalized by them in explaining their passion for collecting recipes and for preparing elaborate meals for others.

When patient is not able to control/restrict themselves from food intake, they start eating binges. Binge eating is done in secret and is usually followed by self-induced vomiting.

The other associated features are laxatives and diuretics abuse to lose weight, ritualistic exercising, extensive cycling/walking/jogging/running, etc.

Strange Behavior about Food

- Hiding food all over the house
- Carrying large quantities of candies within their bags/purses
- Disposing food in napkins and hiding food in pockets
- A patient with anorexia nervosa will cut meat into very small pieces and then will rearrange all of the pieces in his/her plate.
- They will never talk about their strange/weird behavior.

Comorbidity: Obsessive compulsive behavior, depression and anxiety. A patient with anorexia nervosa will tend to be rigid and perfectionist.

Somatic complaints: Epigastric discomfort

Compulsive stealing (of candies, laxatives, clothes or other items)

Poor sexual adjustment (markedly decreased interest in sex)

- Premorbid history of substance abuse
- Physical signs in profound weight loss (dependent edema, bradycardia, hypotension)
- Amenorrhea
- Induced vomiting
- Hypokalemic alkalosis in case patient vomits
- Altered serum electrolyte levels

Food-restricted Type

It is prevalent among 50% of all patients with anorexia nervosa (Fig. 73). The patient restricts himself from food intake. The patient will attempt to consume less than 300 to 500 calories per day.

Fig. 73: Food-restricted type

Purging Type

It is characterized by alternate attempts at rigorous dieting with intermittent binge episodes. When patient is done with binge eating, it ignites anxiety in the patient and to compensate for the unwanted calories, he/she will indulge themselves in self-induced vomiting, laxative abuse, diuretics abuse and emetics (Fig. 74).

At times, purging can happen without prior binge eating but only ingesting few calories.

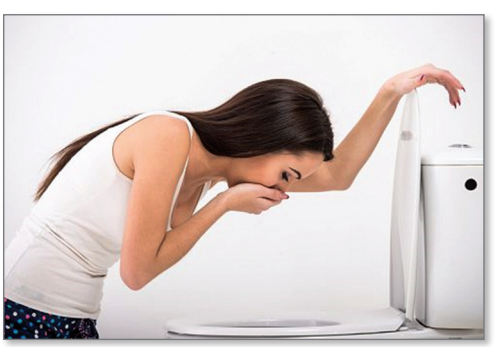


Fig. 74: Purging type

DSM-5 Diagnostic Criteria for Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

- Intense fear of gaining weight or of becoming fat or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

The minimum level of severity is based, for adults, on current body mass index (BMI) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI >17 kg/m^2

Moderate: BMI <16–16.99 kg/m

Severe: BMI <15–15.99 kg/m

Extreme: BMI <15 kg/m

Prognosis

Prognosis of anorexia nervosa varies among patients.

In some patients, spontaneous recovery can happen without any medical interventions or treatment. At times, a fluctuating course may result in which first weight gain occurs which is followed by relapse.

Another possibility is a deteriorating course which may result in death of the patient. The cause in that case will be complications of starvation.

If patient has regained sufficient weight again, then relapse may occur and patient will again exhibit preoccupation with food and body weight. Patient with anorexia nervosa will have poor social relationships and are prone to depression.

Patients with anorexia nervosa will have good prognosis if they admit their hunger and do not use denial as a defense mechanism.

Medical Management

- **Hospitalization**
  - Maintain nutritional status of the patient.
  - Maintain hydration.
  - Maintain electrolyte imbalance.
  - Those patients, who have body weight less (20%) than normal is a candidate for hospitalization.
  - The treatment of anorexia nervosa constitutes a comprehensive treatment plan and includes hospitalization, if required.
  - The decision for hospitalizing a patient is made on the basis of patient's medical condition.
  - Hospitalization will bring outstanding positive outcomes if staff maintains a firm and supportive approach with patient of anorexia nervosa.
  - The positive reinforcement can be in the form of praise and the negative reinforcement is restriction of exercise.
  - The treatment is successful only when patients are willing to cooperate and comply with therapeutic interventions. Although in most of the cases, patients rarely accept the recommendation of health

care professionals without arguing and criticism. In that case, give health education on benefits of hospitalization such as insomnia and depression of the patient will be treated.

- Weigh patient daily, usually early in the morning after emptying the bladder.
- Daily fluid intake and urine output should be recorded.
- Monitor serum electrolyte levels in case of vomiting.
- The staff should make washroom inaccessible for the patient for at least 2 hours after meals because patient will do regurgitation after every meal.
- Instruct patient to eat normally as it will relieve constipation. Occasionally stool softeners can be used.

Patients with anorexia nervosa also need immediate attention at the time of recovery, i.e., at the time when they again start eating. If patient starts eating large amount of calories, then there is possibility of stomach dilation and circulatory overload. Therefore medical interventions in this case includes following:

- The patient should be given 1500–2000 calories per day, i.e., about 500 calories above the amount required to maintain present weight.
- Give food in divided calories in six equal feedings in one complete day.
- Patient must be discouraged to eat large portions of food at one sitting.
- The diet can be supplemented with some liquid foods.

- **Psychotherapy**
  - **Cognitive behavioral therapy:** Research has evidenced that cognitive behavioral therapy has been proved to be effective in treatment of anorexia nervosa. The key feature of CBT in case of patient with anorexia nervosa is monitoring (Fig. 75). The therapist instructs patient to monitor following:
    - Daily food intake
    - Feelings and emotions in relation with food
    - Binging and purging behaviors
    - Problems in interpersonal relationships because of disease condition

    Fig. 75: Psychotherapy

    The therapist challenges the patient to reconstruct his thoughts by cognition and change negative emotions and thoughts in regard with eating to positive and beneficial thoughts. Basically, core beliefs of the patient in regard with food and eating are reconstructed in cognitive behavioral therapy.

    Another approach in CBT is problem solving method. In this method, patient learns to make and implement coping strategies to cope with food related and interpersonal problems.
  - Individual psychotherapy
  - Supportive psychotherapy focused on positive reinforcement
    - Restriction of negative behaviors such as exercise, self-induced vomiting, etc.
    - **Dynamic psychotherapy:** Dynamic therapy is expressive supportive therapy. Because patient of anorexia nervosa exhibits great resistance towards therapeutic interventions, therefore, the main initial therapy is just focused on building a therapeutic alliance.

      Do not interpret patient's emotions on their behalf because it will only invalidate their own experiences. Use empathy and take a very genuine interest in knowing what patient actually

thinks and feels. Respect expression of patient's emotions and thoughts. The therapist should be flexible in his approach.

- Family therapy (to reduce social influence; to discourage wrong image of beauty as a complete thinness).
  Address family issues in causation of anorexia nervosa. Brief counseling sessions can be used in combination with individual psychotherapy. Some form of family counseling can also help managing patients with anorexia nervosa.

- **Pharmacology**
  - Cyproheptadine
  - Amitriptyline
  - Other drugs (clomipramine, chlorpromazine, fluoxetine)
  - Treat depressive symptoms with antidepressants

BULIMIA NERVOSA

Definition

Fig. 76: Bulimia nervosa

Bulimia nervosa is characterized by binge eating followed by inappropriate efforts to stop weight gain such as self-induced vomiting, use of laxatives, etc. (Fig. 76).

Binge eating refers to eat an abnormal amount of food in a short time. The food is abnormally excessive in relation with proportion required.

Bulimia nervosa is basically binge eating plus inappropriate methods of stopping weight gain plus feelings of guilt, depression and self-disgust. Patients with bulimia nervosa maintain an ideal body weight.

Bulimia nervosa is usually a failed attempt to adopt anorexia nervosa patterns. When individuals are not able to restrict their food intake, they adopt an alternative to deal with stress caused by eating. They eat large portions of food at one time followed by guilt of eating in excess followed by compensatory mechanisms to get rid of food already eaten such as self-induced vomiting, use of laxatives, purging or excessive exercise, etc.

Some individuals exhibit binge eating as admitting defeat against hunger pangs generated by efforts for restricting food intake. This is usually a failure of effort in such individuals to maintain a socially desirable level of thinness. Other individuals use binge eating as a means to self-medicate during periods of emotional distress.

Prevalence

The world's one to four percent of general population is suffering from bulimia nervosa. Bulimia nervosa is a disorder of young women. Approximately 20% of all college women experience bulimic symptoms at one or the other times of their college life.

Etiology

- **Biological factors:**
  - Neurotransmitters (serotonin/norepinephrine)

- Increased levels of endorphins
- Exaggerated response from hunger center in brain. Bulimia nervosa is most common in those who are first degree relatives of persons with the disorder.
- An exaggerated perception of hunger signals

- **Social factors:**
  - Individuals who expect high standards from themselves are more prone to be affected with bulimia nervosa because of high social expectations.
  - Family history of depression
  - Neglect and rejection by parents
  - Interpersonal conflicts in family relations
- **Psychosocial factors:**
  - Extroverts are more prone to get bulimia nervosa in comparison with introverts.
  - Emotionally labile and alcohol addicted are at more risk for developing bulimia nervosa.
  - Dominating superego in the structural mind.
  - Patients who suffer from bulimia nervosa are outgoing, angry and impulsive in nature and they often exhibit behaviors such as alcohol dependence, shoplifting and are emotionally labile. Their behavior sometimes includes suicide attempts.
  - Uncontrolled eating is their ego-dystonic behavior.
  - Although patients with bulimia nervosa are having dominating super-ego but they lack control over their superego and their ego strength is weakened as compared to those with anorexia nervosa.
  - Their lack of self-control is manifested as substance dependence and self-destructive sexual relationships plus binge eating and purging.
  - Premorbid history of separation anxiety.
  - Bulimia nervosa is a symbolic presentation of the internal psychological environment of the patient. For instance, food is symbolically presented as a caretaker from which patients do not wish to separate and regurgitating is a symbolic wish for separation.

Sub-types of Bulimia Nervosa

- **Purging type:** Bulimic patients who purge. They regularly engage themselves in self-induced vomiting and use of laxatives to maintain weight.
- **Non-purging type:** Bulimic patients who do not purge. These have less body image disturbance and have less anxiety in relation with eating. They may be obese. They often use strict dieting, fasting and vigorous exercise to maintain an ideal body weight.

Signs and Symptoms

- Binge eating (Episodic: Usually once a week or more for at least 3 months)
- Use of laxatives
- Rigorous exercise
- Self-induced vomiting
- Use of diuretics
- Use of enemas
- Abuse of emetics
- Severe dieting

- **Strenuous exercise:** These all are known as compensatory behaviors.
- Normal body weight or slightly below normal range.
- Morbid fear of weight gain/fatness
- Preoccupation with getting fat
- Depression
- A relentless drive for thinness
- A disproportionate self-evaluation
- Binging usually precedes vomiting by about one year.
- Vomiting is usually induced by sticking a finger down the throat. Some patients have so programmed will that they can induce vomiting if they wish to.
- Vomiting makes patient comfortable in their mind as it will allow them to continue eating without fear of gaining weight.
- Acid content of vomiting may cause damage to tooth enamel.
- Following are the choices of food of patients with bulimia nervosa:
  - High caloric food
  - Sweet eatables
  - Soft/smooth textured food, i.e., cakes, pastries, etc.
  - Bulky foods such as pizzas, burgers, etc.
  - Patients with bulimia nervosa often eat food in private and do it so rapid that they do not even chew it properly.
- Almost 90% of the patients with bulimia nervosa maintain normal weight but some of them may be underweight or overweight.
- Patients with bulimia nervosa exhibit worries and nervousness in relation to their body image, sexual attractiveness and appearance.
- There may be premorbid history of pica, i.e., eating non-nutritive substances and struggles during meals, etc.
- The other comorbid conditions with bulimia nervosa are mood disorders and impulse control disorders. They are at risk for substance use disorders and personality disorders plus anxiety disorders plus dissociative disorders.
- There might be premorbid history of sexual abuse in patients with bulimia nervosa.

DSM-5 Diagnostic Criteria for Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
  - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Prognosis

Bulimia nervosa is a chronic disorder with variable courses among different treated and untreated cases. The untreated cases become chronic and then even with treatment, they exhibit small improvements in the course of disease. The treated cases may have full/partial recovery. Relapse is also seen in 30% of the cases who were previously treated. The mortality rate in bulimia nervosa in accordance with DSM-5 has been estimated to be 2% per decade.

Medical Treatment

The patients of bulimia nervosa are not secretive about their signs and symptoms of the disorder; therefore, they usually comply with the treatment modalities and can be treated as outpatient cases. Patients of bulimia nervosa usually do well with psychotherapy.

In case, symptoms of the bulimia nervosa are worse and some additional symptoms are present such as suicidal ideation or substance abuse, etc. then there is need for hospitalization.

Electrolyte and metabolic disturbances are also an indication for hospitalization for patient with bulimia nervosa.

Psychotherapy

- **Cognitive-behavioral therapy (CBT):** Cognitive behavioral therapy for patients of bulimia nervosa includes 18–20 sessions over a period of five to six months. CBT is believed to be the benchmark, first line treatment for bulimia nervosa. Cognitive behavioral therapy is implemented as follows:
  - Work on interrupting the behavioral pattern of binging and dieting
  - Work on individual's dysfunctional cognitions such as patients' beliefs about food, weight, body image and perceptions about his/her physical appearances.
- **Dynamic psychotherapy:** Dynamic psychotherapy is employed to discourage the use of unhealthy defense mechanisms such as introjection and projection.
  - Patients with bulimia nervosa also use a defense mechanism of splitting. They consciously categorize their food into two categories, i.e., food that is nutritious and food that is unhealthy such as junk food, etc. This conscious splitting works unconsciously in the signs and symptoms of bulimia nervosa. Unconsciously, junk food is treated as bad emotions/interjects and by expelling this unhealthy food in vomiting patient believes that all that is destructive, bad (hate) in his/her life has been expelled.

Pharmacology

- **SSRIs (fluoxetine):** Antidepressants can help deal with depressive symptoms and are helpful in reducing binge eating. The combination of antidepressants and cognitive behavioral therapy can do wonders for the patient with bulimia nervosa.
- Tricyclics (imipramine, desipramine, trazodone)
  - MAO inhibitors
  - Carbamazepine
  - Lithium

Nursing care plan for eating disorders is depicted in Table 18.

Table 18: Nursing care plan for eating disorders (anorexia nervosa/bulimia nervosa)

Nursing diagnosis	Nursing interventions	Outcome criteria
Imbalanced nutrition: Less than body requirements related to refusal to eat, self-induced vomiting, use of laxatives	• Assess nutritional status of patient. • Monitor body weight. Assess BMI. • Maintain intake-output chart. • Stay with patient while eating. • Serve food in an attractive manner. • If patient does not eat by oral route, administer through IV line to maintain weight. • Dietary supplements should be given. • Correct malnutrition. • Counseling about ideal body image.	The patient will maintain an ideal weight.
Disturbed body image related to depressed mood and wrong interpretation of beauty.	• Provide positive reinforcement about eating balanced diet. • Help patient understand that thinness is not an ideal way to perceive beauty. • Allow expression of thoughts and emotions in relation with social pressure of being thin. • Tell patient that he/she is having an unrealistic image of body. • Help patient to accept him/her. • Provide individual psychotherapy.	The patient will understand the concept of ideal body image and benefits if maintaining an ideal weight.

5L: SEXUAL DISORDERS

INTRODUCTION

Sexuality is a normal behavior of humankind. Anyone who experiences any abnormality in experiencing the pleasure related to act may have a sexual disorder. Sexual disorder may also refer to an abnormal way to express one's sexuality which is harmful for oneself as well as for the sexual partner.

Sex is an important area of interest in the medical field.

According to Hippocrates, clitoris is the site for female sexual arousal. The first psychologist to discuss sex openly was Sigmund Freud. He named sexual drive as Libido. He tried to explain the effects of sexual impulse on human behavior.

Research exclaimed that there is need for the development of drugs to prevent contraception, assisting erection, hormone replacement therapy in case of menopause. The recent advancement in pharmacology and other treatment modalities have done wonders in the field of sexuality.

In general population, sex is not only a topic of interest but of curiosity also. Many of the anatomical illustrations of intercourse are available on internet.

The sexuality of an individual can only be guessed not determined. One cannot predict by anatomy and physiology of an individual how he/she will perform in sexual activity. The anatomy and physiology undoubtedly has its influence on the sexuality in general terms and it is also shaped by cultural background and one's relationship with others and one's personal developmental experiences.

The relationship of an individual is at two levels of intimacy:

1. Physical intimacy
2. Mental intimacy

Physical intimacy can be employed by an individual by force also if only one party is interested like in rape and sexual assault, etc. Even in marital relationships, even if only one person is interested in doing sexual activity at a time, it can be done with another person's little cooperation or even by force also.

On the other hand, mental intimacy is much more potent and difficult to achieve only by one person's willingness. If two are emotionally involved and are interested to achieve a greater level of intimacy, it will help attain the maximum pleasure in sexual (physical) intimacy.

Sigmund Freud has rightly explained that anxiety is the hallmark symptom of every mental disorder and he exclaimed that every anxiety is rooted in the repressed libido. Thus, Repressed libido is the cause for other mental disorders, especially anxiety and panic attacks.

An individual who is not efficiently expressing his/her sexual desires becomes a candidate for psychological problems and sexual dysfunctions.

Basically, sex is a pleasurable activity for every human being. An individual is having feelings of intimate happiness only for those persons with whom they are sexually attracted and have passion and love.

If the sexual activity is normal and satisfying, it will bring pleasure to oneself and one's spouse. Normal sexual behavior will bring stimulation to primary sex organs, i.e., testes in males and ovaries in females.
A normal sexual behavior will never be compulsive and with inappropriate feelings of guilt or anxiety.

TERMINOLOGY RELATED TO SEXUALITY

- **Psychosexual:** The term psychosexual implies to personality development in accordance with Sigmund Freud. Freud exclaimed that personality is so affected by sexuality of an individual. But Psychosexual Theory also proposed that psychosexual is the term that is more than sexual feelings and behavior.
  - All pleasurable activities and impulses like eating, partying, just sleeping next to your loved one, etc. are originally sexual.
  - Anyways, it will not make any sense to label all pleasure obtaining behaviors as sexual because it can cause chaos with internal motivations of an individual.
  - The another fact that may interest you is that at times, some individuals may use sexual activity to demonstrate their non-sexual motives such as dependency, power, aggression and status, etc.
  - In any case, an individual's sexuality can help us understand his/her motivations, interaction and real personality.
- **Sexual identity:** Sexual identity is the sum of sexual characteristics of an individual. It includes external genitalia, internal genitalia, chromosomes, hormones, gonads plus secondary sex characteristics, i.e., pubic hair, enlarged breasts and widened hip of females.
- **Gender identity:** Gender identity is an individual's sense of maleness or femaleness.
- **Gender role:** Gender role implies adopting behaviors that would display the status and position of a male or female. The major contribution in adopting gender role is of learning. For example, a girl is being taught to be sober and submissive and a boy is taught to be aggressive and bold.
- **Sexual orientation:** It depicts the object of an individual's sexual impulses.
  - Heterosexual (opposite sex)
  - Homosexual (same sex)
  - Bisexual (both sexes)

- **Masturbation:** Masturbation is usual and normal sexual behavior that comes before object-related sexual behavior. Although it is quite discussed and condemned, but it is also universally practiced. Research exclaimed that nearly all men and 3/4th of all women masturbate some or the other time during their lives. It is characterized by self-stimulation of genitals.
- **Coitus:** The coitus for the first time is a celebratory observation in many cultures. Especially in Indian set-up, it is usually believed that first coitus should be done on the first night after marriage ceremony takes place. This is so celebrated, taken as a custom and treated as a sacrament.

  On the other hand, advancement in technology and innate curiosity of an individual is not bowed to societal norms. In Modern era, it is taken as casual as eating food at restaurant. Males go for intercourse in their pride and self-esteem for the first time and when they are into the act, they just go with the flow without any second thought in their mind.

  Females are obsessed with their cultural ambivalence regarding loss of virginity. Therefore, they try to avoid coitus until they can have an easy mastery over the situation and meanwhile masturbation is their cup of tea. It is research evidenced that young woman with a history of masturbation approaches intercourse with confidence and an anticipation of positive outcome.
- **Homosexuality:** It describes an individual's sexual orientation toward the same gender. The term used for homosexuality in males is Gay men and in females, it is called as Lesbians.
- **Homophobia:** It is a negative attitude and fear toward homosexuals and homosexuality.
- **Love and intimacy:** According to Freud, an individual's psychological health is determined by two factors; his/her ability to love and to work. An individual who is able to receive and give love is considered to be mentally healthy and is more capable of genuine intimate relationships.

When individuals enter into relationships, they strive for the growth of love and intimacy in it and sex acts as an enzyme to ignite that spark for love and intimacy with a minimum of fear and conflict.

It is named as **Active Receiving,** i.e., while loving, an individual permits oneself to be loved. No one can love you and express his/her intimacy if you don't permit the receiving.

COMPONENTS OF SEXUAL HISTORY

- **Identification data:**
  - Name
  - Age
  - Gender
  - Occupation
  - Relationship status-single/married/separated/divorced/serious involvement/casual dating, etc.
  - **Sexual orientation:** Heterosexual/homosexual/bisexual—nobody will be so open in the first interview to tell his/her sexual orientation but later in the sessions, the therapist may explore these questions.
- **Present sexual activity:**
  - Satisfactory/unsatisfactory
  - Reasons for unsatisfactory sexual relationship
  - **Any dysfunction related to anatomy and physiology:** Lack of desire/erectile disorder/anorgasmia/premature ejaculation/inhibited female arousal/pain during intercourse, etc.
  - Frequency of sexual activity (with coitus/non-coitus sexual activity)
  - **Libido:** Frequency of sexual desires/impulses/fantasies, etc.

  - Account/explanation of typical sexual interaction
  - Sexual compulsion, if any
- **Presexual history:**
  - Childhood sexuality
  - Genital self-stimulation
  - Learning about sex
  - Attitude toward being naked and seen nakedness
- **Childhood sexual activities:**
  - Awareness of self as a boy/girl
  - Genital self-stimulation
  - Sexual play

According to DSM-5, sexual disorders are classified as follows:

- Male hypoactive sexual desire behavior
- Female sexual interest/arousal disorder
- Male erectile disorder
- Female orgasmic disorder
- Delayed ejaculation
- Premature ejaculation
- Genito-pelvic pain/penetration disorder
  - Dyspareunia
  - Vaginismus

WHAT ARE SEXUAL DYSFUNCTIONS?

An individual is believed to experience sexual dysfunction if he/she is unable to respond to sexual stimulation or experience pain during intercourse. The dysfunction can be any disturbance either in pleasure/desire or performance of the act.

In other words, sexual dysfunction is an individual's inability to take part in a sexual relationship because of underlying issues related to disturbed pleasure/desire of the sex and dysfunctional performance of the sexual activity.

No sexual dysfunction is without the association of other mental disorders, such as depression, anxiety, personality disorders, etc. Sexual disorders are usually self-existing means they keep it alive by themselves and the associated troubles are ongoing performance anxiety and inability to encounter pleasure.

Here, the functional partner, who is sexually healthy, often responds with anger and distress because he/she is having feelings of deprivation and does make calculations that he/she is an insufficiently attractive or inadequate for sexual activity. But this is not the case; it is because of inadequate and inefficient sexual partner.

We must find out in that scenario, who is the culprit. And whether the sexual problem has arisen because of relationship difficulties or physiological dysfunctions.

MALE HYPOACTIVE SEXUAL DESIRE BEHAVIOR

Definition

Male hypoactive sexual desire behavior is characterized by lack of interest or inability to experience pleasure in sexual activities for at least a period of 6 months.
This often results in absenteeism from sexual activity.

- Such males never experienced spontaneous erotic/sexual thoughts during their lifetimes.
- A female can't be put in this category if she does not experience spontaneous erotic/sexual thoughts and if her desire/arousal is triggered by sexual encounter.
- Do not confuse decreased desire with decreased activity.
- Sometimes, the erotic thoughts and fantasies are still there, but affected men are no longer able to act upon them.
- The reasons could be health issues, unavailability of a partner or some other sexual dysfunction such as erectile disorder, etc.

Prevalence

Male hypoactive sexual desire disorder is more prevalent in young adults and constitutes two percent of all men between the ages of 16–44 years.

DSM-5 Diagnostic Criteria

- Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life.
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to these effects of a substance/medication or another medical condition.

Etiological Factors

- Low sexual desire
- Unconscious fears about sex
- Unresolved phallic psychosexual phase of development
- Unresolved oedipal conflicts
- Males, who have fixation at the phallic stage of psychosexual development are afraid of female sexual organs and believe that their sex organ will be castrated if they approach sexual activity. This is given the name "Vagina Dentata" by Sigmund Freud. Freud exclaimed that males who have vagina dentata unconsciously believe that vagina has teeth.
- Chronic stress
- Anxiety disorders

- Depressive disorders
- Another reason could be abstinence from sex for a prolonged period of time which may have resulted in suppression of sexual impulses.
- A deteriorating relationship may also be the cause for male hypoactive sexual desire disorder.
- Some men use this behavior as an expression of hostility toward sexual partner.
- Availability of an appropriate partner
- Inadequate self-esteem
- Dysfunctional biological derive
- Inability to accept oneself as a sexual being
- A good relationship in nonsexual areas with the partner.

It is noteworthy that sexual contacts and satisfaction varies among persons and with time in the same person.

FEMALE SEXUAL INTEREST/AROUSAL DISORDER

Definition

Female sexual interest/arousal disorder is characterized by absenteeism from sexual activity for at least 6 months period and is associated with reduced sexual interest/arousal.

Women are different in experience of sexual activity. Women do not proceed stepwise in sexual activity from desire to arousal rather they have synchronicity with the sexual activities beginning from the feelings of arousal.

Therefore, no one dysfunction is a complete disorder in females rather often they may have either/or both inability to experience arousal and as well as difficulty achieving orgasm along with experience of pain.
The associated features with female sexual interest/arousal disorder are as follows:

- Decrease or paucity of erotic thoughts, feelings and fantasies
- Decreased impulse to initiate sex
- Decreased receptivity to partner's act of being friendly toward somebody when you want to indulge in sexual activity
- Inability to respond to partner stimulation

Etiological Factors

- A poor subjective sense of arousal
- Dysfunctional vaginal lubrication
- Vaginal congestion
- Lack of a subjective sense of excitement
- Dysfunctional brain activation in areas controlling genital response and arousal
- Abnormal hormonal pattern
- **Time of the month:** It is generally observed that women are either hyper desirous of sexual activity at the time of ovulation immediately after menses or before the onset of menses.
- Altered levels of testosterone, Estrogens, prolactin and thyroxin levels
- Medications such as antihistaminic or anticholinergic drugs may cause a decrease in vaginal lubrication.
- Life stresses
- Aging

- Menopause
- Lack of adequate sexual stimulation
- Overall general health
- Marital discord

DSM-5 Diagnostic Criteria

- Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:
  - Absent/reduced interest in sexual activity.
  - Absent/reduced sexual/erotic thoughts or fantasies.
  - No/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate.
  - Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
  - Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
  - Absent/reduced genital or non-genital sensations during sexual activity in almost all or all (approximately 75–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a non-sexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

MALE ERECTILE DISORDER

Definition

Male erectile disorder is characterized by inability to obtain a penile erection to complete penetration and ejaculation. It is also known as impotence.

Male erectile disorder is not just dysfunctional penile erection but it is often having associated problems of feelings of powerlessness, helplessness and low self-esteem.

In primary form of disorder, a man with male erectile disorder has never been able to obtain an erection sufficient for insertion. The male erectile disorder which is acquired is different from the primary male erectile disorder.

In acquired male erectile disorder, a man may have successfully achieved penetration at some time in his sexual life but with the passage of time, he is not able to achieve penetration successfully.

There is another category known as situational male erectile disorder in which a man is able to have coitus with penile erection with his partner in certain circumstances. It is not fully understood but it has happened with some men that they are able to have coitus with a prostitute but are unable to have intercourse with their own partner.

Prevalence

In the general population, acquired male erectile disorder has been found to be present in 10–20% of all men. The chief complaint is erectile dysfunction. The prevalence rate of erectile disorder among men increases with age.

Not all men will experience male erectile disorder in their advanced ages; having an available sex partner is believed to enhance potency. It is observed that twenty percent of men fear erectile dysfunction prior to their first experience of intercourse.

The male erectile disorder can be organic or psychological. Many of the times, the cause is psychological rather than organic and with little support and encouragement, things can work out for the person.

Take a detailed sexual history and find out if the person reports that he is having spontaneous erections at those times when he even does not have a plan to have intercourse, or does have good erections with masturbation and having morning erections.

Etiological Factors

- An inability to reconcile feelings of affection toward a woman with desirous feelings toward her.
- Punitive superego
- An inability to trust
- Feelings of inadequacy
- Being undesirable as a partner
- Moral prohibition
- Fear/anxiety/anger related to expression of sexual impulse
- Inability to communicate one's needs or anger/strong emotions in direct and in a constructive manner
- Anxiety before each sexual encounter will reinforce episodes of erectile disorder further.

DSM-5 Diagnostic Criteria

- At least one of the three following symptoms must be experienced on almost all or all (approximately 75–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
  - Marked difficulty in obtaining an erection during sexual activity.
  - Marked difficulty in maintaining an erection until the completion of sexual activity.
  - Marked decrease in erectile rigidity.
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

FEMALE ORGASMIC DISORDER

Another Name: Inhibited female organism/anorgasmia

Definition

Female orgasmic disorder is defined as an inability to experience orgasm after sexual excitement. In other words, no orgasm after sex/coitus is experienced by a woman who is affected with disorder. It is also known as inhibited female organism/anorgasmia.

This disorder is recurrent and persistent in nature and is characterized by delay and absence of orgasm after sexual excitement.

In literal sense, anorgasmia is inability to attain/reach orgasm by masturbation or coitus. Women may complain that they are distressed as there is lack of climax and they do not receive any pleasure from sexual activity.

The associated features of female orgasmic disorder are as follows:

- There are two kinds of stimulation in women, i.e., clitoral stimulation and vaginal stimulation.
- Physiologically, both clitoral stimulation and vaginal stimulation are similar.
- Freud believed that women need to give up clitoral sensitivity and be sensitive to vaginal stimulation to achieve sexual maturity. This is found not to be true by modern research.
- Women have reported that they obtain a unique satisfaction from an orgasm precipitated by coitus. This may be attributed to the intimacy attained through intercourse.
- Some other research based on the reports and comments made by women about their sexual experience stated that women attain orgasm during coitus by a combination of two acts; manual clitoral stimulation and penile vaginal stimulation.
- The disorder can be either primary or acquired.
- In primary female orgasmic disorder, a female has never experienced orgasm by any kind of stimulation and it is for a lifetime.
- In acquired orgasmic disorder, a woman may have previously experienced at least one orgasm whether by masturbation or while dreaming during sleep.
- It is shown by studies that women achieve orgasm more consistently with masturbation as compared to coitus with a partner.

Prevalence

- Among all women, 10% have reported to never achieve orgasm by any means; not by clitoral stimulus or by penile vaginal stimulation.
- This disorder is more commonly found in unmarried women than among married women.
- Overall prevalence of female orgasmic disorder is found to be 30% from all possible causes.
- Recent twin studies suggest that there may be some genetic basis for the disorder and it can't be fully considered as the result of psychological differences.

Etiological Factors

- Fear of pregnancy
- Rejection by a sex partner
- Any injury to the vagina
- Hostility/anger toward men
- Poor body image
- Guilt feelings about sexual impulses
- Fear of loss of control
- Cultural expectations
- Social restrictions

Signs and Symptoms in Relation with Anorgasmia

- Lower abdominal pain
- Itching
- Vaginal discharge
- Increased tension
- Irritability
- Fatigue

DSM-5 Diagnostic Criteria

- Presence of either of the following symptoms and experienced on almost all or all (approximately 75–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
  - Marked delay in, marked infrequency of, or absence of orgasm.
  - Markedly reduced intensity of orgasmic sensations.
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

DELAYED EJACULATION

Another name: Retarded ejaculation

Definition

Delayed ejaculation refers to a man's disability to ejaculate during sexual activity. It is also known as retarded ejaculation.

Men with delayed ejaculation have never been able to ejaculate during partnered sexual experience. But this delayed ejaculation is rare with masturbation.

Orgasm and ejaculation are different. In some cases, men are able to ejaculate but there is no subjective feeling of pleasure. This is known as orgasmic anhedonia.

Prevalence

Among general population, the incidence of the delayed ejaculation is 5%.
The prevalence among today's generation is higher than the last decades and that can be attributed to use of drugs that have a side-effect of delayed ejaculation and increased use of internet pornography.

Pornography has caused many psychological issues in young generations. These sites offer different levels of stimulation involving variety of acts and sexual positions. When people are frequent users of these sites prior to live sexual interaction, they do not develop neuronal synapses that will enable them to respond normally with actual life partners. This is the reason that they fail to achieve climax.

Etiological Factors

- Severe psychopathology

- Rigid familial and cultural background
- Having a very strict or censorious moral attitude toward self-indulgence or sex
- Perceiving sex as a sinful activity
- Unconscious guilt feelings
- Difficulty with closeness in sexual relations
- Distractibility at the time of arousal
- Interpersonal difficulties
- Ambivalent feelings toward having pregnancy in future
- Loss of sexual attraction with partner
- Demands by partner
- Unexpressed hostility toward men

DSM-5 Diagnostic Criteria

- **Either of the following symptoms must be experienced on almost all or all occasions (approximately 75–100%) of partnered sexual activity (in identified situational contexts or, if generalized, in all contexts), and without the individual desiring delay:**
  - Marked delay in ejaculation.
  - Marked infrequency or absence of ejaculation.
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

PREMATURE EJACULATION

Definition

Premature ejaculation refers to a condition in which a man ejaculates one minute before penetration.

Disorder of premature ejaculation is persistent and recurrent in nature in which men achieve orgasm or ejaculation against their wish. Usually this premature ejaculation happens before or within approximately 1 minute after penetration.

This disorder is commonly observed in men who are homosexual and do not wish for vaginal penetration. One must consider other factors also such as age, novelty of the sex partner and frequency of intercourse.

Prevalence

This disorder is more commonly observed in educated men as compared to less educated or illiterate. Among all sexual disorders in men, 35–40% of the complaints are about premature ejaculation.
The disorder can be categorized into two on the basis of the underlying etiological factors:

- Premature ejaculation that has happened because of physiological dysfunction
- Behaviorally conditioned cause anxiety regarding the sexual act
- Unconscious fears about vagina
- Negative cultural conditioning

- Sexual contacts with prostitutes can also trigger premature ejaculation in men. Because prostitutes demand sexual act to be completed quickly.
- Young, inexperienced men
- Stressful marital relationships
- Developmental background

DSM-5 Diagnostic Criteria

- A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it.
- The symptom in Criterion A must have been present for at least 6 months and must be experienced on almost all or all (approximately 75–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts).
- The symptom in Criterion A causes clinically significant distress in the individual.
- The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

SEXUAL PAIN DISORDERS

Genito-Pelvic Pain/Penetration Disorder

Definition

Genito-pelvic pain/penetration disorder refers to a syndrome, in which there may be pain during intercourse, tension of pelvic floor muscles, fear of pain in relation to penetration during sexual activity. This group of conditions are collectively known as genito-pelvic pain/penetration disorder.

The disorder is named as syndrome because it is characterized by one or more of the above complaints. Two major conditions of this disorder are:

1. **Dyspareunia:** Persistent pain during intercourse.
   This pain is recurrent and persistent genital pain. The pain can occur fore, during or after intercourse. The resulting outcome will be unpleasant and unbearable intercourse. It is not a true diagnosis if pain is there because of organic etiology and a lack of lubrication.
   Common etiological factors are as follows:
   - History of rape
   - Childhood sexual rape
   - Tension and anxiety about the sexual activity may involuntary bring contraction of the pelvic floor muscles
   - Hormonally induced physiological changes in vagina
2. **Vaginismus:** Constriction/tightening of the vagina during sexual activity
   Vaginismus causes interference with intercourse and difficult penile insertion. The disorder may be complete or partial. In complete vaginismus, no penetration of the vagina is possible, not by penis or fingers or speculum.
   In partial vaginismus, penetration is difficult but not impossible entirely. This may be due to pelvic floor muscle tightening.

Penetration is achieved in many cases with lubrication, smallest size speculum or with fingers if the etiology is not organic but psychological.

Prevalence

Vaginismus is most commonly found in highly educated women and in high socioeconomic status. Anticipation of the intercourse may cause vaginismus.

Etiological Factors

- Strict religious upbringing
- Emotional abuse by sexual partner
- Surgical or dental interventions which have had psychological impact that any such act will be a breach of body integrity

DSM-5 Diagnostic Criteria

- Persistent or recurrent difficulties with one (or more) of the following:
  - Vaginal penetration during intercourse.
  - Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts.
  - Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during or as a result of vaginal penetration.
  - Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.
- The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
- The symptoms in Criterion A cause clinically significant distress in the individual.

The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of a severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Treatment of Sexual Disorders

- Individual psychotherapy
- Exploration of unconscious conflicts/motivation/fantasy
- Exploration of interpersonal difficulties
- Behavioral techniques
- **Dual sex therapy:** Therapy is given with the concept that need of treatment is for the couple when a dysfunctional person is in a relationship. In such cases, both partners must participate in the therapy because dysfunction has distressed both the parties.
  The conflicts in the interpersonal relationships are because of disharmony and dissatisfaction in sexual relationships. Therapist must emphasize the sexual activity of both parties.
  The key features of dual therapy are as follows:
  - Clarification, discussion and working through relationship problems
  - Discuss the psychological aspect of sexual activity
  - Establish communication among partners
  - By effective communication, work and interrupt couple's destructive pattern of relationships.

- Work out with sexual inadequacy that involves lack of information, misinformation and/or performance fear.
- Begin with some small exercises focusing on enhancing sensory awareness to touch, sight, sound and smell.
- Motivate couples to obtain pleasure without the pressure of performance or penetration.
- Sexual foreplay is so important. Every couple must understand that foreplay is a pleasurable alternative to intercourse and orgasm.
- The couple should understand the needs of one another. If one partner gets excited (usually the non-dysfunctional partner) then the other partner is encouraged to bring him/her orgasm by other means such as manual stimulation, etc.
- Open communication about the sexual activity will resolve many of the interpersonal barriers that may have interfered with the sexual activity among partners. Expression of mutual needs is encouraged.
- Genital stimulation without the urgency to perform is also helpful to resolve anxieties and fears related to sexual activity.
- Encourage couple to try various positions for intercourse.

- **Techniques and exercises:**

  Vaginismus: There are size-gradated dilators which are used to treat vaginismus. Women who are suffering with vaginismus are instructed to dilate her vaginal opening with her fingers or with size-gradated dilators.

  Dyspareunia: Dilators are also helpful to combat the symptoms of dyspareunia.

  The treatment of *vaginismus* and dyspareunia can be coordinated with other disciplines, especially physiotherapists who can help patients relax their perineal muscles.

  Premature ejaculation: There is one exercise which can be employed to treat premature ejaculation. This exercise is known as Squeeze Technique. It is used to raise the threshold of penile excitability. In the squeeze technique, any partner will be stimulating the erect penis to achieve earliest sensations. Mainly, coronal ridge of the glans is forcefully squeezed that will raise the threshold of sensation of ejaculation. The resulting outcome will be sexual arousal without anxiety and increased confidence in one's sexual performance.

  Another exercise used in case of premature ejaculation is stop-start technique. In this exercise, woman stops all stimulation to the genitalia of man when they sense an impending ejaculation and no squeeze is used.

  Male erectile disorder: The person suffering with male erectile disorder is asked to masturbate for full erection and ejaculation.

  Female orgasmic disorder: Here the use of vibrators is employed while woman will masturbate. The site for stimulation which is used is clitoris as orgasm in women depends on adequate clitoral stimulation.
- Hypnotherapy
- Behavior therapy
- Mindfulness
- Group therapy
- Analytically oriented sex therapy
- Pharmacological agents
  - For erectile disorder
    - Viagra

- Vasomax
- Papaverine
- Prostaglandin E1
- Transurethral alprostadil (MUSE)

- Other pharmacological agents
  - Antianxiety drugs
  - Antidepressants
  - Dopaminergic agents are used to treat and improve libido and sex function
  - Hormone therapy
  - Antiandrogens
  - Antiestrogens
- Mechanical treatment approaches
  - Vacuum pump
- Surgical treatment
  - Male prostheses
  - Vascular surgery

5M: CHILD AND ADOLESCENT PSYCHIATRY DISORDERS

INTRODUCTION

In DSM-5, following are the child and adolescent psychiatry disorders given in the list.

- Intellectual disability
- Communication disorders
  - Language disorder
  - Speech sound disorder
  - Child-onset fluency disorder (Stuttering)
  - Social (pragmatic) communication disorder
- Autism spectrum disorder
- Attention deficit hyperactivity disorder
- Specific learning disorder
- Feeding and eating disorders of infancy or early childhood
  - Pica
  - Rumination disorder
  - Avoidant/restrictive food intake disorder
- Elimination disorders
  - Encopresis
  - Enuresis

INTELLECTUAL DISABILITY

Definition

Intellectual disability is defined as a sub-average mental ability and an intelligent quotient of below average level. It is also known as mental retardation.

Classification of Intellectual Disability

- Mild (IQ of 50–70)
- Moderate (IQ of 35–50)
- Severe (IQ of 20–35)
- Profound (IQ of less than 20)

Etiology

- Genetic factors
- Down syndrome
- Fragile X syndrome
- Phenylketonuria
- Rett syndrome
- Maple syrup urine disease
- Acquired causes
  - Birth injuries
  - Prenatal period
  - Rubella
  - Syphilis
  - Toxoplasmosis
  - Herpes simplex
  - HIV
  - Fetal alcohol syndrome
  - Prenatal drug exposure
  - Head trauma

Signs and Symptoms

- Cognitive deficits
- Communication deficits
- Poor self-esteem
- Lack of social communication
- Lack of speech development
- Deficit self-care

Treatment

- Preventive measures
  - Antenatal care

  - Avoid drugs in pregnancy
  - Nutrition
  - Prevent birth injuries
  - Institutional delivery
- Behavioral interventions
- Family education
- Social skills training

COMMUNICATION DISORDERS

Children who are not able to communicate effectively may have many underlying etiologies. These disorders may be mild or severe.

Type of communication disorder	Definition
Language disorder	Language disorder is characterized by deficits in vocabulary, articulation, forming sentences, use of grammar to express ideas of mind.
Speech sound disorder	Speech sound disorder is characterized by inability to produce correct sounds.
Child-onset fluency disorder (stuttering)	Stuttering is characterized by deficits in the fluency of speech with involuntary motor movements.
Social (Pragmatic) communication disorder	This disorder is characterized by lack of ability to communicate verbally and non-verbally for social interactions.

AUTISM SPECTRUM DISORDER

Definition

Autism is characterized by deficits in social communication, behavioral domain and language formation and usage. It is also known as pervasive developmental disorder. Autism is basically a genetic disorder.

Treatment

- Parent teaching
- Social skills training
- Behavioral therapy
- Cognitive-behavioral therapy
- Treating and educating autistic children
- Vocational training
- Virtual therapy

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention deficit hyperactivity disorder is characterized by a marked reduction in attention span and increased impulsivity.

SPECIFIC LEARNING DISORDER

As name suggests, specific learning disorder is characterized by a deficit in a specific learning skill such as mathematics, language, etc.

Table 19 explains the feeding and eating disorders of infancy or early childhood

Table 19: Feeding and eating disorders of infancy or early childhood

Name of disorder	Description
Pica	Eating non-nutritive substances
Rumination disorder	Regurgitation of food into mouth after eating
Avoidant/Restrictive Food Intake Disorder	Lack of interest in eating food and avoiding eating purposely.

Table 20 explains the elimination disorders.

Table 20: Elimination disorders

Name of disorder	Definition
Encopresis	Retention of feces resulting in constipation purposely by children.
Enuresis	It is characterized by involuntary passage of urine, usually occurs at night.

ASSESS YOURSELF

Long/Short Answer Questions

1. a. Enlist five signs and symptoms of alcoholism.
   b. Write down the nursing management of an alcoholic patient.
2. a. Define mania.
   b. Enlist any three signs and symptoms of mania.
   c. How you will meet the nutritional needs of a manic patient?
3. Define the following terms:
   a. Personality
   b. Bizarre behavior
   c. Psychiatric nursing
   d. Stupor
   e. Compulsion or compulsive movements
   f. Insight
   g. Agitation
   h. Flight of ideas
   i. Delusion of grandeur
   j. Anxiety
   k. Euphoria
4. Write short notes on:
   a. Differentiate between endogenous (psychotic) depression and exogenous (neurotic) depression
   b. Differentiate between hysterical (conversion disorder) fit and epileptic fit
   c. Nursing care plan of five priority needs of patient with schizophrenia
   d. Nursing care plan of five priority needs of patient with psycho-active substance abuse
   e. Nursing care plan of five priority needs of patient with phobic neurosisEating disorders
   f. Substance abuse

g. Mental retardation
h. Attention-deficit hyperactivity disorder (ADHD)
i. Differentiate between neurosis and psychosis
j. Conversion disorder
k. Types of delusion

5. a. Define anxiety.
   b. Explain the levels of anxiety with clinical manifestations.
   c. Describe the nursing approaches used to help the individual to cope with anxiety.
6. Write the signs and symptoms (clinical features) of the following disorders:
   a. Schizophrenia
   b. Acute anxiety state (anxiety neurosis)
   c. Manicdepressive psychosis (MDP)
7. a. What is meant by schizophrenia?
   b. Enlist the types of schizophrenia.
   c. Write down the nursing management of schizophrenic patient.
8. a. Define delirium (acute organic brain syndrome).
   b. Mention five signs and symptoms of delirium.
   c. Discuss nursing management of delirium patient.
9. a. Define schizophrenia.
   b. Elaborate types of schizophrenia.
   c. Discuss Bleuler's 4 'A' symptoms of schizophrenia.
   d. Describe nursing management of a catatonic stupor patient.
10. Describe the biological causes of mental illness.
11. a. Define schizophrenia.
    b. Write causes, signs and symptoms of schizophrenia.
    c. Describe the management of schizophrenic patient.

Multiple Choice Questions

1. Which disorder is characterized by recurrent, intrusive thoughts leading to performance of ritualistic behavior?

a. Phobia
b. GAD
c. OCD
d. Panic disorder

2. An anxiety disorder marked by excessive anxiety with a thought of losing one's control is known as:

a. Panic disorder
b. GAD
c. OCD
d. Phobia

3. Poverty of ideas is a manifestation of:

a. Mania
b. Schizophrenia
c. Dissociative reaction
d. Depression

4. Dementia praecox was the previous name of:

a. GAD
b. Histrionic personality disorder
c. Schizophrenia
d. BPAD

5. Unipolar depression is also known as:

a. Major depressive disorder
b. Emotional disturbances
c. Neurotic depression
d. Depressive neurosis

6. Suspiciousness is a manifestation of which kind of schizophrenia?

a. Disorganized type
b. Paranoid type
c. Undifferentiated type
d. Residual type

7. Disorientation occurs in:

a. Schizophrenia
b. Organic mental disorder
c. BPAD
d. PTSD

8. Delusions are seen in all, except:

a. Schizophrenia
b. Mania
c. Depression
d. Compulsions

9. Cloudiness of consciousness is seen in:

a. Dementia
b. Dissociative fugue
c. Amnesia
d. Delirium

10. A mild form of depression is known as:

a. Dysthymia
b. Cyclothymia
c. Depressive neurosis
d. Neurotic depression

11. Which is the following is not a symptom of schizophrenia?

a. Ambivalence
b. Inappropriate affect
c. Autism
d. Amnesia

12. Compulsive acts are done in response to:

a. Anxiety
b. Orders
c. Commanding hallucinations
d. Obsessions

13. Which of the following symptoms are present in PTSD?

a. Flashbacks
b. Nightmares of traumatic incidents
c. Re-experiencing the traumatic events in mind
d. All of the above

14. Dissociative reactions are manifested by:

a. Dissociative fugue, dissociative amnesia, sleepwalking, dream state
b. Dissociative amnesia and dream state
c. Dissociative fugue and sleep walking
d. Dream state and sleep walking

ANSWERS KEY

1. c **2.** a **3.** d **4.** c **5.** a **6.** b **7.** b **8.** d **9.** d
10. a **11.** d **12.** d **13.** d **14.** a

Unit

6

BIOPSYCHOSOCIAL THERAPIES

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Learn about various therapeutic modalities used in psychiatric health care area.

UNIT OUTLINE

- Biopsychosocial Therapy
- Psychopharmacology
- Individual Psychotherapy
- Group Psychotherapy
- Behavioral Therapy
- Occupational Therapy
- Family Therapy
- Milieu Therapy
- Somatic Therapy: Electroconvulsive Therapy
- Insulin Therapy

KEY POINTS

- The study of psychopharmacological agents is known as psychopharmacology.
- Psychopharmacological agents are also known as psychotropic drugs.
- The first and foremost individual psychotherapy is psychoanalysis.
- Group psychotherapy is a form of psychotherapy in which a homogeneous or a heterogeneous group is formed which works together to meet the emotional needs of one another under the guidance of a trained psychotherapist.
- Behavior therapy refers to bring out functional adaptive behavior to improve the quality of life.
- Every right and desirable behavior pattern must be rewarded and positively reinforced.
- Tolerance is defined as a phenomenon in which an increased amount of dose is required to produce the desired effects.
- Biopsychosocial therapy

BIOPSYCHOSOCIAL THERAPY

A biopsychosocial therapy refers to all the treatment modalities in psychiatry which are used to treat the psychiatric patient. The therapy may be biological such as ECT, psychological such as Behavioral therapy and/or social such as Milieu therapy.

The main divisions of biopsychosocial therapies are as follows:

- Psychopharmacology
- Psychosocial therapies
- Somatic therapy

All of these biopsychosocial therapies are discussed as follows:

PSYCHOPHARMACOLOGY

Research in the field of psychiatry has led to knowledge of brain functioning and how neurotransmitters play a role in causation and treatment of mental disorders. This results in invention of many pharmacological drugs which are helpful in successful treatment of mental disorders.

Because these pharmacological agents are helpful in treatment of mental (psychological) disorders, they are collectively known as psychopharmacological agents/drugs. The study of psychopharmacological agents is known as **psychopharmacology.**

Psychopharmacological agents are also known as psychotropic drugs.

The psychopharmacological drugs are classified as follows:

- Antipsychotic drugs
- Antidepressants
- Antimanic drugs
- Antianxiety drugs
- Antiparkinson drugs

Antipsychotics (Neuroleptics/Major Tranquilizers)

Antipsychotics are the psychopharmacological drugs which are used to treat psychotic disorders.

Indications

- Acute psychosis
- Schizophrenia
- Delusional disorder
- Bipolar disorder
- Brief psychotic disorder
- Comorbidity with mood disorders
- Comorbidity with substance abuse

Classification of Antipsychotics

- **Typical antipsychotics** (first generation antipsychotics)
  - Phenothiazines
    - Chlorpromazine (50–1200 mg/24 hours in divided dosages)
    - Fluphenazine (1–20 mg/24 hours in divided dosages)
    - Perphenazine (6–64 mg/24 hours in divided dosages)
    - Prochlorperazine (15–150 mg/24 hours in divided dosages)
  - Butyrophenone
    - Haloperidol (2–100 mg/24 hours in divided dosages)
  - Dibenzoxazepine
    - Loxapine (15–100 mg/24 hours in divided dosages)
- **Atypical antipsychotics** (second generation antipsychotics)
  - Benzisoxazole
    - Risperidone
  - Dibenzodiazepine
    - Clozapine
  - Thienobenzodiazepine
    - Olanzapine
  - Benzothiazolylpiperazine
    - Ziprasidone
  - Dibenzothiazepine
    - Quetiapine

To understand the mechanism of psychotropic drugs, one must learn the concept of neurotransmission. Because every psychotropic drug (an antipsychotic, antidepressant, antimanic, etc.) will act through neurotransmitters, i.e., chemical messengers of brain.

Main neurotransmitters in brain are as follows:

- Dopamine
- Serotonin (5-ht)
- Gaba (gamma aminobutyric acid)
- Norepinephrine
- Epinephrine, etc.

How does Neurotransmitters Work?

The nerve impulse (message) is stored in neurotransmitters. The message is transmitted through neurons to neurons and the last effectors may be neurons/glands or muscles. In Figure 1, the neurotransmitters are stored in small vesicles in the axon terminals, i.e., end portion of neuron.

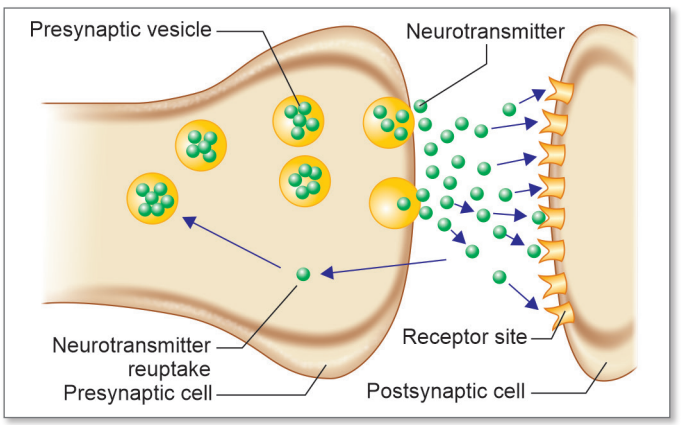


Fig. 1: Neurotransmission of nerve impulses

The space between two neurons is known as synapse where neurotransmitters will be released before transmitting to another neuron through dendrites, i.e., receiving portions of axon.

The neuron which is sending the neurotransmitters is known as presynaptic cell named because it is situated before synapse and the one which receives neurotransmitters is known as postsynaptic cell named because it is situated after the synapse.

Mechanism of Action

The main neurotransmitter responsible for psychosis is dopamine

Neurotransmitters are chemicals which are generated in brain and they communicate messages in the form of nerve impulses throughout our brain and body. Every neurotransmitter in the brain must be in a required proportion; its excess or lack can cause mental sickness.

Dopamine is a neurotransmitter and its excess in the brain can cause psychotic thinking. In psychosis, the person lacks touch with reality and a gross impairment in personal and social functioning.

Antipsychotics work by blocking postsynaptic dopamine receptors. Most of the typical antipsychotics block dopamine receptors in the brain while newer atypical drugs are thought to block dopamine as well as serotonin and other neurotransmitters also.

Role of a nurse in administration of antipsychotic drugs is depicted in Table 1.

Table 1: Side-effects of antipsychotic drugs along with nursing management (role of a nurse in administration of antipsychotic drugs)

Side-effect	Nursing management (role of a nurse)
Orthostatic hypotension	• Assess blood pressure in three positions, i.e., lying, sitting and standing. • Keep records of all the assessment of blood pressure and report to the consultant. • **Health education:** Teach patient to rise slowly from a lying or sitting position.
Sedation	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time or any other antipsychotic with a lesser side-effect can be administered. • **Health education:** Teach patient that he/she should not drive or operate any machinery.

Contd...

Side-effect	Nursing management (role of a nurse)
Photosensitivity	• **Health education:** Teach client to wear protective clothing, sunscreens and sunglasses when they are out in the sun.
Nausea	• Administer antipsychotics with food to combat the effects of nausea.
Skin rash	• Report any signs of skin rashes and intervene accordingly.
Agranulocytosis	• A rare complication. • Symptoms are sore throat, fever and malaise. • Assess complete blood count.
Anticholinergic effects • Dry mouth	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water.
• Blurred vision	• **Health education:** Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls.
• Constipation	• Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity.
• Urinary retention	• Report to the consultant, if patient complains of any difficulty in urination. • Monitor intake and output of the patient.
Hormonal disturbances • Decreased libido • Gynecomastia	• Reassure the patient that the symptoms will be reversed when after discontinuation of the drug.
• Retrograde ejaculation	• Discuss with the consultant about the symptoms and another antipsychotic may also be prescribed.
• Amenorrhea	• Reassure the patient that the symptoms will be reversed when after discontinuation of the drug. • **Health education:** Ask the patient to continue with the contraceptives because amenorrhea is a side-effect of antipsychotics and ovulation is occurring naturally with no effect of drugs.
• Weight gain	• Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient.

In psychiatry, the **major adverse drug reactions are EPS, i.e., extrapyramidal symptoms.** EPS are untoward adverse drug reactions due to use of antipsychotic drugs for treatment of psychotic disorders (Table 2).

Table 2: Extrapyramidal symptoms and their treatment

EPS	Clinical manifestations	Treatment/nursing management
Tardive dyskinesia	Involuntary movements of mouth, neck and trunk	• Discontinue/decrease the offending drug. • Choose an alternative drug to deal with psychosis.
Dystonia	Spasm of neck, face, jaw and tongue muscles	• Discontinue/decrease the offending drug. • IM benztropine or diphenhydramine

Contd...

EPS	Clinical manifestations	Treatment/nursing management
Akathisia	Motor restlessness	• Discontinue/decrease the offending drug. • Mirtazapine (15 mg OD) • Benzodiazepines • Propranolol (30–120 mg/day in divided doses) • Anticholinergics
Parkinsonism	Rigidity, bradykinesia (slowness of movement), tremor	• Discontinue/decrease the offending drug. • Anticholinergics
Neuroleptic malignant syndrome	Fever, hypertension, altered mental status, muscular rigidity, profuse perspiration and salivation	• Discontinue the offending drug. • Maintain nutritional status to restore water and nutrient levels. • Skeletal muscle relaxants (dantrolene). • Treat hypoxia and metabolic acidosis. • Electroconvulsive therapy as a last resort with varying results.

Antidepressants

Antidepressants are the psychopharmacological agents which are used to treat depression and other mental disorders in which depression may be a secondary effect.

Indications

- Major depression
- Dysthymic disorder
- Depression with substance use, especially alcoholism
- Depression with other mental disorders such as psychosis, schizophrenia, mental retardation and/or anxiety disorders
- Melancholia
- In depressive phase of BPAD.

Classification of Antidepressants

- Tricyclics
  - Amitriptyline (75–300 mg/24 hours in divided dosages)
  - Clomipramine
  - Desipramine
  - Doxepin
  - Imipramine (75–300 mg/24 hours in divided dosages)
  - Trimipramine
- Selective serotonin reuptake inhibitors (SSRIs)
  - Citalopram
  - Fluoxetine
  - Escitalopram
  - Paroxetine
  - Sertraline

- Monoamine oxidase inhibitors (MAO inhibitors)
  - Isocarboxazid
  - Phenelzine
  - Tranylcypromine
- Others
  - Bupropion
  - Mirtazapine
  - Trazodone
  - Nefazodone
  - Venlafaxine
  - Duloxetine

Mechanism of Action

The main neurotransmitter responsible for occurrence of depression is serotonin

A decrease in serotonin, nor-epinephrine and/or dopamine concentrations may result in depression. Therefore, if a drug has to treat depression, it must increase the concentrations of serotonin, nor-epinephrine and dopamine at receptor site.

All the classes of antidepressants work to increase concentrations of serotonin, nor-epinephrine and dopamine concentrations at receptor site. Tricyclics, SSRIs and others block the reuptake of neurotransmitters by pre-synaptic neurons. In this way, concentrations of neurotransmitters in the synaptic cleft, i.e., space between pre-synaptic neuron and post-synaptic neuron is increased.

MAOIs do accomplish upsurge of neurotransmitters by an enzyme MAO which inactivates neurotransmitters; this MAO is inhibited through MAO inhibitors and result will be increased concentrations of neurotransmitters.

Role of a nurse in administration of antidepressants is depicted in Table 3.

Table 3: Side-effects of antidepressants along with nursing management (role of a nurse in administration of antidepressants)

Side-effects	Nursing management (role of a nurse)
Tricyclics	
• Dry mouth	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water.
• Blurred vision	• **Health education**: Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls.
• Constipation	• Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity.
• Urinary retention	• Report to the consultant, if patient complains of any difficulty in urination. • Monitor intake and output of the patient.

Contd...

Side-effects	Nursing management (role of a nurse)
• Weight gain	• Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient.
• Photosensitivity	• **Health education:** Teach client to wear protective clothing, sunscreens and sunglasses when they are out in the sun.
• Sedation	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time or any other antipsychotic with a lesser side-effect can be administered. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
Selective serotonin reuptake inhibitors	
• Insomnia	• Administer the drug early in day. • **Health education:** Teach patient to avoid caffeinated beverages such as tea, coffee, etc. Teach the patient about relaxation techniques.
• Sexual dysfunction	• Men—abnormal ejaculation • Women—inability to feel pleasure in sexual activity. • Consultant can prescribe another antidepressant on complains of patient.
• Weight loss	• Weight management strategies. • Calorie intake should be in required proportions. • Keep a record of patient's weight on a daily basis. • On prolonged use of SSRI, weight gain may occur.
• Headache	• Do administer prescribed analgesics. • If analgesics could not alleviate headache, another antidepressant may be prescribed.
• **Serotonin syndrome**	• **Definition:** It is a drug interaction in which two drugs which upsurge serotonin neurotransmission are administered concurrently. • **Clinical manifestations:** ▪ Altered mental status ▪ Agitation ▪ Blood pressure changes ▪ Profuse sweating ▪ Tremors ▪ Hyperreflexia • **Nursing management** ▪ Discontinue the antidepressant immediately. ▪ Report the symptoms to consultant promptly. ▪ The consultant should prescribe drugs which inhibit serotonin neurotransmission. ▪ The symptoms will be reversed after discontinuation of offending agent.

Contd...

Side-effects	Nursing management (role of a nurse)
Mono amine oxidase (MAOIS) inhibitors	
• **Hypertensive crisis**	• **Definition:** MAOIS have dietary interactions with foods containing tyramine. Therefore, if a person is on MAOIS, he/she must change his/her diet accordingly to avoid hypertensive crisis. • **Foods containing tyramine:** ▪ Cheese ▪ Smoked meats ▪ Smoked fish ▪ Some beers ▪ Overripe fruits ▪ Soya products ▪ Beans • **Clinical manifestations:** ▪ Occipital headache (severe) ▪ Nausea/Vomiting ▪ Nuchal rigidity ▪ Fever ▪ Diaphoresis ▪ Hypertension (severe) ▪ Palpitations ▪ Chest pain ▪ Coma • **Treatment/nursing management:** ▪ Discontinue the offending drug promptly. ▪ Assess vital signs and keep a record. ▪ Prescribe and administer short-acting antihypertensive drugs. ▪ Control fever by cold sponging and other methods.
Other side-effects	
• Reduction of seizure threshold	**Nursing management** • Take history of seizures, if any. • Use drugs cautiously, if patient has history of seizures. • Take seizure precautions. • Anticonvulsants may be administered.
• Priapism (persistent erection of penis which is painful)	**Nursing management** • It usually occurs with trazodone. • Report the symptom to consultant. • Discontinue the drug. • If symptom do not reverse, surgical intervention may be required.
• Hepatic failure	**Nursing management** • Report clinical manifestations of hepatic failure such as jaundice, anorexia, gastrointestinal (GI) complaints, or malaise, etc. • Intervene promptly.

Antimanic Drugs

Antimanic drugs are the psychopharmacological agents which are used to treat mania. In BPAD, the psychopharmacological agents used to stabilize the mood are known as mood stabilizing agents.

Classification of Mood-stabilizing Agents (Antimanic Drugs)

Antimanic Drugs

- **Lithium carbonate** (acute mania: 1800–2400 mg/maintenance: 900–1200 mg)

Anticonvulsants

- Clonazepam
- Carbamazepine
- Valproic acid
- Gabapentin
- Lamotrigene
- Topiramate

Calcium channel blockers

- Verapamil

Antipsychotics

- Olanzapine
- Chlorpromazine
- Quetiapine
- Risperidone
- Ziprasidone

Indications (lithium carbonate)

- Mania phase of bipolar disorder
- Bipolar depression
- Prophylaxis of cluster headache/migraine
- Alcohol dependence

Indications (anticonvulsants)

- Bipolar mania
- Seizures
- Epilepsy
- Migraine prophylaxis

Indications (calcium channel blockers)

- Bipolar mania
- Migraine
- Angina/arrhythmias

Indications (antipsychotics)

- Schizophrenia
- Bipolar mania

Mechanism of Action

Lithium crosses the blood brain barrier and is distributed for action in the central nervous system. It interacts with neurotransmitters and balances their proportions in brain.

Other mood-stabilizing agents' mechanism of action is unknown. The discovery of use of valproic acid as an antimanic drug was an accident achievement.

Role of a nurse in administration of mood-stabilizing drugs is depicted in Table 4.

Table 4: Side-effects of mood-stabilizing drugs along with nursing management (role of a nurse in administration of mood-stabilizing drugs)

Side-effects	Nursing management (role of a nurse)
Antimanic Lithium carbonate • Dry mouth • Nausea/vomiting • Drowsiness • Tremors • Hypotension • Weight gain • Polyuria	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water. • Administer antimanic drug with food to combat the effects of nausea. • The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time. • **Health education:** Teach patient that he/she should not drive or operate any machinery. • Report the symptom promptly. • A beta blocker may be administered to treat tremors. • Monitor vital signs every 4 hourly. • Assess orthostatic hypotension. • Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient. • Monitor weight on a daily basis. • Maintain intake and output chart.
Anticonvulsants • Nausea/vomiting • Drowsiness • Blood dyscrasias • Prolonged bleeding time • Skin rash	• Administer anticonvulsant drug with food to combat the effects of nausea. • The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time. • **Health education:** Teach patient that he/she should not drive or operate any machinery. • Blood tests on a regular basis of a patient who is receiving anticonvulsants. • Usually occurs with valproic acid. Blood tests (BT) must be done on regular intervals. • It is a symptom with patients receiving Lamotrigine. Report the symptom to consultant immediately.
Calcium channel blockers • Drowsiness • Nausea/vomiting • Constipation • Hypotension	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time. • **Health education:** Teach patient that he/she should not drive or operate any machinery.

Contd...

Side-effects	Nursing management (role of a nurse)
	• Administer anticonvulsant drug with food to combat the effects of nausea. • Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity. • Monitor vital signs every 4 hourly. • Assess orthostatic hypotension.
Antipsychotics • Orthostatic hypotension	• Assess blood pressure in three positions, i.e., lying, sitting and standing. • Keep records of all the assessment of blood pressure and report to the consultant. • **Health education:** Teach patient to rise slowly from a lying or sitting position.
• Sedation	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time or any other antipsychotic with a lesser side-effect can be administered. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
• Photosensitivity	• **Health education:** Teach client to wear protective clothing, sunscreens and sunglasses when they are out in the sun.
• Nausea	• Administer antipsychotics with food to combat the effects of nausea.
• Skin rash	• Report any signs of skin rashes and intervene accordingly.
• Agranulocytosis	• A rare complication. • Symptoms are sore throat, fever and malaise. • Assess complete blood count.
• **Anticholinergic effects** ▪ Dry mouth	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water.
▪ Blurred vision	• **Health education:** Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls.
▪ Constipation	• Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity.
▪ Urinary retention	• Report to the consultant, if patient complains of any difficulty in urination. • Monitor intake and output of the patient.

Contd...

Side-effects	Nursing management (role of a nurse)
• **Hormonal disturbances** ▪ Decreased libido ▪ Gynecomastia ▪ Retrograde ejaculation ▪ Amenorrhea	• Reassure the patient that the symptoms will be reversed when after discontinuation of the drug. • Discuss with the consultant about the symptoms and another antipsychotic may also be prescribed. • Reassure the patient that the symptoms will be reversed when after discontinuation of the drug. • **Health education:** Ask the patient to continue with the contraceptives because amenorrhea is a side-effect of antipsychotics and ovulation is occurring naturally with no effect of drugs.
• Weight gain	• Encourage exercise and fluid intake. • Weigh the patient and keep a record of patient's weight on a daily basis. • **Health education:** Ask patient to have a less calorie diet yet a balanced one. Consultation with a dietitian, if requested by patient.
• Extra pyramidal symptoms	• Report the symptoms promptly. • Intervene accordingly.

Lithium Toxicity

Lithium carbonate is the most effective treatment against Mania. But its use is dangerous in spite of its benefits. Because Lithium is an antimanic drug which has a very narrow therapeutic index, i.e., the dosages of lithium are cautiously calculated and monitored in blood. A slight increase in serum level of lithium carbonate can cause toxicity.

Normal serum level of lithium is: 0.5–1.5 mEq/L

Clinical manifestations of lithium toxicity is given in Table 5.

Table 5: Clinical presentation of lithium toxicity

Clinical presentation	Serum lithium level	Clinical manifestations
Acute	1.5–2 mEq/L	• GI upset (nausea, vomiting, abdominal pain), Neuromuscular signs (ataxia, dizziness, confusion)
Acute on chronic	2–2.5 mEq/L	• Both GI and neurological signs and symptoms (blurred vision, stupor, coma, seizure, anorexia, severe nausea and vomiting)
Chronic	Above 2.5 mEq/L	• Neurologic symptoms only (convulsions, coma, oliguria and death)

Nursing Responsibility

- Measure lithium level as a ward routine procedure for patients undergoing lithium therapy.
- Monitor lithium levels in symptomatic patients.
- Supportive therapy/symptomatic treatment should be given to patients having lithium toxicity.
- Maintain a patent airway to prevent aspiration pneumonia as patient is having GI upset.
- Seizure precautions and medications should be initiated.

Antianxiety Drugs (Anxiolytics/Minor Tranquilizers)

Antianxiety drugs are the psychopharmacological drugs which are used to treat anxiety disorders.

Indications

- Anxiety disorders
- Anxiety symptoms
- Acute alcohol withdrawal
- Convulsions
- Preoperative sedation
- Status epilepticus
- Skeletal muscle spasms

Classification of Antianxiety Drugs

- Antihistamines
  - Hydroxyzine
- Benzodiazepines
  - Alprazolam
  - Chlordiazepoxide (librium) (15–100 mg/24 hours in divided dosages)
  - Clonazepam
  - Diazepam (6–50 mg/24 hours in divided dosages)
  - Lorazepam (2–6 mg/24 hours in divided dosages)
  - Oxazepam
- Azaspirodecanediones
  - Buspirone

Mechanism of Action

Antianxiety drugs inhibit neurotransmitter GABA at receptor site and produce a relaxing effect in Limbic system and reticular activating system; thereby depresses central nervous system resulting in sedation, hypnosis or coma.

Role of a nurse in administration of antianxiety drugs is given in Table 6.

Table 6: Side-effects of antianxiety drugs along with nursing management (role of a nurse in administration of antianxiety drugs)

Side-effects	Nursing management (role of a nurse)
Drowsiness	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
Tolerance	Tolerance is defined as a phenomenon in which an increased amount of dose is required to produce the desired effects. This is very common side-effect of antianxiety drugs. **Clinical manifestations** • Insomnia • Muscle cramps • Anxiety

Contd...

Side-effects	Nursing management (role of a nurse)
	• Depression • Tremors • Delirium • Convulsions **Management** • Teach the patient not to discontinue the drug abruptly. • Educate the patient that abrupt withdrawal is life-threatening.
Increasing effects of other CNS depressants	Alcohol and other drugs which cause CNS depression must not be taken when patient is on antianxiety drugs.
Orthostatic hypotension	• Assess blood pressure in three positions, i.e., lying, sitting and standing. • Keep records of all the assessment of blood pressure and report to the consultant. • **Health education:** Teach patient to rise slowly from a lying or sitting position.
Dry mouth	• Maintain oral hygiene of the patient. • Provide patient with sugarless candy, ice cubes and frequent sips of water.
Nausea and vomiting	• Administer anti-anxiety drug with food to combat the effects of nausea and vomiting.
Blood dyscrasias	Blood tests on a regular basis of a patient who is receiving antianxiety drugs.
Paradoxical excitement	**Definition:** The patient develops the effects opposite to the desired effects of the drug. **Management:** • Discontinue the offending anti-anxiety drug.
Potentiates depressive symptoms	• Assess mental status examination especially mood and affect. • Initiate suicidal precautions with depressive patients.

Antiparkinsonian Drugs

In psychiatry, anti-parkinsonian drugs have a greater importance. These drugs are used not only to treat Parkinsonism but to treat pseudoparkinsonism, i.e., an extrapyramidal symptom of antipsychotics also.

Indications

- Parkinsonism
- Treatment of EPS

Classification of Antiparkinsonian Drugs

- Anticholinergics
  - Benztropine
  - Biperiden
  - Procyclidine
  - Trihexyphenidyl
- Antihistamines
  - Diphenhydramine (benadryl)

- Dopaminergic agonists
  - Amantadine (symmetrel)

Role of a nurse in administration of antiparkinsonian drugs is depicted in Table 7

Table 7: Side-effects of anti-parkinsonian drugs along with nursing management (role of a nurse in administration of anti-parkinsonian drugs)

Side-effects	Nursing management (role of a nurse)
Drowsiness	• The psychiatric nurse should report about sedation of patient to the consultant. • An arrangement can be made to administer the drug at bed time. • **Health education:** Teach patient that he/she should not drive or operate any machinery.
Urinary retention	• Report to the consultant, if patient complains of any difficulty in urination. • Monitor intake and output of the patient.
Blurred vision	• **Health education:** Teach patient that this symptom will subside after few weeks. • Teach patient that he/she should not drive or operate any machinery. • Clear the way of the patient to prevent falls.
Constipation	• Provide foods rich in fiber. • Encourage fluid intake. • Encourage physical activity.
Orthostatic hypotension	• Assess blood pressure in three positions, i.e., lying, sitting and standing. • Keep records of all the assessment of blood pressure and report to the consultant. • **Health education:** Teach patient to rise slowly from a lying or sitting position.

INDIVIDUAL PSYCHOTHERAPY

Psycho means having a psychological basis and therapy means treatment. Therefore, in simple terms, psychotherapy refers to the psychological intervention for a therapeutic purpose.

The first and foremost individual psychotherapy is **psychoanalysis**. The approach of psychoanalysis is individual, i.e., one to one relationship between psychoanalyst and the patient and this is known as individual psychotherapy.

Concept of psychoanalysis: Psychoanalysis is the process in which through free association and catharsis, patient's repressed emotions and psychological conflicts are brought to surface and through application of understanding, they are resolved.

Catharsis: An emotional discharge of repressed psychological conflicts.

Free association: The patient is asked to speak whatever comes into his mind, the content of the thought may not be logical, sensible to the patient but the psychoanalyst will interpret and find out the repressed emotions.

Indications of Individual Psychotherapy

- Anxiety disorders
- Obsession
- Conversion disorder
- Depression
- Personality disorders
- Sexual dysfunction
- Compulsion

Most of the neurotic disorders can be treated with psychoanalysis.

Process of Individual Psychotherapy

The psychoanalysis is based on the psychosexual theory given by **Sir Sigmund Freud**. This states that all of the unconscious neurotic conflicts can be brought to the surface and worked through. The process of the psychoanalysis given by **Sir Sigmund Freud** involves following stages:

- **Recollection (Stage 1)**
  - First step in stage one is to teach the patient about methods, routines and requirements of analysis.
  - A therapeutic alliance is established and all the rules of psychoanalysis are taught.
  - **Free association:** The patient is allowed to express his/her problems and content of the thought is not supervised which means patient can speak whatever comes into his mind.
  - **Catharsis:** The patient disconnected ideas and expression may join and an emotional discharge of psychological conflicts can occur while describing his/her problems through free association.
- **Repetition (Stage 2)**
  - This is a transition stage in which patient feels an emotional gratification by psychoanalyst. Ideas may be projected onto psychoanalyst and a neurotic transference may occur. Transference refers to identifying the therapist as one of significant person of patient' life.
  - This brings safety and comfort with patient and can be used for therapeutic purpose to resolve unconscious psychological conflicts.
  - This results in gradual increase of surfacing of unconscious psychological conflicts.
  - The patient will now repeat childhood patterns, recall traumatic childhood events and a return to the previous developmental level can be identified where there is root of neurosis.
  - Expression of the thought here will be helpful in resolving the repressed unconscious psychological conflicts.
- **Working through (Stage 3)**
  - This is the termination phase and patient gets ready for leave in this final stage.
  - The irrational transference toward psychoanalyst is subsided through understanding.
  - The patient develops maturity and mastery over psychological conflicts.
  - Termination should not be abrupt but gradual. The patient can come for follow-up assistance, if required.

Role of a Psychiatric Nurse in Individual Psychotherapy

- The psychiatric nurse builds a psychotherapeutic nurse-patient relationship for building a therapeutic alliance in individual psychotherapy.
- The psychiatric nurse reinforces positive behaviors in individual psychotherapy.
- The psychiatric nurse keeps a therapeutic environment for a patient undergoing individual psychotherapy.
- The psychiatric nurse allows free expression of emotions in a therapeutic way without being defensive.

- Learning psychotherapy is beneficial for psychiatric nurse for her own personal growth and exploration.
- In Individual psychotherapy, the psychiatric nurse establishes peak performance as an active member of health care team.
- The psychiatric nurse can help the patient in resolving spiritual and life adjustment issues.
- The psychiatric nurse who is well versed with methods of individual psychotherapy can help coping with health problems.

GROUP PSYCHOTHERAPY

Definition and Meaning

Group psychotherapy is a form of psychotherapy in which a homogeneous or a heterogeneous group is formed which works together to meet the emotional needs of one another under the guidance of a trained psychotherapist.

Homogeneous group is the collection of people who are having the same emotional problems.

Heterogeneous group is the collection of people who are carefully selected to resolve emotional problems of one another.

Formation of the Group

- A general interview with each patient is done before selecting him/her to be a part of group therapy.
- The therapist collects a great deal of information about all the patients who could participate in group therapy for the benefit of one another.
- Usually, homogeneously composed small groups are ideal for group psychotherapy.

Setting for Group Psychotherapy

- IPD
- OPD
- Partial hospitalization units
- Community health centers
- Private institutions

Size of the Group

The group may have very few as 3 and maximum up to 15 members who can participate in group psychotherapy.

Frequency and Length of Group Psychotherapy

Frequency: Once a week and must be continuous.
Length of session: 1–2 hours

Types of Group

- Homogeneous group
- Heterogeneous group

Indications of Group Psychotherapy

- Anxiety disorders
- Marital conflicts
- Relationship problems
- Neurotic disorders
- Conflicts with authority figures
- Depressive patients

Contraindications of Group Psychotherapy

- Antisocial personalities
- Actively suicidal patients
- Manic patients
- Patients having delusions
- Violent patients

Process of Group Psychotherapy

- Selection of participants.
- The trained expertise should explain the procedure in as much detail as possible.
- The therapist answers all the questions of the group members before starting first session.
- Each patient reacts differently to the group psychotherapy because of different past and psychological conflicts.
- On the given subject, the group members are allowed to express their thoughts and ideas.
- In the process of expressing thoughts and ideas, unresolved conflicts and burdens may also come on surface. Transference among patients may occur.
- Through interpretation of thoughts and application of empathy, these conflicts can be resolved in group psychotherapy.
- During group therapy, patients learn new coping strategies to deal with their psychological burdens and also the successful execution of problem-solving process.
- Patient do learn new healthy defense mechanisms and their application in dealing with psychological problems such as:
  - Altruism
  - Abreaction
  - Acceptance
  - Catharsis
  - Empathy
  - Insight
  - Interaction
  - Interpretation
  - Reality testing
  - Transference
  - Ventilation, i.e., expression and sharing of personal information which may be secretive.
- At the end of every session and discussion, the therapist will conclude the learning and establish new ways of problem-solving which can now be implemented in future.

Role of a Psychiatric Nurse in Group Psychotherapy

The psychiatric nurse who is providing group psychotherapy does perform following functions:

- The psychiatric nurse selects, organizes and leads a collection of members to work together to resolve emotional problems.

- The psychiatric nurse encourages constructive discussions among group members.
- The psychiatric nurse channelizes all the work of group members toward maximum attainment of goals.
- The psychiatric nurse collects all the relevant information in a screening interview to form an ideal group for group psychotherapy.
- The psychiatric nurse maintains confidentiality of the information for a therapeutic purpose.
- The psychiatric nurse keeps a record of all the information and expression among group members.
- The psychiatric nurse works as a modulator and channelizes the discussion in the right direction.
- The psychiatric nurse chooses the size and composition of the group undergoing psychotherapy.

BEHAVIORAL THERAPY

Behavioral therapy refers to bring out functional adaptive behavior to improve the quality of life. Behavioral therapy has its basis in learning theories. Every individual learns his/her behavioral actions and responses during his life and this behavior pattern is much influenced by family, peer group and society. Sometimes, individuals learn dysfunctional behavioral patterns which can cause psychological problems.

For example, over pampered children are more likely to develop dependency issues. Children showing a great deal of tantrums, if parents fail to fulfil the demands of the child may have been raised in a dysfunctional way and do not appreciate delay in desires fulfilment.

Any of the reasons, which make an individual to adopt dysfunctional patterns of behavior, is a wrong adaptation method.

Behavioral therapy implies correction of dysfunctional pattern and re-learning.

John B Watson was the Father of Behavioral Psychology.

Origin of Behavioral Therapy

Learning theories:

- Pavlov Theory of Learning
- Systematic Desensitization by Wolpe
- BF Skinner Learning Experiment

Behavioral Therapy Approaches

Systematic desensitization: It is also known as gradual exposure therapy. In systematic desensitization, the patient is gradually exposed to the feared stimulus (anxiety provoking stimulus) until patient attains a sense of relaxation with mild or no anxiety. Indications are phobias, obsessions, compulsions, and sexual disorders.

The process of systematic desensitization consists of following steps:

Step 1 Patient is asked to make a hierarchy of the anxiety provoking situations in an ascending order, i.e., the lesser anxiety provoking stimulus at the top and so on.

Step 2 Teach patient relaxation techniques such as mental imagery or deep breathing exercises.

Step 3 Exposing the patient to the least anxiety provoking stimulus; one at the top of the hierarchy and tackling the situation with relaxation technique instead of anxious behavior.

Step 4 Again exposing the patient to the previous anxiety provoking stimulus, if he/she has not conquered it yet. If patient's anxiety has been resolved and there is no anxiety on exposure to the stimulus then patient can move to the next anxiety provoking stimulus in the hierarchy.

Step 5 The patient moves in the hierarchy and reaches the highest anxiety provoking stimulus gradually and overcome it in steps.

- **Flooding:** It is also called implosion. Flooding is different from systematic desensitization in which there is gradual exposure to anxiety provoking stimulus.
  In flooding, at once exposure to the anxiety provoking stimulus is done without use of hierarchy.
  Sometimes, imagined flooding is used in which no real exposure to the anxiety provoking stimulus is made; instead the feared object is confronted only in imagination.
- **Virtual therapy:** The feared stimulus is confronted through computerized simulations.
- **Participant modeling:** Learning and adopting new behavior patterns through imitation and observation.
- **Assertive training:** Assertiveness is defined as protecting one's rights without violating the rights of others. Many people are passive aggressive, aggressive or non-assertive. They learn assertiveness through observing behavior of assertive persons under supervision of behavioral therapist.
- **Aversion therapy:** Every wrong behavior pattern is punished and in this way, a specific behavioral response is generated. Punishment may be in form of noxious stimuli such as electrical shock, social disapproval, emetics, etc.
- **Positive reinforcement:** Every right and desirable behavior pattern is rewarded and positively reinforced. The rewards may be in form of social appraisal, food and/or praise, etc.

Role of a Psychiatric Nurse in Behavioral Therapy

- The psychiatric nurse encourages positive reinforcement.
- The psychiatric nurse can correct wrong behavioral patterns in neurotic patients.
- Behavioral therapy can be very useful in child psychiatry and should be implemented by a psychiatric nurse working with children.
- The psychiatric nurse can implement behavioral techniques for phobic, anxious patients.
- The psychiatric nurse can implement behavioral approaches for patients having sexual dysfunctions.
- The psychiatric nurse can use token economy, i.e., a kind of positive reinforcement in which tokens are given every time patient demonstrates desirable behavior and when a particular number of tokens are collected; an incentive is given to the patient. This behavioral approach is very effectively used by psychiatric nurses with schizophrenic patients.
- The psychiatric nurse uses behavioral techniques with alcohol dependence patients to encourage abstain from alcohol.
- The psychiatric nurse can also correct anti-social behavior of adolescents.

OCCUPATIONAL THERAPY

Occupational therapy is the use of occupations for a therapeutic purpose. Occupational therapy is given by occupational therapist.

The American Occupational Therapy Association defines an occupational therapist as someone who helps people across the lifespan and participate in the things they want and need to do through the therapeutic use of everyday activities (occupations).

Indications

- Differently-abled persons
- Persons with physical injuries
- Persons with physical impairments

Occupational therapy is a multidisciplinary approach and can be executed with the help of other professionals such as physical therapist, speech therapist, psychiatric nurse, social worker, etc.

Advantages of Occupational Therapy

- It improves quality of life of patient.
- Occupation helps to improve self-esteem of the patient.
- Occupation improves personality of the patient.
- Occupation adds to the income of the patient and in turns raises the confidence of the patient.
- Occupation helps in improving patient health in every dimensions; physically, mentally, spiritually, vocationally, etc.

Areas of Occupational Therapy

The American Occupational Therapy Association has given following areas of occupational therapy:

- Education
- Work
- Rest and sleep
- Play
- Recreation
- Activities of daily living (bathing, toileting, combing, grooming, etc.)
- Instrumental activities of daily living (care of equipment/clothing/pets/kitchen)
- Social interactions

Settings of Occupational Therapy

- Day care centers
- OPD
- IPD
- Rehabilitation centers
- Special schools

Role of a Psychiatric Nurse in Occupational Therapy

- The psychiatric nurse can encourage patient in institutions for occupational therapy.
- Motivation by a psychiatric nurse to participate in occupational activities can bring life to a patient who lacks confidence and is of a low self-esteem.
- The psychiatric nurse can help to improve quality of life of a psychiatric patient by indulging him/her in meaningful life activities.
- The psychiatric nurse can also be a member of health team who do participate in occupational therapy areas.
- The psychiatric nurse assists patients in ADLs and IADLs.

FAMILY THERAPY

Family is the basic structural and functional unit of society. Family is the foundation on which society is established. Family functions, if altered, can cause various psychological problems and conflicts in the members of family.

Family therapy is the therapeutic psychological approach to correct the family dysfunction.

Definition: Family therapy is the psychotherapeutic approach which will improve family functioning in terms of relationships, communications and understanding of one another.

Indications of Family Therapy

- Relational difficulty
- Marital maladjustment
- Social maladjustment
- Miscommunication and misunderstandings in family members
- Broking family (at the urge of divorce or separation)
- Conversion disorder
- Adolescent crisis/adult problems

Process of Family Therapy

- **Consultation:** Family therapy starts with a screening interview with family as a whole or a particular member of family, who is the focus of intervention. Family therapy is needed, may not have a clear indication. The family member may complain about behavior of another family member or issues of child may come at surface after marriage and so on. The problem diagnosis is made by family therapist after screening interview of family members.
- **Interview:** Family is a group having common goals in society and have "we feeling" altogether. The family therapist must treat family as a group and understands its functioning. The family is already an established group. The first task of a family therapist is to understand the functioning of the established group. The interdependency among family members must be learned by family therapist and how he has to inspire the whole group in adopting new ways of family functioning.

The family therapist must not be passing judgments over verbalized material of family members and maintain confidentiality among family members also unless it is permitted and mandatory approach for correcting flaws.

Free association is not recommended in family therapy as it can lead to domination of the talk by one dominant family member. A careful catharsis of one member unto other should be the approach of family therapist.

Frequency and Length of Family Psychotherapy

Frequency: Once a week and must be continuous.
Length of session: 1–2 hours

Role of a Psychiatric Nurse in Family Therapy

- The psychiatric nurse is the source of information about family and family members, if they are staying in cottage.
- The psychiatric nurse can help in initial screening and interviews.

- The psychiatric nurse can help to establish family goals and dynamics.
- The psychiatric nurse can keep a record of all the information and maintains its confidentiality.
- The psychiatric nurse can learn family therapy and its methods in detail and can help inward patients to communicate and reside as a family with more communication among patients which brings love and laughter in institutionalization.
- The psychiatric nurse must intervene accordingly with the family member, who is suffering psychological problems because of family disputes.
- The patient of conversion disorder is a challenge for family to intervene according to the therapeutic modalities. The psychiatric nurse may contribute largely for a patient with conversion disorder and his family.
- The psychiatric nurse can provide social counseling and psychological support to the family members.

MILIEU THERAPY

The word Milieu is taken from French language and it is used in place of word *middle*. In psychiatry and English translation, it refers to *environment*.

Many of the mental disorders are having origin in their faulty environment. Milieu therapy is based on the concept that, if patient's environment can be made therapeutic, it might improve mental health of psychiatric patients.

Milieu therapy changes the patient's environment to be therapeutic, adaptive and conducive for patient's health.

Definition

A scientific structuring of the environment in order to effect behavioral changes and to improve the psychological health and functioning of the individual (Skinner, 1979).

Goals of Milieu Therapy

- To manipulate patient's environment in a therapeutic way.
- To teach patient new healthy ways of coping and adaptive strategies; this can be adopted to improve the quality of life of patient.
- To foster a sense of independence in patient.

Principles of Milieu Therapy

- Mutual respect
- Maximum purposeful interaction
- Promotion of autonomy
- Encouraging socialization
- Effective use of peer pressure for therapeutic purpose
- Team work
- We feeling
- Encouraging acting out behavior
- Therapeutic group discussion
- Temporary seclusion for therapeutic purpose

Need for Milieu Therapy

In institutions, patient is not autonomous and is not able to take independent decisions. The patient usually develops feelings of dependency. The concept of deinstitutionalization could not be adopted by every psychiatric patient because of lack of cooperation by family and community. Therefore, patients remain in institution and lacks interaction and social responsibilities. It makes a psychiatric patient unfit for the community. To combat these negative effects of institutionalization, milieu therapy came into existence.

Strategies of Milieu Therapy

- **Distribution of power:** The milieu therapy works in this manner that no one person in the group will dominate. The work of the group will be divided among members and in this way the power will be distributed. It encourages group members' participation and increases the self-esteem of patient. The patient will learn to be an active member of the family and a productive member of the community. Accomplishment of the work triggers patient mind to participate and power empowerment brings productiveness.
- **Open communication:** Milieu therapy is based on the effective communication in which therapeutic communication techniques are used. The communication will be using an open-ended question which encourages ventilation, catharsis and resolution of psychological conflicts. It enables the patient to understand empathy and practice it when he again becomes a member of community.
- **Structured interactions:** Structured interactions are those interactions which are planned under supervision. These interactions are discussion over the matters rather than arguments. Structured interactions are learning communication in a better way which will enables patients to learn the individual differences among family and community. It would be very helpful when patient will again go into community.
- **Work-related activities:** The activities of milieu therapy are work performances which are graded later.
  - Gardening
  - Cooking
  - Washing utensils and keeping them in arrangement
  - Washing clothes, ironing, keeping them in given shelves or closets.
  - Dining
  - Housekeeping, etc.
  - All of the work activities, minor or major, will make the patient a productive member of the community.
- **Community participation:** All of the activities of the milieu therapy are coordinated and executed in the same manner as they are done in community. Community people also participate in milieu therapy. For example, a psychiatric patient who is undergoing milieu therapy may went to a nearby market in community to purchase food items.
- **Environmental adaptation:** The milieu therapy teaches environmental adaptation to the psychiatric patients by using adaptation model. It teaches patients to use more adaptive techniques to the environment and helps in improving coping with environmental stresses.

Role of a Psychiatric Nurse in Milieu Therapy

- The psychiatric nurse can help to establish a therapeutic environment for the psychiatric patient by planning in ward routine accordingly.

- The psychiatric nurse plans activities and interactions with patients who are undergoing milieu therapy.
- The psychiatric nurse can indulge patients in art, drawing, bed side lamps, pictures, making bulletin boards, file making, etc.
- The psychiatric nurse can initiate effective communication among patients of milieu therapy.
- The psychiatric nurse ensures physical environment to be conducive for milieu therapy.
- The psychiatric nurse encourages larger group interaction.
- The psychiatric nurse explores the feasibility of social skills training in milieu therapy.
- The psychiatric nurse can make conclusive observation of psychiatric patients undergoing milieu therapy.

SOMATIC THERAPY: ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) is a very controversial procedure in spite of its efficacy. Majority of the community people do consider this therapy as very inhumane. Like other therapies, it is not appreciated among psychiatric patients and even health care workers.

Many of the members of health care team also don't have a positive outlook toward electroconvulsive therapy.

Definition of ECT

Electroconvulsive therapy is the induction of grandma seizures through induction of an electric current with use of electrodes.

Types of ECT

ECT can be classified on the basis of location.

- Unilateral (front temporal region on the dominant side)
- Bilateral (front temporal regions on both sides)

Types of Convulsions

Tonic-clonic seizures

Duration of Seizures

Minimum 25 seconds in which 10–15 seconds are of tonic phase

Frequency

It depends on the severity of disease. ECT may be administered alternatively or thrice per week.
Number: 6–12 treatments on an average. Maximum 20

Indications of ECT

- Major depression
- Mania
- Schizophrenia
- Neuroses
- OCD
- Personality disorders

Contraindications of ECT

There is no absolute contraindication for ECT. ECT may be administered cautiously in following conditions:

- Increased intracranial pressure
- Cardiovascular disorders
- Osteoporosis
- Pulmonary disorders
- High risk pregnancy

Mechanism of Action

The exact mechanism is not known. The ECT is believed to upsurge the neurotransmitters in the brain. After ECT, there is a significant increase in level of neurotransmitters in the brain such as serotonin, norepinephrine, and dopamine, etc.

Amount of Current

About 70–130 volts, it can be decided on the basis of patient's weight and amount of current required to produce convulsions.

Adverse Effects of ECT

- Transient memory loss
- Confusion
- Disorientation
- Brain damage
- Fractures and dislocations

Role of a Psychiatric Nurse Before Administration of ECT

- Keep patient NPO for last 6 hours before administering ECT.
- Make patient sit in waiting room.
- Keep a calm environment in the waiting room by keeping lights dim, noise free.
- The patient should be asked to void before ECT.
- The psychiatric nurse can provide magazines or other written material for patient to read.
- Be with the patient.
- Keep preanesthetic drugs ready for the patient.
- Take a written consent from significant relative after explaining the procedure.
- The psychiatric nurse should take a history of the patient focusing on presence of any cardiovascular or neurogenic disorders and any other contraindications of ECT.
- The psychiatric nurse should check for any metallic article with patient even, if it is a pace-maker in heart. Report to the physician immediately.
- Remove any make-up and dentures.
- The psychiatric nurse should check for loose clothing suited for ECT treatment.
- The psychiatric nurse must maintain personal hygiene of the patient especially hair care allowing removal of oil from hair.
- The psychiatric nurse should take the patient on a stretcher to ECT room after completion of pre-ECT care.

The first and foremost task even before administering ECT is administration of Pre-ECT medication. The Pre-ECT medication is administered in waiting room or ECT room depending upon the institution policy.

Pre-ECT Medication

1 Anesthetic agent + 1 muscle relaxant + 1 anticholinergic

Anesthetic agents used in ECT are:

Thiopental sodium 0.25 gm to 0.5 gm IV ---------- Barbiturate
Methohexital---------- Barbiturate
Etomidate ---------- Non-barbiturate
Ketamine---------- Non-barbiturate
Alfentanil ---------- Opioids
Propofol---------- Non-barbiturate

In most Indian institutions, methohexital, thiopental sodium or propofol is commonly used anesthetic agent.

Muscle Relaxant Used in ECT

Inj. succinylcholine 30–50 mg is a muscle relaxant

Anticholinergic used in ECT

Inj. atropine decreases the secretions and is helpful in prevention of aspiration pneumonia

- A padded mouth gag and tongue depressor is placed to prevent tongue bite during convulsions.
- Provide oxygenation to prevent apnea after convulsions.
- Provide electrodes which are kept ready in NS or with jelly.
- Record the timing and duration of convulsions.
- Prompt suctioning as needed.

Role of a Psychiatric Nurse after Administration of ECT

- Monitor vital signs of the patient every 15 minutes and do not shift the patient until patient has normal range of vital signs.
- While shifting the patient, put on the side-rails to prevent falls and injury to the patient.
- Shift the patient when he/she responds to simple commands such as open your mouth.
- Allow sleep and rest as demanded by patient.
- Offer a glass of water after half an hour of ECT administration.
- Re-orient the patient to time, place and person.
- Record vital signs.
- Allow the patient to eat the meal.
- Make observation of any change or injuries.
- Resume the daily ward routine with patient.

INSULIN THERAPY

Insulin therapy is also known as Insulin Coma therapy in the field of psychiatry. In which by regular large doses of insulin, a hypoglycemic state is induced in a psychiatric patient to calm the brain up till level of coma.

This method of treating psychiatric disorders is obliterated now and is no more in use. It was discovered by Austrian-American psychiatrist **Manfred Sakel** in 1927. Insulin therapy was used in 1940s.
Insulin therapy and convulsive therapies were altogether known as shock therapies.

Method of Administering Insulin Therapy

This therapy can only be given under strict supervised conditions in labor-intensive treatment. Therapy must be administered by trained staff. When the patient starts improving with repeated comas, doses of insulin can be subsequently reduced.
Each episode of coma lasts for one hour to the max.

Indications of Insulin Therapy

- Schizophrenia
- Delusional disorder

Adverse Effects of Insulin Therapy

- Hypoglycemia
- Perspiration
- Pallor
- Excessive salivation often resulting in drooling
- Agitation
- Convulsions may occur before or after insulin therapy

Role of a Psychiatric Nurse in Insulin Therapy

Nowadays insulin therapy is banned and if any institution or private organization is administering it without legal permission and consent of patient, it must be reported for legal enquiries.

ASSESS YOURSELF

Previous Years' Questions

Write short notes on:

1. Pre ECT nursing care
2. Role of nurse in group therapy
3. Extrapyramidal symptoms
4. Nursing responsibilities for a person undergoing ECT
5. Lithium toxicity
6. Nursing care of patient after ECT
7. Side-effects of antipsychotic agents
8. Occupational therapy
9. Nursing management of a patient on lithium therapy
10. Psychoanalysis
11. Antipsychotic drugs
12. Behavior therapy

Multiple Choice Questions

1. Which of the following is not a kind of antidepressant class?

a. Tricyclic antidepressants
b. Monoamine oxidase inhibitors (MAOIs)
c. SSRIs
d. Phenothiazines

2. Which of the following drugs are used to treat anxiety?

a. Anxiolytics
b. Antipsychotics
c. Insulin
d. Hypnotics

3. Which of the following is not an EPS?

a. Tardive dyskinesia
b. Dysphasia
c. Neuroleptic malignant syndrome
d. Pseudoparkinsonism

4. Behavioral therapy is based on:

a. Learning theories
b. Dream analysis
c. Catharsis
d. Cognition

5. Benzodiazepines are to treat:

a. Depression
b. Anxiety disorders
c. Schizophrenia
d. Mood disorders

6. The major communication skill to be learned in milieu therapy is:

a. Empathy
b. Silence
c. Acceptance
d. Probing

7. Which of the following is not an approach of behavioral therapy?

a. Flooding
b. Aversion therapy
c. Systematic desensitization
d. Counter transference

8. In systematic desensitization, which of the following is done?

a. Hierarchy of anxiety provoking stimulus
b. Diary
c. Journal writing
d. Token economy

9. Dream analysis of repressed emotions is done in which of the following?

a. Behavior therapy
b. Psychoanalysis
c. Learning theory
d. Insulin therapy

10. Family therapy attempts:

a. Effective therapeutic communication
b. Resolution of psychological conflicts
c. To make the patient fit for community
d. All of these

11. Token economy is executed in:

a. Individual psychotherapy
b. Behavioral therapy
c. Family therapy
d. Dream analysis

12. MAOIs therapy does not recommend?

a. Fats
b. Minerals
c. Fluid intake
d. Foods containing tyramine

ANSWERS KEY

1. d **2.** a **3.** b **4.** a **5.** b **6.** a **7.** d **8.** a **9.** b
10. d **11.** b **12.** d

Unit

7

COMMUNITY MENTAL HEALTH

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Describe the concept of community mental health in relation to provide comprehensive care to the patients.

UNIT OUTLINE

- Community Mental Health
- Community Health Center in Provision of Mental Health Services
- National Mental Health Program
- Importance of Community Mental Health
- Scope of Community Mental Health
- Attitudes Toward Mentally-ill
- Stigma and Discrimination Related to Mentally-ill
- Community Mental Health Nursing
- Community Mental Health Services
- Prevention of Mental Illness (Preventive Psychiatry)

KEY POINTS

- The Directorate General of Health Services has recently revised the National Mental Health Program in 2016.
- The original NMHP was launched in 1982 and was revised with every five-year plan.
- A mentally healthy community can be a useful weapon for development of community as a whole.
- Long-term centers are very beneficial for those who are chronically/mentally-ill but because of limited bed capacity in mental hospitals, can be shifted in residential/long-term continuing care centers where they will be provided with treatment and rehabilitative services.

COMMUNITY MENTAL HEALTH

Definition

Community Mental Health is the provision of mental health services by using decentralized approach of rendering mental health services.

Purposes

- To supplement the hospital mental health care.
- To provide basic mental health care services in those areas where mental health hospitals/day care center, etc. are not available.
- To decrease the cost of mental health care services.
- To make mental health care services accessible to community.
- To provide home mental health care discouraging isolation from community.
- To discourage aggregation of mentally-ill patients in central hospitals.
- To practice psychiatric epidemiology, i.e., a science which is researching the depth of mental disorders on which a refined mental health care system can be developed and evaluated.

COMMUNITY HEALTH CENTER IN PROVISION OF MENTAL HEALTH SERVICES

National Mental Health Program has adopted the concept of developing community mental health center by integrating with general health care services. By training and educating community center workers (medical officer, community health nurse, anganwadi workers, school teachers, social workers, community leaders) in the field of psychiatry, NHMP has done a marvelous work in the field of psychiatry. This program is revised periodically on the basis of current needs of the community.

NATIONAL MENTAL HEALTH PROGRAM

The Directorate General of Health Services has recent revision of National Mental Health Program in 2016. The original NMHP was launched in 1982 and was revised with every five-year plan.

NMHP was launched to address the need of qualified mental health care professionals and lack of mental health care facilities in India. In 1996, District Mental Health Program (DMHP) was added to the existing NMHP.

In 2003, NMHP was revised again with the following two innovative strategies:

1. Modernization of State Mental Hospitals
2. Upgradation of Psychiatric wings of Medical Colleges/General Hospitals.

In 2009, there was a revision of NMHP again focusing on Manpower development scheme.

Objectives of National Mental Health Program

- To ensure the availability and accessibility of minimum mental health care for all in the foreseeable future.
- To encourage the application of mental health knowledge in general health care and in social development.
- To promote community participation in the mental health service development.
- To enhance human resource in mental health sub-specialties.

Components of National Mental Health Program

District and sub-district level activities under NMHP are given as follows:

District Mental Health Program

Working for provision of minimum mental health care services and expecting it to be accessible to community in future. To accomplish this, following measures are decided for implementation:

- Accessibility and availability of mental health OPD and IPD services with a bed capacity of at least 10.
- Out-reach component with following measures:
  - DMHP will execute four satellite clinics in one complete month with following interventions: Counseling in schools/colleges.
  - Life skills training in schools.
  - Suicide prevention services.
- Training and education of health care workers in community health centers.
- Spreading awareness about mental illness and combating stigma related to mental illness and toward mentally-ill person.
- Community participation; working with NGOs, self-help groups in community for promotion of mental health.

Every targeted intervention is fostering implementation of mental health act in community as a whole. DMHP has covered 241 districts, so far and it is working for the expansion of program in other districts too and to cover all the districts of country in future.

The very important next component of DMHP is to increase the manpower working in the field of mental health. For this, mental health care workers are hired by Government on contractual basis. The following disciplines are recruited:

- Psychiatrist
- Clinical psychologist
- Psychiatric nurse
- Psychiatric social worker
- Community health nurse
- Field officer
- Ward assistant

Every district is getting a support of ₹83.2 lakhs for implementation of DMHP.

Public Private Partnership

National rural health mission has adopted PPP to implement mental health care services with NGOs and self-help groups working in the field of mental health in community. For this, a financial support of ₹5 lakhs is given per NGO.

Day Care Center

Day care center are helpful for those mentally sick clients who got discharged from hospital and continue mental health care services in community or for those who dislike hospitalization and want to be treated in community only. In day care center, they get rehabilitation and treatment of mental illness. Every day care center is receiving a financial support of ₹50000/year for execution of program.

Residential/Long-term Continuing Care Center

These long term center are very beneficial for those who are chronically mentally-ill but because of limited bed capacity in mental hospitals, can be shifted in residential/long term continuing care center where they will be provided with treatment and rehabilitative services. A financial support of ₹9 lakh is given annually.

Community Health Center

In a community mental health center, OPD and IPD services are given along with emergency psychiatric services in community. These center also provide counseling services. Every community health center is having manpower of one medical officer, one clinical psychologist and one psychiatric social worker. The community health center nurse works as a psychiatric nurse in community with training and education.

Primary Health Center

Primary health care center are also providing IPD and OPD, counseling and emergency services for the allotted community. PHC is involved in mental health promotion activities. PHC manpower for mental health is two community health workers.

Mental Health Services in Medical Colleges/General Hospitals in Psychiatric Wings

In medical colleges and general hospitals, mental health care services are provided in psychiatric wings. A financial support of ₹15 lakhs is given annually. The psychiatric wing is headed by HOD of psychiatry department.

Mental Health Helpline

A national mental health helpline available for 24 hours exists for information regarding metal health care services.

- **Tertiary care activities:** Tertiary care activities cover Scheme A and Scheme B which are manpower development schemes.

  Scheme A. Center of excellence in mental health
  - Upgrading existing mental hospitals with manpower and mental health care facilities, lab facilities, etc.
  - Financial support of ₹ 33 crores approx. per year.

  Scheme B. Establishing PG training departments
  - Establishing post graduate programs in Government Medical Colleges and Government Mental Hospitals.
  - Financial support of ₹ 1 crores approx. per year.
- Upgrading two mental health institutions for provision of neurological and neurosurgical facilities:
  - NIMHANS, Bengaluru
  - CIP, Ranchi
- Supporting state and central mental health authorities
- Research and survey
- Monitoring and evaluation
- Central information, education and communication
- Central mental health team
- Mental health information system
- Training/workshops

Role of Nurse in National Mental Health Program and Psychiatric Care in Community

The community mental health nurse:

- Helps in provision of mental health care services to the community.
- Provides training and education to the nursing assistants working in community health center.
- Provides counseling services in community.
- Gives life skill training in schools and colleges of community.
- Helps in providing minimum/basic mental health care services in community.
- Creates awareness among community people about mental disorders and their management.
- Attends workshops for information regarding current trends in mental health field and spread the information to fellow workers.
- Can do research and surveys in the field of psychiatric nursing.
- Can give health education to the patients, families ad community.
- Can help in eliminating stigma related to mental illness by spreading knowledge about mental illness.
- Helps in effective execution of Mental Health Act.
- Manages and provides care and mental health care services to drug addicts in the community.
- Implements DMHP activities in community.
- Provides training to the student nurses in the field of the mental health.
- Implements preventive psychiatry and helps in prevention of mental disorders especially among vulnerable population such as antenatal women, children, elderly and adolescents.

IMPORTANCE OF COMMUNITY MENTAL HEALTH

Community mental health is very important component of health care services. Mental health is the field which lacks qualified mental health care professionals and mental hospitals in general. Community mental health was always a concern for every five year program to take care of community mental health.

WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It clearly demonstrates the importance of a person's mental health without which, he/she can't be completely healthy. Mental health is very important dimension of health.

Community is the sum of inhabitants in a particular geographical area. As one individual can't be said healthy without dimension of mental health; a community can't be said a healthy community without community mental health. Therefore, community mental health is very important and determines the success and health of the nation altogether.

The importance of community mental health can be understood through advantages of a good community mental health under the following headings:

- A mentally healthy community is a productive community.
- A community can be educated about mental illnesses and in this way, their occurrence can be prevented; the result will be low incidence of mental disorders.
- A mentally healthy community will be able to perform life activities in an adaptive manner with more flexible approaches.
- A mentally healthy community will bring forth mentally healthy children.
- A mentally healthy community will be more successful.
- A mentally healthy community will be able to cope with life stressors and use their potentials to the maximum.
- A mentally healthy community will be cooperative, understanding and caring.
- A mentally healthy community can be a useful weapon for development of community as a whole.
- A mentally healthy community will be able to appreciate and utilize natural resources efficiently.
- A mentally healthy community can train children, adolescents and adults of the community to be better citizens of nation.
- A mentally healthy community is free from mental disorders.

SCOPE OF COMMUNITY MENTAL HEALTH

Scope means the extent to which an area or a subject can be expanded. Community mental health is the mental health of the total community which means it includes all age groups, all strata, all religions, all socio-economic statuses and everything which forms community. Therefore, scope of community mental health is much wider and vast. The scope of community mental health can be understood under following headings:

- **Decentralization:** The very first thing which demonstrates scope of community mental health is that burden of mental illness on a nation is divided and because of lack of adequate number of mental hospitals, a community mental health center took the divided responsibility and now a decentralized approach is used for rendering mental health care services.
- **Advanced nursing practice and standards:** Community mental health is an advanced nursing practice which states that an individual who is being hospitalized is confined and sometimes becomes an unfitting member of the community. On the other hand, if he/she is treated in the community, prognosis of mental disorder will be better and he/she will stay in community only.

- **Education and research:** Another scope of community mental health is in the field of education and research, e.g., a patient who is treated in hospital having BPAD can be compared in terms of prognosis with a patient with same disorder in community and the findings of the research can be used for better mental health care and may add to the body of knowledge of community mental health.
- **Vulnerable population:** Vulnerable population such as children, women, elderly, differently abled, mentally retarded, etc. can be a part of a productive community by social skill training and vocational rehabilitation, etc.
- **School guidance and counseling services:** The community mental health approach has provided guidance and counseling services in schools and colleges.
- **Day care center/partial hospitalization:** By using partial hospitalization approach, various day care center, day hospitals and day treatment programs have been established which work in community itself.
- **Half-way home:** Is another approach of community mental health to deal with those mentally sick patients who don't need full hospitalization but only a regular follow-up.
- **Early detection of mental disorders:** By community health professionals, a mental disorder can be detected at a very early stage and with an aggressive treatment, it can be fully prevented.
- **NMHP and DMHP:** By using and collaborating with community mental health services, national level mental health programs are executed in the country.
- **Rehabilitation:** The community mental health services are providing rehabilitation to chronically mentally-ill patients, differently abled, drug-addicts, etc. to enhance the scope of community mental health.

ATTITUDES TOWARD MENTALLY-ILL

Attitude refers to the beliefs/opinions of an individual or a community toward any person, situation or event. Community people have a negative attitude toward a mentally-ill person. The following is list of attitudes of community toward a mentally-ill person. Community people:

- Believe that mentally-ill persons are mentally retarded and not capable of doing anything good.
- Believe that mentally-ill persons are harmful/dangerous creatures and not to be resided in community along with other members of the community.
- Often reject mentally-ill persons to work, participate in social gatherings, etc.
- Believe that mental illness is a life-long disease and no mentally-ill person can ever be cured.
- Believe that everyone who goes to the mental hospital is mentally-ill whether he/she works over there or getting treatment in form of guidance and counseling.
- Believe that over qualified individuals are insane; therefore, one should learn any subject in limits.
- Believe that mentally-ill persons are demon-possessed and need to be rectified by spiritual leaders or some tantrics who know witchcraft.
- Believe that mental sickness is due to bad deeds of the mentally-ill person.
- Believe that mentally-ill persons need to be isolated.
- Believe that mentally-ill persons can't be trusted.

Although attitudes of community people are constantly changing with awareness and education, general attitude of community is in this way in underdeveloped less educated regions.

STIGMA AND DISCRIMINATION RELATED TO MENTALLY-ILL

The mentally-ill people often face stigma and discrimination because of society's reaction and attitude toward mental illness; symptoms of mental illness. The stigma and discrimination of a society toward anything is usually inherited and passes on from one generation to another through passive learning.

Originally, stigma is stereotype behavior, i.e., if one person in the community is discriminating, other people in the community will also do the same without knowing the rationale. A feeling of distrust, avoidance and negativity exists in the community toward mentally-ill person.

Stigma associated with mental illness often results in labeling the mentally sick according to his/her appearance, behavior and socioeconomic status, e.g., people may call a manic patient as an over-decorated Christmas tree, etc.

Media has also affected stigma toward mental illness. Many movies symbolize mentally-ill as an idiot person in the family who is not worthy and acceptable to the community.

Mentally-ill person may have very few or no friends at all.

Stigma also rears his head in workplace of an individual. A mentally-ill person is not accepted and appreciated in his/her workplace. Many times, he/she may be rejected for his mental illness.

Link, Cullen, Struening and Shrout, 1989 had classified stigma into two types:

1. **Social stigma:** It is characterized by prejudicial attitudes and discriminating behavior directed toward individuals with mental health problems as a result of the psychiatric label they have been given.
2. **Perceived stigma/self-stigma:** In contrast, *perceived stigma* or *self-stigma* is the internalizing by the mental health sufferer of their perceptions of discrimination.

Because of advancement in technology and education in society, mental stigma has been reduced to a great extent but the walls of stigma are still there.

COMMUNITY MENTAL HEALTH NURSING

Community mental health nursing is the treatment approach based on standards of psychiatric nursing using nursing process and bio-psychosocial treatment modalities which must be accessible and available to community people.

Goals of Community Mental Health Nursing

- To integrate mental health care services in institutions and in community.
- To impart knowledge and understanding to student nurses.
- To acknowledge benefits of community approaches in treatment of patients such as health education, awareness programs, rehabilitation services.
- To enhance PPP for the speedy implementation of NMHP and DMHP.
- To add to the body of knowledge of subject.
- To encourage research and survey in the field of mental health.
- To apply theoretical principles of mental health nursing in community area.
- To increase community understanding of mental disorder.
- To encourage mental health promotion.
- To implement preventive psychiatry.

COMMUNITY MENTAL HEALTH SERVICES

Community mental health services are implemented at three levels:

1. International mental health level
2. National mental health level
3. State mental health level

International-level Mental Health Services

- **WHO:** World Health Organization has developed mental health services provision at an international level. WHO plays a major role in research and survey in the field of mental health. WHO has also contributed to mental health by funding many mental health programs nationally and internationally.
- **UNESCO:** The United Nations Educational Scientific and Cultural Organization (UNESCO) has arranged the use of satellites for mental health promotion and preventive services. It has also contributed to research in mental health field.

National Level Mental Health Services

- **National mental health program:** NMHP has its components in district and sub-district levels. It has various activities such as DMHP, Public private partnership, Day care center, Residential/long-term continuing care center, CHCs, PHCs, Mental health services in general hospitals/medical colleges, mental health helpline, upgrading national mental institutions, Research and survey, mental health information system, IEC, etc.
- National mental hospitals (NIMHANS, CIP, etc.) are offering postgraduate programs in psychiatry.
- National rehabilitation center.
- Research and survey in the field of psychiatry.
- Tertiary care activities under scheme A and B.

State Level Mental Health Services

- Day care center
- Half-way homes
- Training and education for community health workers
- Seminars and workshops in the field of psychiatry
- Ongoing researches in field of psychiatry
- District Mental Health Program with following targeted interventions and objectives:
- Accessibility and availability of mental health OPD and IPD services with a bed capacity of at least 10.
- **Outreach component:** DMHP will execute four satellite clinics in one complete month with interventions such as counseling in schools/colleges, life skills training in schools, suicide prevention services.
- Training and education of health care workers in community health center.
- Spreading awareness about mental illness and combating stigma related to mental illness and toward mentally-ill person.
- Community participation; working with NGOs, self-help groups in community for promotion of mental health.

Every targeted intervention is fostering implementation of mental health act in community as a whole. DMHP has covered 241 districts, so far and it is working for the expansion of program in other districts too and to cover all the districts of country in future.

The very important next component of DMHP is to increase the manpower working in the field of mental health. For this, mental health care workers are hired by government on contractual basis.

PREVENTION OF MENTAL ILLNESS (PREVENTIVE PSYCHIATRY)

Prevention is aimed at inhibiting the occurrence of mental illness, its early detection and treatment and rehabilitation.

Definition of Preventive Psychiatry

It is reducing the incidence of mental and behavioral disorders in community by early detection and treatment based on evidenced based interventions.

Aims of Preventive Psychiatry

- Reducing incidence of mental disorders.
- Reducing relapse rate.
- Reducing the risk of occurrence of mental disorders in vulnerable population.
- Reducing the disease rate in vulnerable population.
- Reducing the impact of mental illness on diseased, family and community.

Classification of Preventive Psychiatry

- Primary preventive psychiatry interventions.
- Secondary preventive psychiatry interventions.
- Tertiary preventive psychiatry preentions.

Primary Preventive Psychiatry Interventions

- Prevention of marital discords
- Prevention of divorce
- Antenatal care
- Balanced nutrition
- Premarital counseling
- Child-guidance clinics
- Prevention of child abuse
- Preventing violence
- Preventing risky sexual behavior
- Good teaching practices
- Educating new mothers in taking care of mental health
- Prevention of substance abuse
- Grief and bereavement counseling to prevent depression
- Counseling services for widows, single persons

- Preventing behavioral problems
- Suicide prevention programs

Secondary Preventive Psychiatry Interventions

- Early detection and treatment of high-risk groups
- Effective health care services
- Accessible mental health care services
- Aggressive treatment in early stage of mental illness
- Drug compliance
- Suicide prevention strategies for those who have previous suicide attempt

Tertiary Preventive Psychiatry Preventions

- Rehabilitative services
- Vocational rehabilitation
- Psychosocial rehabilitation
- Life skills training

Prevention of Mental Illness during Childhood

Children come in the category of vulnerable population. The following interventions can be done to prevent the occurrence of mental illness during childhood:

- Teach antenatal mothers for balanced nutrition.
- Prevent anemia in an antenatal mother. Encourage folic acid, iron supplements.
- Prevent birth-injuries during delivery.
- Discourage use of alcohol or any other substance during pregnancy.
- Avoid smoking during antenatal period.
- Safe-delivery practices to prevent infections to child.
- Prevent neglect of the child. Provide care and affection in the early years of life.
- Teach parenting skills.
- Assess all developmental milestones and report any delay or abnormality.
- Use behavioral modification techniques, if the child is having any behavioral problem such as temper tantrums, etc.
- Prevent child's physical and sexual abuse.
- Rear up the child in a safe and non-threatening home environment.
- Never perform any sexual activity in front of child.
- Discipline the child with positive reinforcement.
- Be with the child and listen to him/her as, if he/she is the most amazing and intellectual person of this world. Your treatment will create the same thoughts in the child and this could be the first step in raising the self-esteem of the child to reach self-actualization, i.e., the highest mental health sign.

Prevention of Mental Illness during Adolescent Period

- Prevention starts with assessment of the adolescent. Assess the mental status of the adolescent and collect a baseline data for intervention.

- Compare the adolescent with the normal growth and development of adolescent period. Intervene, if any abnormality is found.
- Discourage destructive behaviors.
- Educate about safe sex practices.
- Teach about ill-effects of teenage pregnancy.
- Talk with the adolescent and allow him/her to express his/her thoughts about this transitory period and secondary sexual signs and symptoms.
- Screening should be done to identify high-risk adolescents.
- Health education should be given on transition coping with adolescent period.
- Bio-psychosocial therapies can be given to perfect adaptation.
- Exercise is beneficial for mental and physical health.
- Anger management skills can be taught to adolescents.
- Stress management is the asset of prevention in every age group.

Prevention of Mental Illness during Adulthood

- Stress management is the asset of prevention in every age group.
- Anger management skills need to be learned by adults.
- Exercise is good for promotion of mental health.
- Nutrition is essential component to maintain mental health.
- Managing work stress can contribute to healthy lifestyle which in turn will promote mental health of adults.
- Health education and awareness programs regarding mental disorders should be implemented.
- Safe-sex practices can prevent guilt and unnecessary psychological burden and will encourage good mental health.
- Premarital counseling should be given to prevent occurrence of stress and depression and other mental disorders.
- Marital counseling can be instituted for promoting mental health.
- Guidance clinics referrals are made for managing acute stresses of life.

Prevention of Mental Illness in Old Age (Elderly)

- Prevent elderly physical and sexual abuse.
- Provide a caring and affectionate environment in home.
- Encourage participation in social activities.
- Talk and listen to elderly.
- Be with the elderly. Don't isolate them, especially from family and friends.
- Special care and attention should be given to elderly whose spouse is dead. They are at greater risk for depression and suicidal tendencies.
- Take care of physical health of elderly.
- Pay attention to availability of needed medicines for elderly.
- Elderly people are usually financially dependent. This may decrease their self-esteem. Acceptance is the key to tackle this mind stressor.
- Elderly people are at risk for delirium and dementia. Reorient them as often as possible. Hang calendars with big letters in room. An extensive care is demanded for prevention of organic mental disorders.

- Encourage active support systems.
- Provide a calm and safe environment.
- Be consistent in your behavior and routines.

ASSESS YOURSELF

Previous Years' Questions

1. What should be your attitudes toward mentally-ill person?
2. Explain the role of a nurse in community mental health services.

Multiple Choice Questions

1. Early detection and treatment is an approach of:

a. Primary prevention b. Secondary prevention
c. Rehabilitation d. Tertiary prevention

2. Which of the following is not a component of NMHP?

a. Tertiary care services b. PPP
c. DMHP d. Dementia clinics

3. Who gets education and training under NMHP services in community health center?

a. Community health nurse b. Medical officer
c. Nursing assistant d. All of these

4. Which among the following is not a vulnerable population?

a. Elderly b. Adults
c. Children d. Differently abled

5. Among the following, which is the major concern to teach adolescents?

a. Nutrition b. Hygiene
c. Safe-sex practices d. Morals and ethics

6. In nutrition of antenatal women, which of the following nutrient is of primary concern?

a. Fat b. Minerals
c. Folic-acid d. Water

7. DMHP is an approach of:

a. INC b. NMHP
c. WHO d. UNESCO

8. The original NMHP was launched in the year:

a. 1990 b. 1982
c. 1977 d. 1983

9. In which year, DMHP was added to NMHP?

a. 1996 b. 1992
c. 1986 d. 1997

10. OPD and IPD services must be established in the field of mental health with a bed capacity of at least:

a. 12 b. 10
c. 15 d. 20

11. Community people are having following attitude toward a mentally sick:

a. Positive b. Indifferent
c. Sensitive d. Negative

12. Self-stigma is also known as:

a. Isolated stigma b. Social stigma
c. Perceived stigma d. Idiotic stigma

ANSWERS KEY

1. b **2. d** **3. d** **4. b** **5. c** **6. c** **7. b** **8. b** **9. a**
10. b **11. d** **12. c**

Unit

8

PSYCHIATRIC EMERGENCIES AND CRISIS INTERVENTION

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Learn about various psychiatric emergencies and their management.
- Describe the concept of crisis intervention.

UNIT OUTLINE

- Psychiatric Emergency
- Major Psychiatric Emergencies
- Minor Psychiatric Emergencies
- Psychiatric Emergencies in Children
- Crisis
- Crisis Intervention
- Crisis and its Intervention in Aids
- Adolescent Crisis

KEY POINTS

- Psychiatric emergency is an acute disturbance in the mind equilibrium which, if not attended immediately, may lead to potentially harmful acts for the psychiatric patient as well as for others in community.
- A psychiatric emergency is said to be a major psychiatric emergency, if it is potentially fatal.
- A child has his/her own way to demonstrate underlying stressors in home or in family.
- Protect oneself and others in casualty. The first and the foremost thing to be done in emergency is to ensure safety of own and others.

PSYCHIATRIC EMERGENCY

- **Meaning:** Emergency means a dangerous/harmful situation or disturbance which requires immediate attention.
- **Psychiatric emergency:** It refers to those emergency situations in the field of psychiatry which possess an immediate threat to the behavior, thought or behavior of the psychiatric patient and requires instant intervention.

Psychiatric emergency is an acute disturbance in the mind equilibrium, which if not attended immediately, may lead to potentially harmful acts for the psychiatric patient as well as for others in community.

Types of Psychiatric Emergencies

Psychiatric emergencies can be classified as major or minor based on the degree of threat it possesses for psychiatric patient and others.

- **Major psychiatric emergency:** A psychiatric emergency is said to be a major psychiatric emergency, if it is potentially fatal.
- **Minor psychiatric emergency:** A psychiatric emergency is said to be a minor psychiatric emergency, if it requires an immediate attention but a non-life threatening situation (Table 1).

Table 1: Psychiatric emergencies in adults

Major	Minor
Suicide	Underactive patient
Overactive patient	Withdrawal symptoms
Violent behavior	Acute psychosis
Adverse drug reactions	

MAJOR PSYCHIATRIC EMERGENCIES

Suicide

Suicide is a major psychiatric emergency as it is potentially fatal.

Suicide may be defined as a wishful killing of oneself. Before any committed suicide, there is a time period in which an individual makes a plan for dying in his own mind. This crucial time period is the time for a professional to intervene to safeguard the life of an individual.

Risk Factors

- **Gender:** Men commit suicide more and women attempt suicide more.
- **Age:** Suicide risk advances as age advances.
- **Religion:** Orthodox people are more prone to suicides.
- **Marriage:** Married people have a lower risk of suicide. Unmarried people are more prone to suicide.
- **Occupation:** The higher the socioeconomic status, the higher the risk of suicide. Students are among the first to commit suicides and the second highest risk is among psychiatrists.
- **Physical health:** People with chronic or terminal illnesses are at more risk of committing suicides.
- **Mental illness:** Among all mental illnesses, depressive patient's accounts for 80% of the persons who commits suicides. The other risk lies among schizophrenics and patients having organic mental disorders. Up to 15% of drug addicts especially alcoholics commit suicide.
- **Previous suicidal behavior:** A previous suicidal attempt makes an individual more prone to commit suicide.
- **Parasuicidal behavior:** Parasuicide is a term used to describe the behavior of self-mutilation but not having any intention to die. These people are more prone to attempt suicide rather than commit it.

Emergency Interventions

- Safeguard the person by any means. Keep him safe from any inflictions and injuries.
- With all of your efforts, prevent the occurrence of suicide.

Case study: One psychiatric patient was attempting suicide while he was planning to jump out of window from 7th floor. Psychiatric nurse saw the patient and immediately held the patient from underarms and picked him up. In this way, she prevented the occurrence of suicide.

Under Control Interventions

- Make an adequate assessment in association with suicide.
- Treat underlying psychopathology.
- Provide a safe and non-provoking environment. Patient's room should be free from any sharp instruments, knives and glasses.
- Ask patient whether he/she has a plan for suicide. An individual who is having a suicide plan is more likely to commit it.
- Establish a strong support system.
- Provide guidance and counseling.
- Establish a contract between a therapist and suicidal client. The contract states that whenever an individual will experience suicidal impulses, he/she will contact the therapist as soon as possible without committing suicide.
- The last resort for suicide is hospitalization in which one to one observation will be made to keep the patient safe.

Overactive Patient

Mania is characterized by three-triad symptoms of elated mood, pressure of speech and over-activity. Overactive patient is treated as a psychiatric emergency because an overactive patient exhibits potential danger to self and others.

Clinical Manifestations

- Violent
- Impulsive behavior
- Increased libido to the extent of committing rape
- Severe agitation

Emergency Interventions

- Lithium is the drug of choice for an overactive patient.
- Restraining according to the need of the patient.
  - Pharmacological (rapid tranquilizers in combination with antipsychotics)
  - Mechanical or physical restraining
  - Verbal restraining

Under Control Interventions

- Seclusion for safety of others
- Hospitalization

Violent Behavior

Some psychiatric patients show hostile behavior as a result of psychopathology and exhibit potential/actual threat for oneself and others.

Clinical Manifestations

- Agitation
- Verbal threats
- Abusive
- Violent

Emergency Interventions

- Restraining according to the need of the patient.
  - Pharmacological (combination of lorazepam and haloperidol)
  - Mechanical or physical restraining
  - Verbal restraining

Under Control Interventions

- Seclusion
- Encourage expression of ideas, thoughts and emotions.
- Teach anger controlling techniques.

Adverse Drug Reactions

In psychiatry, the **major adverse drug reactions are extrapyramidal symptoms (EPS).** EPS are untoward adverse drug reactions due to use of anti-psychotic drugs for treatment of psychotic disorders (Table 2)

Table 2: Clinical manifestations and treatment

EPS	Clinical manifestations	Treatment
Tardive dyskinesia	Involuntary movements of mouth, neck and trunk	• Discontinue/decrease the offending drug. • Choose an alternative drug to deal with psychosis.
Dystonia	Spasm of neck, face, jaw and tongue muscles	• Discontinue/decrease the offending drug. • IM benztropine or diphenhydramine
Akathisia	Motor restlessness	• Discontinue/decrease the offending drug. • Mirtazapine (15 mg OD) • Benzodiazepines • Propranolol (30–120 mg/day in divided doses) • Anticholinergics
Parkinsonism	Rigidity, bradykinesia (slowness of movement), tremor	• Discontinue/decrease the offending drug. • Anticholinergics
Neuroleptic malignant syndrome	Fever, hypertension, altered mental status, muscular rigidity, profuse perspiration and salivation	• Discontinue the offending drug. • Maintain nutritional status to restore water and nutrient levels. • Skeletal muscle relaxants (dantrolene). • Treat hypoxia and metabolic acidosis. • Electroconvulsive therapy as a last resort with varying results.

MINOR PSYCHIATRIC EMERGENCIES

Underactive Patient

Depression is manifested by three-triad symptoms, i.e., sadness of mood, poverty of ideas and psychomotor retardation. The symptom of psychomotor retardation could be so serious that it can bring the patient to an emergency department where his/her under activity will be treated as a psychiatric emergency.

A depressed underactive patient exhibits a psychiatric emergency because of varying degrees of changes in mood and behavior.

Clinical Manifestations

- Apathy
- Sadness of mood
- Worthlessness, hopelessness, unworthiness
- Suicidal thoughts
- Decreased libido
- Severe anxiety up to level of panic
- Anorexia
- Weight loss

Emergency Interventions

- Encourage ventilation of thoughts, ideas and emotions.
- Encourage talks about fears, frustrations, disappointments, failures, break-ups or any other personal issues.
- Active listening in calm and an unhurried manner.
- Assess for suicidal thoughts and plans. Safe guard the patient and ensure safety of patient.
- Hospitalization, if needed.
- Be with patient with full acceptance and allow one to one relationship and observation.

Under Control Interventions

- Suicide prevention guidelines for protecting and safeguarding the patient.
- Guidance and counseling
- Group therapy
- Marital counseling, if needed
- Encourage support system.

Withdrawal Symptoms/Substance Withdrawal

Drug withdrawal is the syndrome which occurs when a drug-addict abruptly discontinues the intake of the substance. The symptoms which appear after discontinuation or decrease of drug/substance use are known as withdrawal symptoms.

Common Clinical Manifestations

- Abdominal pain
- Drowsiness
- Tardive dyskinesia
- Insomnia
- Delirium
- Seizures

Emergency Interventions

Every substance has its own antidote for treatment of its withdrawal symptoms (Table 3).

Table 3: Substance and treatment for withdrawal symptoms

Substance	Treatment for withdrawal symptoms
Antidepressants withdrawal	Anticholinergic such as atropine
Sympathomimetic withdrawal	Antipsychotics and antidepressants
Volatile nitrates	Cessation of use
Alcohol withdrawal	• Diazepam (Valium R), chlordiazepoxide (Librium R), lorazepam (Ativan R), and oxazepam (Serax R) • Fluid and electrolytes maintenance • Monitor vital signs • Thiamine IM (100 mg)

Contd...

Substance	Treatment for withdrawal symptoms
Opioids withdrawal	IV naloxone, narcotic antagonist
Clonidine withdrawal	Antipsychotics, if needed
Cocaine withdrawal	• Antipsychotics • Benzodiazepines • Antidepressants for withdrawal depression
Sedatives, hypnotics or anxiolytics withdrawal	• Naloxone

Under control Interventions

Guidance and counseling

Acute Psychosis

Acute psychosis is manifested as a sudden impairment of reality testing in which hallucinations, delusions and disorganized speech and personality.

The major manifestations in an acute psychotic episode may be disorganized behavior, agitation and excitement.

Emergency Interventions

- Take vital signs—medical and psychiatric history, history of allergies, check blood glucose, recognize signs and symptoms of agitation, i.e., physical restlessness.
- Check for hostility—pharmacological intervention
  - Antipsychotic medication
  - Haloperidol
  - A combination of lorazepam and haloperidol

    OR
  - Another combination can be of divalproex plus olanzapine or risperidone.

Under Control Interventions

- If the initial dose does not bring results, the medication can be repeated.
- Verbal restraining.
- Behavioral interventions such as offering a blanket, pillow, asking well-being of the patient, offering meals to alleviate the anxiety of the psychotic patient.
- Use physical restraining but with caution. Release them as soon as safely possible.
- A complete physical examination; lab investigations including CT scan and MRI (Table 4).

Table 4: Major and minor psychiatric emergencies in children

Psychiatric emergencies in children	
Major	**Minor**
• Violent behavior and tantrums	• School refusal
• Neglect	
• Fire setting	
• Child abuse	
• Anorexia nervosa	
• AIDS	

PSYCHIATRIC EMERGENCIES IN CHILDREN

Psychiatric emergencies in children are often recognized by parents, teachers and or relatives and then child is taken to the therapists or physicians. Major and minor psychiatric emergencies in children are given in Table 4.

A child has his/her own way to demonstrate underlying stressors in home or in family. He/she may not express it verbally but in conduct. Due to lack of understanding of child psychology, parents often reject the initial alarms given by child and it results in an occurrence of an emergency situation which brings child to casualty in hospital.

Violent Behavior and Tantrums

When a child is violent and showing a great deal of tantrums, it poses a threat to his life and life of others.

Emergency Interventions

- Protect oneself and others in casualty. The first and the foremost thing to be done in emergency are to ensure safety of own and others.
- If the child calms down in emergency area, then:
  - Ask the child to express the thoughts and emotions.
  - Even, if child seems under control, therapist should approach the child with a backup (manpower).
  - If the child is not seemingly under control, give him several minutes to be calm.
- If the child is extremely violent and does not want to be in control, then:
  - The first intervention to be done is Physical restraining.
  - The next intervention may be pharmacological restraint, if needed.

Under Control Interventions

- Approach the child in a calm and non-threatening manner.
- Be non-judgmental and ask the child to share his/her thoughts and emotions.
- Evaluate for underlying psychopathology.
- Involve family members to understand the situation of the child and to learn why of the behavior.
- If the child is having recurrent episodes of tantrums and violent behavior, hospitalization may be the last resort.
- In the absence of any underlying psychiatric illness, no further medication is required to keep the child safe.

Neglect

Neglect means not being cared. Not every child is fortune to have care and affection; some may experience neglect. Neglect hampers a child's physical, mental and emotional growth.

Neglect may be manifested as failure to do:

- Love
- Providing food
- Providing shelter
- Education
- Supervision.

Causes of Neglect

- Very young parents
- Very busy parents for whom child is not the priority
- Ignorant parents
- Self-absorbed parents
- Parents struggling themselves with life or illness (physical or mental).
- Negative relationship between a caretaker and a child: Here, child refuses food and the caretaker also withdraws; resulting in neglect of nutritional needs: Severe malnutrition.
- Apathy (lack of emotions) of caretaker

Emergency Interventions

- Take the child out from troubled environment and keep him/her in a safe non-threatening place.
- For a child experiencing neglect, Psychiatric hospital may be the safest place to survive.
- Supervise the child and guide regarding meals; provide food in a loving and caring manner.
- Intervene for physical abuse, if any.

Under Control Interventions

- If the therapist suspects parents for child abuse, report to appropriate channel for safety of the child.
- If the family is cooperative and the child is not in danger, then involve parents in taking care of the child.
- Follow-up for a neglected child is mandatory.
- Educate the family about neglect and its ill-effects. Care is to be taken of the neglected child.

Fire Setting

A child may/may not set a fire with an intention to harm others but only for the play purpose with matchsticks. Whatever may be the purpose, but setting a fire is injurious and fatal for the child and others in the surrounding environment.

Fire-setting may be an impulsive act for some children who feel pleasure by igniting fires and leaves the situation without any effort to extinguish it.

Causes

- Lack of supervision
- Child's interest in playing with matches impulsive behavior

Emergency Interventions

- Ensure safety
- Prevent further occurrences

Under Control Interventions

- Take history whether the fire setting was once or a repeated recurrent occurrence.
- Psychiatrist must evaluate for the underlying psychopathology. Take family history of family discord, conflicts, and punishments to child, harsh or rude behavior with child.
- If there is a history of recurrent ignition of fires, hospitalization may be recommended.
- Counsel the parents of child.
- Never leave the child unattended, without supervision with other children.
- Behavioral therapy focused on positive reinforcement is main psychological intervention.

Child Abuse

Many of the young children are victims of physical and sexual abuse. Surprisingly, the offender is one of the nearest relatives or a family friend rather than an outsider. Young children are often afraid to tell others what has happened with them? Who was the offender?

Physical and sexual abuse occurs in all age groups of both genders, in all socioeconomic levels and in all ethnic groups. The abuse may vary in severity. At any stage, child abuse is a psychiatric emergency.

Assessment

- The sexually abused child does have sexual knowledge which is not expected from that developmental stage.
- The sexually abused child is sometimes sadistic, i.e., deriving pleasure from inflicting pain to sexual partner; and aggressive as they have learned sexual behavior in a bad way.
- Fear
- Anxiety
- Depression

Emergency Interventions

- **Physical examination:** Observe pain, STDs, irritation and itching of Urinary system. Observe genitalia for bruises and laceration.
- Observe gait and ask the child to walk and sit.
- If the therapist suspects child abuse, child and parents should be interviewed separately.
- Take history in a careful manner.

Under Control Interventions

- Follow-up is mandatory. The abused child may not speak on day one of interview. Therefore, child must be interviewed in a very polite way and no probing should be used as the abused child is already afraid.
- Use anatomically correct dolls to assess child abuse.

Case study: One girl who was being sexually abused by her grandfather was given two dolls to play. One doll was a male doll and another was a female doll. The girl was made to play and she was being observed while playing. While playing, the girl child used to keep the male doll over the female doll.

After the play, therapist did ask girl child, "Who is the female doll?" The girl child replied, "That is me". The therapist then asked girl child, "Who is the male doll"? Then the girl child replied, "That is my grandfather".

Use of play is very efficient way to assess child abuse. Play is the expression of a child and must be observed very carefully.

Anorexia Nervosa

Anorexia nervosa is an eating disorder in which a person has an obsession to be excessively slim and manifested by refusal of food. It is mostly a disorder of females.

Clinical Manifestations (Appears after Puberty)

- Amenorrhea
- Malnutrition
- Nutritional deficiencies
- Distorted body image

Assessment

The body weight of an anorexic is catastrophically less than the ideal, i.e., ≥30% of body weight. At this stage, anorexia nervosa is considered as a psychiatric emergency.

Emergency Interventions

- Massive nutritional support
- CBC analysis
- 24-hour nutritional recall; nutritional assessment

Under Control Interventions

- Hospitalization
- Prevention and correction of complications-electrolyte imbalances, hormonal imbalances

AIDS

Acquired immunedeficiency syndrome is a psychiatric emergency when it is being transmitted by an infected mother to a neonate or in an adolescent through an infected sexual partner. Sometimes, adolescents who are drug-addicts also catch infection by using infected needles.

A child or an adolescent is often brought to the hospital when there is a panic about the occurrence of AIDS about which they might have heard through newspaper, magazine or any health care professional.

Emergency Interventions

- Screening
- AZT, i.e., azidothymidine for treating asymptomatic patients.

Under Control Interventions

- The person who is found non-infected after screening, must be educated and counseled about disease transmission and safe sex practices.
- Overrule any organic mental illness in an infected person. The infected person might have symptoms of impaired memory, impaired cognition, social withdrawal and/or organic psychosis.

School Refusal

Many of the children refuse to go to school on day one or when their grade is up. The most common cause is separation anxiety.

Emergency Interventions

- Take history (since, when child had refused to go to school).
- Treat separation anxiety on an urgent basis; as an underlying cause.
- Bring the child to school even, if the child feels distressed and take help from a teacher or a school counselor. Make the child comfortable in school environment.
- Use positive reinforcement while child stays at school.

Under Control Interventions

Behavioral therapy using behavioral modification techniques.

CRISIS

Definition and Meaning

Everyone faces sudden traumatic incidences one or another time of life. The stressful dreads create disequilibrium in the normal life of a person and threaten his/her homeostasis. This emergency threatening condition is known as crisis.

A sudden event in one's life that disturbs homeostasis during which usual coping mechanisms cannot resolve the problem (Lagerquist, 2001)

Types of Crisis

- Individual crisis (an individual's experience of a threat)
  - Suicidal threats
  - Suicide
  - Homicide
  - Loss (financial/loved one/self-esteem/status/dignity/honor)
- Mass crisis (a community/society's experience of a threat)
  - Terrorism
  - Natural disaster
  - Riots/revolts

Classification of Crisis by Baldwin (1978)

This classification is based on degree of severity.

- **Dispositional crisis:** It refers to the acute reflex action to an external stimulus. An individual's immediate response to a stressful life event is known as dispositional crisis, e.g., an act of violence at home, a roadside accident, etc.
- **Crisis of anticipated life transitions:** Life has normal anticipated transitions, e.g., a student will be an employee one day after college, a married girl will be a mother, and a promotion will bring a new role with new responsibilities.

  Although transition is desirous for an individual, but he/she feels lack of control over the situation and treats this transition as a crisis.
- **Crisis resulting from traumatic stress:** When an individual faces a traumatic event in his life, then even after the traumatic event is over; his/her stress is not overruled. He/she continuously lives in the fear of reoccurrence of the act or individual may suffer from reliving the same experience again and again in his mind. This is known as crisis resulting from traumatic stress, e.g., all the passengers who travelled in Titanic who have been saved may be fearful of travelling in any ship again or they may feel fearful while looking at sea. Because although the traumatic event is over, their experience with traumatic event is still alive in their mind.
- **Maturational/developmental crisis:** Maturity is the asset of an individual. A mature person is always appreciated. But to behave mature is not easy for everyone.

  Many individuals face a crisis situation when there is a compulsive need to behave mature or when there is a development to a higher level. These individuals are afraid of the unknown in the future. They are more comfortable and contented with less mature and lower developmental level. Their coping mechanisms fail at the next developmental level and therefore, it poses a threat to their equilibrium and they face crisis, e.g., rejection of a proposal demands growth which is not acceptable for an individual who treats maturity as a crisis.
- **Crisis reflecting psychopathology:** Many of the individuals are already struggling in their lives and in the middle of all those pre-existing psychopathologies, if any new stressor comes; it will complicate the resolution. This is known as crisis reflecting psychopathology, e.g., an individual who has already been diagnosed with panic attacks will be afraid to experience any new trauma or stress.
- **Psychiatric emergencies:** In this stressful life situations, general functioning of an individual is severely impaired.

CRISIS INTERVENTION

- **Ewing (1978)** has defined crisis intervention as the informed and planned application of techniques derived from the established principles of crisis theory, by persons qualified through training and experience to understand these principles, with the intention of assisting individuals or families to modify personal characteristics such as feelings, attitudes and behaviors that are judged to be maladaptive.
- **Hafer** and **Peterson (1982)** refer to crisis intervention as the kind of psychological first aid that enables to help an individual or group experiencing a temporary loss of ability to cope with a problem or situation.

  Crisis interventions can be executed in both OPD and IPD settings by a trained health care professional who is qualified in techniques of crisis intervention.

Phases of Crisis Intervention Focused on the Role of the Psychiatric Nurse

The phases of the crisis intervention are comparable with the steps of nursing process and are briefly discussed here:

Phase 1 Assessment

Assessment means to gather all the subjective and objective data to form a basis for intervention. The psychiatric nurse who is a crisis helper collects all relevant information in relation to crisis such as:

- What/who is the stressor?
- What are the consequences of crisis?
- When the crisis has occurred?
- What precipitated the stress?
- Has the mental coping abilities of the individual been assessed?
- Has individual faced the similar or a different crisis in the past?
- If yes; what coping strategies were used in the past? Were they successful?
- What is the strength of support system of the individual?
- Has individual any suicidal tendency or plan?
- How does individual perceive him/herself in a crisis situation—as a strengthened or a week personality?

On the basis of collected information, the individual care plan can be established with the following nursing diagnoses:

- Ineffective coping strategies
- Risk for potential/actual danger
- Anxiety
- Fear

Phase 2 Planning

Planning is the writing of the execution in mind. The psychiatric nurse will sit with the needy person who is facing crisis and will develop a plan to be executed for solving problems. The psychiatric nurse will make count of all the support and resources available to tackle the crisis situation.

The psychiatric nurse and the needy facing crisis, will develop a hierarchy of coping strategies to be used for crisis intervention in the ascending order of their previous success. The method which is thought to be most successful will be listed on the top and so on.

Phase 3 Intervention

Intervention is the actual execution of the plan. All the plans and coping strategies which were listed previously will now be tried and evaluated until the problem is solved and crisis situation is under control.

Tasks of Intervention Phase

- Be with the person who is facing crisis. The mere presence of help (psychiatric nurse) can ensure the progress of crisis intervention.
- Never rationalize the situation. Logical explanations and rationales are of no use for a person who is experiencing a massive stress. The needy are not in a situation to understand why of the occurrence?

- Use therapeutic communication techniques to establish a therapeutic NPR. Discourage/avoid non-therapeutic communication techniques such as probing, advising, etc.
- When an individual faces panic, he/she is more at urge of losing control and behaves in an impulsive manner. Limit setting of **behavior** is another important task in crisis intervention.
- Allow the person to express his thoughts, ideas and emotions in a calm and non-threatening environment.
- Real interventions:
  - Sit with the individual and discuss/clarify the problem that the individual is facing.
  - Acknowledge emotions of an individual. The most expected emotions in the crisis may be an expression of anger, panic anxiety, and destructive thoughts.
  - Help the person to acknowledge what has precipitated the crisis?
  - **Problem-solving process:** The first thing to be done is to help an individual to confront the situation. Encourage discussion of coping strategies and try every coping strategy in the hierarchy. Make realistic goals and together achieve them.
    Explore alternative coping strategies and help them to alleviate future crisis situations.
    Identify support systems and teach the individual to use them effectively in times of stress.

Phase 4 Evaluation

When you have tried all the coping strategies available, you must evaluate the results of their use. Whether the coping strategy was effective in alleviating the stress and it was successful in resolving the crisis.
The successful coping strategies should be taught to the individual for future use and resolution of crisis.

CRISIS AND ITS INTERVENTION IN AIDS

AIDS, i.e., Acquired Immunedeficiency Syndrome; its diagnosis itself is the major crisis. An individual who has been diagnosed with such terminal illness faces a major crisis.

The signs exhibited by an individual who is diagnosed with AIDS will be hopelessness, depressive thoughts as he/she is facing a major crisis.

An individual with AIDS may exhibit depression; a co-morbidity because of fears in relation to dying.

Role of a Psychiatric Nurse in Major Crisis for an Individual with Aids

- **Encourage acceptance:** Denials can only delays adaptation. Although it is really very difficult for anyone to experience the fear of dying every day, but acceptance may bring psychological healing.
- **Encourage expression:** An individual with AIDS should be allowed to freely express his thoughts, fears and challenges, emotions of dying.
- Use therapeutic communication techniques always.
- Never give false reassurance by proclaiming statements such as everything is going to be alright, miracles happens every day.
- Instill hope. Allow positive thinking. Instead of focusing on the dying, shift the focus of the individual on living as long as he/she is alive. This is not easy. But, continuous work on individual's mind and help him to learn how one negative thought can be replaced with a positive one can bring wonder results.

  An individual having terminal illness once shared with a psychiatric nurse, "I feel that there are only thrones for me in life and I will never be able to experience any goodness of flowers of life". The psychiatric nurse remained silent for some time and then she said, "Yes, thrones but the same thrones which fell on

Lord Jesus' head and became crown". The individual started crying and a catharsis, i.e., an emotional discharge brings everything on surface and it helped the individual with AIDS to accept his illness.

- The psychiatric nurse or any other professional can't stop the death but can bring life in remaining living of an individual. Speak about goodness of life. Encourage those behaviors which could bring happiness and peace to an individual who is facing crisis.
- Make a list of all the Do's which an individual with AIDS can feel and experience happiness and with the help of available support system, achieve as many goals as possible.
- Encourage to comply with the therapeutic regimen.
- Allow prayers, meditation, etc.
- Be with the individual. Your mere presence is more than enough to meet psychological needs of an individual who is in crisis.

ADOLESCENT CRISIS

Adolescence is the transition period between childhood and adulthood. In this period, an individual develops physiological and sexual signs of puberty, hormonal upsurge to be a mature human body.

One author has mentioned adolescents as a "Work in Progress". Approximately, for 75% of the adolescents are successful in adapting to adulthood, remaining are maladjusted and face great hurdles and difficulties in this transition period and treat it as an adolescent crisis.

Erik Erikson has described in his theory of psychosocial development that an individual is having tasks of Ego identity verses Role confusion in adolescent period.

- **Ego identity:** An individual counts all of his previous experiences till adolescence and integrates those experiences with current changes, this is known as ego identity. If an individual is successful in performing the task of ego identity, he/she is having normal adaptation and there is no resulting adolescent crisis.
- **Role confusion:** Some of the individuals are not capable to mold themselves into new experiences of life and fails to establish a new identity with new roles and responsibilities and there is resulting adolescent crisis.

Emergency Manifestations

- Suicidal attempts and ideation
- Substance abuse
- Wandering behavior
- Eating disorders

Role of a Psychiatric Nurse in Adolescent Crisis

- Encourage free expression of thoughts, ideas and emotions by an individual who is facing an adolescent crisis.
- Treat for substance use and eating disorders.
- Be with adolescent and ensure his safety.
- Explain about the normal bodily/emotional changes during transition, e.g., pubic hairs, development of breast, urge to have sexual contact, attraction toward opposite gender, etc. Tell adolescent that it is normal to experience these kinds of changes.

- Explore more about cognitive development. Encourage the shift of focus from concrete ideas to abstract ideas. Explain to the adolescent that there are many more things in the world which may be invisible to the eyes but can be felt because they are alive, e.g., love, hate, art, personalities, inspirations, maturity. Talk more about the abstract ideas.
- Encourage moral development.
  - Most of the times, adolescents heard these kinds of statements such as-You are not that mature to take your own decisions OR you are no more a kid; we don't expect this kind of behavior from you. You are grown up.
  - Sometimes, they are treated as a child and sometimes as an adult. This creates confusion about their identity and they never understand what behavior should be adopted of a child or of an adult.

  Here, an adolescent needs guidance and counseling. The focus of guidance and counseling will be in such ideas that no one can move back to the previous stage of development; one has to progress further to be mature and to be a fitted member of the community.

  The psychiatric nurse/therapist should help an adolescent to inculcate moral development, i.e., to behave in a manner acceptable to the society being focused on ethics and etiquettes.
- Use behavior modification techniques to foster ego identity as a sign of successful adaptation to adulthood/maturity.

ASSESS YOURSELF

Previous Years' Questions

1. Write a short note on EPS.
2. Write a short note on withdrawal symptoms of drug addiction.
3. Discuss the management of patient with hyperactivity.
4. Discuss the management of patient with suicidal tendencies.
5. Write a short note on suicidal patient.

Multiple Choice Questions

1. Which of the following is not a major psychiatric emergency of children?

a. Child abuse
b. Refusal of school
c. Neglect
d. Tantrums

2. Suicide is more prevalent in:

a. Unmarried
b. Employed
c. Low socioeconomic status
d. Women

3. Akathisia refers to:

a. Sensory disturbances
b. Cognitive dysfunction
c. Motor restlessness
d. Memory loss

4. Suicide is more common in which of the following psychiatric illness?

a. Schizophrenics
b. Organic mental disorders
c. Conversion disorder
d. Depression

5. Which of the following substance poses 15% of suicides?

a. Opium
b. Cocaine
c. Alcohol
d. Barbiturates

6. Who among the following professions have a greater risk for suicide?

a. Psychiatrists
b. Teachers
c. Scientists
d. Philosophers

7. Which of the following is a drug of choice for an overactive patient?

a. Risperidone
b. Lithium
c. Propranolol
d. Naloxone

8. Which of the following is not a symptom of acute psychosis?

a. Hallucinations
b. Violence
c. Agitation
d. Poverty of ideas

9. Which of the following EPS is manifested by symptoms of hyperpyrexia and hypertension and renal insufficiency?

a. Tardive dyskinesia
b. Neuroleptic malignant syndrome
c. Akathisia
d. Dystonia

10. For an overactive patient, which of the following is most effective?

a. Naloxone
b. Risperidone
c. A combination of haloperidol and lorazepam
d. Haloperidol

ANSWERS KEY

1. b **2. a** **3. c** **4. d** **5. c** **6. a** **7. b** **8. d** **9. b**
10. c

Unit

9

FORENSIC PSYCHIATRY/ LEGAL ASPECTS

LEARNING OBJECTIVES

After going through this unit, you will be able to:

- Learn about legal aspects of psychiatric nursing.

UNIT OUTLINE

- Indian Lunatic Act (1912)
- The Narcotic Drugs and Psychotropic Substances Bill/Act (1985)
- Mental Health Act (2017)
- Admission Procedures
- Discharge Procedures
- Standards of Psychiatric Nursing Practice
- Rights of Mentally Ill Patients
- Legal Responsibilities in the Care of Mentally Ill Patients

KEY POINTS

- Indian Lunacy Act is divided into 4 divisions and 8 chapters. This act consists of 100 sections.
- The Narcotic Drugs and Psychotropic Substances Bill, 1985, was passed by both houses of parliament and came into force.
- Psychiatric patients have legal rights which must be protected by all health care members and ethically correct.
- Mental Health Act contains total 16 chapters.
- The American Nurses Association has set standards of nursing practice in the field of psychiatry.
- Admission and discharge procedures for a psychiatric patient are described in chapters IV and V of the Mental Health Act.
- Mental Health Act (1987) has given provision under the law to protect the psychiatric patients' human rights.

INDIAN LUNATIC ACT (1912)

Indian Lunatic Act was derived from English Lunacy Act 1845 and Country Asylums Act 1845. Indian Lunacy Act was adopted by Indian Government in 1912 with amendments related to lunacy and was extended to the whole of India.

The Indian Lunacy Act is divided into 4 divisions and 8 chapters. This act consists of 100 sections.

Part I

Chapter I

This chapter contains authorized detention proceedings and some definitions are as follows:

- **Asylum:** It means an asylum or mental hospital for lunatics established or licensed by the Central Government or any State Government.
- **Cost of maintenance:** In an asylum, including the cost of lodging, maintenance, clothing, medicine, and care of a lunatic and any expenditure incurred in removing such a lunatic to and from an asylum, together with any other charge specified in this regard by the state government in exercise of any power conferred upon it by this act.
- **District court:** It means the Principal Civil Court of original jurisdiction in any area outside the local limits for the time being of the Metropolitan towns.
- **Criminal lunatic:** It means any person for whose detention in, or removal to an asylum, jail, or other place of safe custody.
- **Lunatic**: It means an idiot or a person of unsound mind.
- **Magistrate:** It means a Metropolitan Magistrate District.
- **Medical officer:** It means a gazetted medical officer in the service of the government and includes a medical practitioner declared by general or special order of the State Government to be a medical officer for the purposes of this Act.
- **Medical practitioner:** It means holder of a qualification to practice medicine and surgery which can be registered in India in accordance with the law for the time being in force for the registration of medical

practitioners, and includes any person declared by general or special order of the State Government to be a medical practitioner for the purpose of this Act.

- **Prescribed:** It means prescribed by this Act or by rule made there under.
- **Reception order:** It means an order made under the provisions of this Act for the reception into an asylum of a lunatic other than a lunatic so found by inquisition.
- **Relative:** It includes any person related by blood, marriage, or adoption.
- **Rule:** It means rule made under this Act.

Part II: Reception, Care and Treatment of Lunatics

Chapter II: Reception of Lunatics

Chapter II contains all the procedures to be followed during the admission and discharge of a psychiatric patient.

Chapter III: Care and Treatment: Visitors

Chapter III contains all the rules and proceedings in relation to the care and treatment of lunatics. It also contains rules and proceedings related to visitors to lunatic.

Part III: Judicial Inquisition as to Lunacy

Chapter IV: Proceedings in Lunacy in Presidency towns (Madras, Bombay and Calcutta)

Chapter IV contains the rules and proceedings of a lunatic in presidency town.

Chapter V: Proceedings in Lunacy Outside Presidency Towns

Chapter V contains rules and proceedings of a lunatic outside the presidency town.

Part IV: Miscellaneous

Chapter VI: Establishment of Asylums

Chapter VI contains rules and proceedings related to the establishment of asylums.

Chapter VII: Expenses of Lunatics

Chapter VII contains proceedings related to expenses and payments for lunatics.

Chapter VIII: Rules

Chapter VIII contains following rules:

- Power of State Government to make rules
- Publication of rules
- Penalty for improper reception or detention of lunatics.
- Provision as bonds
- Protection to persons acting under Act

- Power to give effect to warrants and orders of certain courts outside India
- Power to make rules for reception of lunatics received from outside India
- Orders under repealed Acts

THE NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES BILL/ACT (1985)

The statutory control over narcotic drugs was being exercised under The Opium Act, 1857, The Opium Act, 1878 and The Dangerous Drugs Act, 1930. The provisions of these enactments were found to be inadequate because of the passage of time and developments in the field of illicit drug trafficking and drug abuse at national and international levels. To consolidate and to amend the existing laws relating to narcotic drugs, comprehensive legislation was considered necessary.

Therefore, the Narcotic Drugs and Psychotropic Substances Bill, 1985, was introduced in the Lok Sabha. The Narcotic Drugs and Psychotropic Substances Bill, 1985, was passed by both the Houses of Parliament and came into force. This act was amended from time to time, and the most recent amendment was made in 2001.

This act contains 6 chapters, which are briefly discussed below.

Chapter 1: Preliminary

It contains preliminaries, extent of the act, and definitions. The act is extended to all over India, including Jammu and Kashmir. Some of the important definitions are given below:

- **Addict** means a person who has a dependence on any narcotic drug or psychotropic substance.
- **Cannabis** includes charas and ganja.
- **Charas** is a separated resin, in whatever form, whether crude or purified, is obtained from the cannabis plant and also includes concentrated preparations and resin known as hashish oil or liquid hashish.
- **Ganja** is the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops), by whatever name they may be known or designated.
- **Opium** means the coagulated juice of the opium poppy and any mixture, with or without any neutral material, of the coagulated juice of the opium poppy, but does not include any preparation containing more than 0.2% of morphine. Heroin is not opium but a manufactured drug.
- **Psychotropic substance** means any substance, natural or synthetic, or any natural material, or any salt or preparation of such substance or material included in the list of psychotropic substances specified in the Schedule.

Chapter 2: Authorities and Officers

It contains information regarding all authorities and officers in relation to narcotic drugs and psychotropic acts and their powers over the execution of the Act. It includes all the measures to be taken for preventing and combating abuse of narcotic drugs; illicit traffic in narcotic drugs.

- Central government powers
- State government powers

Chapter 2 also contains information about national funds for the control of drug abuse.

Chapter 3: Prohibition, Control and Regulation

It contains rules and proceedings about the prohibition, control, and regulation of all narcotic and psychotropic drugs.

Chapter 4: Offences and Penalties

It contains rules and proceedings about offences and penalties in relation to narcotic drugs and psychotropic drugs.

Chapter 5: Procedure + Forfeiture of Property Derived from or used in Illicit Traffic

It contains the power to issue a warrant, seizure and arrest with/without a warrant in public or in private, and authorization in relation to narcotic and psychotropic drugs.

It also contains forfeiture of property made by manufacturers through illicit drug trafficking.

Chapter 6: Miscellaneous

It contains rules and proceedings in relation to the protection of actions taken in good faith and the power of the government to establish centers for the identification and treatment of drug addicts.

MENTAL HEALTH ACT (2017)

Mental Health Act is an act to provide mental health care and services for psychiatric patients and to protect, promote, and fulfil the rights of psychiatric patients during the delivery of mental health care and services.

The Mental Health Act contains 16 chapters in total which are discussed here briefly.

Chapter I: Preliminary

The Mental Health Act of 1987 is now named the Mental Health Care Act (2017). This act shall extend to the whole of India. Chapter 1 gives definitions in relation to the fields of psychiatry. Some of the important definitions are given below:

- **Caregiver** is a person who resides with a person with mental illness and is responsible for providing care to that person, and includes a relative or any other person who performs this function, either free or with remuneration.
- **Clinical psychologist** is a person having a recognized qualification in Clinical Psychology from an institution approved and recognized by the Rehabilitation Council of India.
- **Family** means a group of persons related by blood, adoption, or marriage.
- **Informed consent** means consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person.
- **Mental health care** includes analysis and diagnosis of a person's mental condition and treatment, as well as care and rehabilitation of such a person for his mental illness or suspected mental illness.

- **Mental health care professional** means a person with a diploma or degree in general nursing or diploma or degree in psychiatric nursing recognized by the Nursing Council of India established under the Nursing Council of India Act, 1947 and registered as such with the relevant nursing council in the State.
- **Mental disorder** means a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, and includes mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation, which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence.
- **Minor** means a person who has not completed the age of eighteen years.
- **Prisoner with mental illness** means a person with mental illness who is under-trial or has been convicted of an offence and is detained in a jail or prison.
- **Psychiatrist** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by a university recognized by the University.

Chapter II: Mental Illness and Capacity to Make Health Care and Treatment Decisions

It contains all the rules and proceedings in accordance with nationally or internationally accepted medical standards. In India, ICD-10 is accepted as a diagnostic criterion for mental disorders.

It establishes all laws related to mental health care services.

Chapter III: Advance Directive

It contains all the rules and proceedings related to the provision of mental health care services for a minor or a person of unsound mind incapable of making the right decision for treatment of mental disorders. It contains the right to take decisions by an authority, relative, or legal guardian.

Chapter IV: Nominated Representative

It contains all the rules and proceedings related to the provision of mental health care services for a person with mental illness who is not a minor and shall have the right to appoint a nominated representative to take decisions on his/her behalf.

It contains all the rights and criteria for being a nominated representative.

Chapter V: Rights of Mentally Ill Patients

Chapter V of the Mental Health Care act contains all the rights of mentally ill patients.

Chapter VI: Duties of Appropriate Government

It contains all the rules and proceedings related to all the state and national level mental health programmes to be executed by the government in the service of mentally sick patients. For example, National Mental Health Programme, Rehabilitation services, Community mental health services.

Chapter VII: Central Mental Health Authority

The central mental health authority is the group of authorities who are responsible for mental health services in nation.

Chapter VIII: State Mental Health Authority

It gives a list of all the state authorities who will be responsible for rendering mental health services in the state.

Chapter IX: Finance, Accounts and Audit

The central government may make central/state authority grants of such sums of money for rendering mental health care services in the state and nation.

Chapter X: Mental Health Establishments

This chapter contains all the rules and proceedings in relation to establishing or running a psychiatric hospital, psychiatric unit, rehabilitation center or any other mental health care facility.

Chapter XI: Mental Health Review Boards

This chapter contains establishing mental health review boards for the execution of mental health acts all over India.

Chapter XII: Admission, Treatment and Discharge

This chapter contains all the rules and proceedings in relation with admission, to the treatment, and discharge of mentally sick patients.

Chapter XIII: Responsibilities of Other Agencies

This chapter contains the rules and responsibilities of other health agencies in relation to the provision of mental health care services. For example, responsibilities of a police in charge in mental health care services.

Chapter XIV: Restriction to Discharge Functions by Professionals not Covered by Profession

This chapter states that no mental health professional or medical practitioner shall discharge any duty or perform any function not authorized by this Act or specify or recommend any medicine or treatment not authorized by the field of their profession.

Chapter XV: Offences and Penalties

This chapter contains all rules and proceedings in relation to all offences and penalties for breach of the Mental Health Act.

Chapter XVI: Miscellaneous

It contains all the other rules and proceedings in relation to the mental health care act that are not covered in other chapters.

ADMISSION PROCEDURES

Admission procedures in the field of psychiatry are clearly mentioned in Chapter IV of the Mental Health Act. Admission in Psychiatric Hospitals/Units/Nursing Homes are of three types:

1. Admission on voluntary basis

2. Admission under authority/order
3. Admission under special circumstances

Admission on Voluntary Basis

Any person who feels the need for psychiatric evaluation or learns that he/she is suffering from any sort of mental sickness can voluntarily come to psychiatric hospitals for admission, if he/she is not a minor.

The consultant should do a psychiatric evaluation of the person within 24 hours and admit the patient, if needed, in accordance with the findings of the psychiatric evaluation.

Admission under Authority/Order

A person who is mentally sick but is not capable of voluntary admission can be brought to a psychiatric hospital for admission by a court of law or an approved authority. For example, Magistrate, Police in charge.

Application/reception order can be given under following categories:

- **Reception order on application:** Any significant relative of the mentally ill patient can forward an application for admission to a psychiatric hospital.
- **Reception order by a magistrate:** If police or any significant community member finds any psychiatric patient in the community who is a threat to self and society; he/she can be detained by police and needs to be produced before magistrate. The magistrate will issue a reception order in the light of two medical certificates as proof of the insanity of person.
- **Reception order after inquest:** This admission is made by district court that is holding an inquisition in regard with a psychiatric patient and may order for admission of the psychiatric patient in hospital for the welfare of him/her who is found to be mentally sick.
- **Admission and detention of a psychiatric patient prisoner:** A psychiatric patient prisoner can be admitted in a psychiatric hospital on the order of court.

Admission under Special Circumstances

Any mentally ill patient who is not willing for voluntary admission or who is a minor, may be admitted in the psychiatric hospital on the application given by a significant relative or a legal guardian in the best interest of mentally sick patient. The psychiatric evaluation must be done by two consultants in the field of psychiatry.

DISCHARGE PROCEDURES

Discharge procedures in the field of psychiatry are clearly mentioned in Chapter V of Mental Health Act. Discharge in psychiatric hospitals/units/nursing homes are of three types:

1. Discharge on voluntary basis
2. Discharge under authority/order
3. Discharge under special circumstances

Discharge on Voluntary Basis

Two consultants can make a psychiatric evaluation and if the findings recommend, they can discharge a mentally ill patient who was admitted voluntary.

Discharge under Authority/Order

- Discharge of a mentally sick patient admitted through a magistrate:

- If after psychiatric evaluation patient is found to be recovered from mental sickness, an application can be forwarded to a magistrate for discharge of the mentally sick patient.
- Discharge of a mentally sick admitted through police:
- After psychiatric evaluation findings in favor of psychiatric patient, if family agrees to take patient home, a discharge can be given.
- Discharge of a psychiatric patient prisoner
- After psychiatric evaluation findings in favor of psychiatric patient, if family agrees to take patient home, a discharge can be given.

Discharge under Special Circumstances

The significant relative of mentally sick patient can give an application for discharge after making an agreement in writing to take care of the mentally sick patient at home.

STANDARDS OF PSYCHIATRIC NURSING PRACTICE

Standards of psychiatric nursing practice signify essentials of practices and procedures in mental health nursing. It provides answers to the following questions—Who, What, When, Where and How of psychiatric nursing practices in clinical and education settings. For maintaining the standards of psychiatric nursing care practice, every nursing intervention must be based on a body of knowledge with evidence-based practices.

Following are the standards of psychiatric-mental health nursing practice given by American Nurses Association (Table 1).

Table 1: Standards of psychiatric nursing practice

Standard	Description
Standard I: Assessment	The psychiatric nurse collects all relevant information in relation to psychiatric illness from both the mentally sick patient and a reliable informant.
Standard II: Diagnosis	On the basis of collected data, the psychiatric nurse formulates nursing diagnoses, referring to the NANDA criterion for establishing nursing diagnoses.
Standard III: Outcome Identification	The psychiatric nurse identifies goals and expected outcomes in formulating an individualized nursing care plan.
Standard IV: Planning	The psychiatric nurse formulates a nursing care plan focused on nursing interventions in collaboration with the psychiatric patient, family, and other health care team members. The ANA recommends evidence-based practices.
Standard V: Implementation	The psychiatric nurse implements the nursing care plan developed.
Standard VA: Counseling	The psychiatric nurse provides counselling services to psychiatric patients for improvement of coping strategies and mental health and to prevent the occurrence of mental disorders and morbidity.
Standard VB: Milieu therapy	The psychiatric nurse must provide a therapeutic environment for promoting the mental health of psychiatric patients in collaboration with other members of the mental health care team.

Contd...

Standard	Description
Standard VC: Promotion of self-care activities	The psychiatric nurse plans nursing care by fostering structured interventions for carrying out activities of daily living + and Instrumental activities of daily living.
Standard VD: Psychobiological interventions	The psychiatric nurse plans and provides psychobiological interventions for the psychiatric patient as well as those persons who are prone to mental sickness in the community.
Standard VE: Health teaching	The psychiatric nurse provides health education to the psychiatric patients, family members and community.
Standard VF: Case management	Now, the case management approach is executed in health care settings by using a multi-disciplinary approach. The psychiatric nurse also works as an active member of the health care team while implementing a case management approach.
Standard VG: Health promotion and health maintenance	The psychiatric nurse employs nursing interventions for the promotion and maintenance of mental health.
Standard VH: Psychotherapy	The psychiatric nurse provides psychosocial therapy to mentally sick patients and their families.
Standard VI: Prescriptive authority and treatment	The psychiatric nurse can also function as a nurse practitioner after being qualified for prescription authority and treatment.
Standard VJ: Consultation	The psychiatric nurse provides consultation services to the psychiatric patient.
Standard VK: Evaluation	The psychiatric nurse must evaluate nursing care interventions for further progress.

RIGHTS OF MENTALLY ILL PATIENTS

The psychiatric nurse must evaluate nursing care interventions for further progress.

Mental Health Act (1987) has given provision under law to protect human rights of psychiatric patients. The following are the rights of mentally ill patients, which must be protected by family, community, and health care workers altogether. The mental health declaration of human rights investigated and exposed the following standards in maintenance of rights of psychiatric patients.

- Right to informed consent.
- Right to information
- Right to refuse treatment
- Right to personal freedom
- Right to have psychiatric treatment with dignity, without discrimination
- Right to physical health
- Right to wear his own clothes of his own choice
- Right to treatment
- Right to complaint
- Right to legal advice

- Right to manage personal property
- Right to will
- Right to file a case against health care professional, if ill-treated
- Right to safe environment
- Right to resume/continue his official duty
- Right to salary for work done
- Right to receive visitors
- Right to practice his/her religion
- Right to telephonic/letter conversation
- Right to nutrition
- Right to leisure
- Right to rest and sleep

LEGAL RESPONSIBILITIES IN THE CARE OF MENTALLY ILL PATIENTS

The field of psychiatry demands a great knowledge of the law (rules and proceedings) from the psychiatric nurse. He/she must learn Mental Health Act, Admission and Discharge Procedures, Narcotic Drugs and Psychotropic Drugs Act and other legal procedures in the field of psychiatry.

- The psychiatric nurse has a legal responsibility for the **admission and discharge of a mentally sick patient in accordance with the law.**
- The psychiatric nurse has a legal responsibility for **maintaining confidentiality** of the information shared by a psychiatric patient.
- The psychiatric nurse has a legal responsibility for taking **an Informed consent** before execution of any nursing or medical interventions especially ECT.
- The psychiatric nurse has a legal responsibility to **protect the legal rights** of a mentally sick patient.
- The psychiatric nurse has **criminal and civil responsibilities** for mentally sick patients.
- The psychiatric nurse has the **legal responsibility of keeping all legal records safe.**
- The nurse has a legal responsibility to **discourage any malpractice and negligence.** The psychiatric nurse must never commit malpractice or negligence.
- The psychiatric nurse has a **legal responsibility to take care of a suicidal patient** and is responsible for initiating suicidal precautions.
- The psychiatric nurse has a **legal responsibility to practice only under state laws and nursing practice acts**.
- The psychiatric nurse has a **legal responsibility to maintain and keep the standards of mental health psychiatric nursing**.

ASSESS YOURSELF

Previous Years' Questions

1. Write a short note on Mental Health Act.
2. Write a short note on legal aspects of psychiatric nursing.
3. Write a short note on admission and discharge of mentally ill patient.

Multiple Choice Questions

1. The most important factor in providing nursing care to mentally sick patients is:
a. Communication
b. Biological variation
c. Environmental control
d. Time orientation

2. The scope of psychiatric nursing practice is legally defined by:
a. Hospital policies
b. Mental Health Act
c. Procedure manuals
d. Physicians

3. The patient's right to refuse treatment is an example of:
a. Statutory law
b. Civil law
c. Nurse Practice Acts
d. Common law

4. Indian Lunacy Act was established in:
a. 1947
b. 1912
c. 1950
d. 2017

5. Mental Health Act, 2017 has following number of chapters:
a. 15
b. 12
c. 8
d. 16

6. Standards of mental health nursing practice are given by:
a. INC
b. SNA
c. ANA
d. MAA

7. Admission and discharge procedures are given in which chapters of Mental Health Act:
a. Chapter IV & V
b. Chapter II & III
c. Chapter XV & XVI
d. Chapter IX & X

8. The mentally sick patient who is a minor can be admitted through:
a. Magistrate
b. Voluntary
c. Police
d. Under special circumstances

9. Which of the following is not a legal right of a mentally ill patient?
a. Freedom
b. Abuse
c. Information
d. Treatment

10. When a psychiatric patient prisoner is recovered from mental illness, then the next step by hospital authority will be:
a. Discharge
b. Produce him/her in front of a magistrate
c. Call police
d. Call patient's relatives to take him/her home

ANSWERS KEY

1. a **2. b** **3. a** **4. b** **5. d** **6. c** **7. a** **8. d** **9. b**
10. b

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Refer 'f' for figure and 't' for table, respectively.

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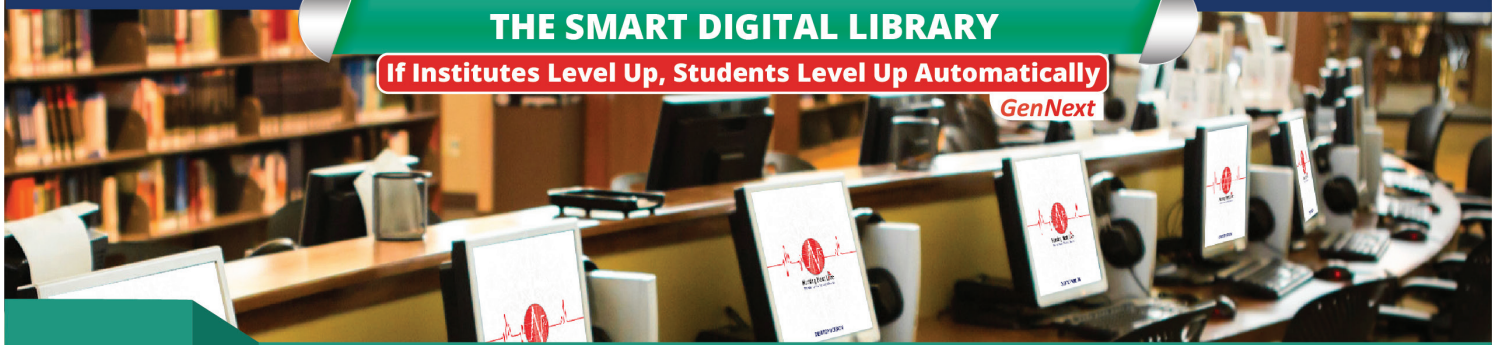

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- Each unit starts with specific Learning Objectives and Unit Outline to provide a glimpse of the unit
- Long and Short Answer Questions along with MCQs have been given under Assess Yourself for self-evaluation

About the Author

Eleena Kumari, *MSc [Mental Health (Psychiatric) Nursing],* is presently working as an Assistant Professor at Khalsa College of Nursing, Amritsar, Punjab. She is a respected faculty on motivation, leadership and innovations in the field of mental health nursing. By blending innovative trends in mental health (Psychiatric) nursing with timeless care of the mind and soul for psychiatric patients, she has eloquently expressed her ideas into this book.

Over three years ago, she set out to find the effectiveness of quality of care in psychiatric units in her research study in which she took opinions of psychiatric patients regarding hospital care and implemented the findings accordingly. This was the very innovative study in which psychiatric patients were considered important to discuss their ideas and views regarding quality of care. The research is published in indexed PGI Nursing Research and Midwifery journals. She is committed to learning and self-improvement. She has written this book with extensive search for innovations in the field of mental health nursing and has tested the usefulness of text in her own career while teaching to nursing students.

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