5th Edition

A Guide to Mental Health & Psychiatric Nursing

Semester V & VI

As per the Revised BSc Nursing Syllabus

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Foreword
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A Guide to
MENTAL HEALTH AND PSYCHIATRIC NURSING

As per the Revised BSc Nursing Syllabus

Fifth Edition

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Foreword
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Syllabus

MENTAL HEALTH NURSING - I

PLACEMENT: V SEMESTER

THEORY: 3 Credits (60 hours)

PRACTICUM: Clinical: 1 Credit (80 hours)

DESCRIPTION: This course is designed to develop basic understanding of the principles and standards of mental health nursing and skill in application of nursing process in assessment and care of patients with mental health disorders.

COMPETENCIES: On completion of the course, the students will be competent to:

1. Trace the historical development of mental health nursing and discuss its scope.
2. Identify the classification of the mental disorders.
3. Develop basic understanding of the principles and concepts of mental health nursing.
4. Apply the Indian Nursing Council practice standards for psychiatric mental health nursing in supervised clinical settings.
5. Conduct mental health assessment.
6. Identify and maintain therapeutic communication and nurse patient relationship.
7. Demonstrate knowledge of the various treatment modalities and therapies used in mental disorders.
8. Apply nursing process in delivering care to patients with mental disorders.
9. Provide nursing care to patients with schizophrenia and other psychotic disorders based on assessment findings and treatment/therapies used.
10. Provide nursing care to patients with mood disorders based on assessment findings and treatment/therapies used.
11. Provide nursing care to patients with neurotic disorders based on assessment findings and treatment/ therapies used.

COURSE OUTLINE

T–Theory

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/ learning activities	Assessment methods
I	6 (T)	◆ Describe the historical development and current trends in mental health nursing ◆ Discuss the scope of mental health nursing	**Introduction** ◆ Perspectives of mental health and mental health nursing, evolution of mental health services, treatments and nursing practices	◆ Lecture-cum-discussion	◆ Essay ◆ Short answer

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/ learning activities	Assessment methods
		◆ Describe the concept of normal and abnormal behaviour	◆ Mental health team ◆ Nature and scope of mental health nursing ◆ Role and functions of mental health nurse in various settings and factors affecting the level of nursing practice ◆ Concepts of normal and abnormal behaviour		
II	10 (T)	◆ Define the various terms used in mental health Nursing ◆ Explain the classification of mental disorders ◆ Explain the psychodynamics of maladaptive behaviour ◆ Discuss the etiological factors and psychopathology of mental disorders ◆ Explain the principles and standards of Mental health Nursing ◆ Describe the conceptual models of mental health nursing	**Principles and concepts of mental health nursing** ◆ Definition: mental health nursing and terminology used ◆ Classification of mental disorders: ICD11, DSM5, Geropsychiatry manual classification ◆ Review of personality development, defense mechanisms ◆ Etiology bio-psycho-social factors ◆ Psychopathology of mental disorders: review of structure and function of brain, limbic system and abnormal neurotransmission ◆ Principles of Mental health Nursing ◆ Ethics and responsibilities ◆ Practice Standards for Psychiatric Mental Health Nursing (INC practice standards) ◆ Conceptual models and the role of nurse: – Existential model – Psychoanalytical models – Behavioural model – Interpersonal model ◆ Preventive psychiatry and rehabilitation	◆ Lecture-cum-discussion ◆ Explain using Charts ◆ Review of personality development	◆ Essay ◆ Short answer

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/ learning activities	Assessment methods
III	6 (T)	• Describe nature, purpose and process of assessment of mental health status	**Mental health assessment** • history taking • Mental status examination • Mini mental status examination • Neurological examination • Investigations: Related Blood chemistry, EEG, CT and MRI • Psychological tests	• Lecture-cum-discussion • Demonstration • Practice session • Clinical practice	• Essay • Short answer • Assessment of mental health status
IV	6 (T)	• Identify therapeutic communication and techniques • Describe therapeutic relationship • Describe therapeutic impasses and its interventions	**Therapeutic communication and nurse-patient relationship** • Therapeutic communication: Types, techniques, characteristics and barriers • Therapeutic nurse-patient relationship • Interpersonal relationship- • Elements of nurse patient contract, • Review of technique of IPR- Johari window • Therapeutic impasse and its management	• Lecture-cum-discussion • Demonstration • Role play • Process recording • Simulation (video)	• Essay • Short answer • OSCE
V	10 (T)	Explain treatment modalities and therapies used in mental disorders and role of the nurse	**Treatment modalities and therapies used in mental disorders** • **Physical therapies**: Psychopharmacology, • Electroconvulsive therapy • **Psychological therapies**: Psycho-therapy, behaviour therapy, CBT • **Psychosocial**: Group therapy, family therapy, therapeutic community, recreational therapy, art therapy (dance, music etc), occupational therapy	• Lecture-cum-discussion • Demonstration • Group work • Practice session • Clinical practice	• Essay • Short answer • Objective type

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/ learning activities	Assessment methods
			◆ **Alternative and complementary**: Yoga, meditation, relaxation ◆ **Consideration for special populations**		
VI	8 (T)	Describe the etiology, psychodynamics/ pathology, clinical manifestations, diagnostic criteria and management of patients with Schizophrenia, and other psychotic disorders	**Nursing management of patient with Schizophrenia, and other psychotic disorders** ◆ Prevalence and incidence ◆ Classification ◆ Etiology, psychodynamics, clinical manifestation, diagnostic criteria/ formulations **Nursing process** ◆ Nursing Assessment: History, Physical and mental assessment ◆ Treatment modalities and nursing management of patients with Schizophrenia and other psychotic disorders ◆ Geriatric considerations and considerations for special populations ◆ Follow up and home care and rehabilitation	◆ Lecture and Discussion ◆ Case discussion ◆ Case presentation ◆ Clinical practice	◆ Essay ◆ Short answer ◆ Assessment of patient manage-ment problems
VII	6 (T)	Describe the etiology, psycho-dynamics, clinical manifestations, diagnostic criteria and management of patients with mood disorders	**Nursing management of patient with mood disorders** ◆ Prevalence and incidence ◆ Mood disorders: Bipolar affective disorder, mania depression and dysthymia etc. ◆ Etiology, psycho dynamics, clinical manifestation, diagnosis	◆ Lecture and Discussion ◆ Case discussion ◆ Case presen-tation ◆ Clinical practice	◆ Essay ◆ Short answer ◆ Assessment of patient manage-ment problems

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/ learning activities	Assessment methods
			• Nursing Assessment History, Physical and mental assessment • Treatment modalities and nursing management of patients with mood disorders • Geriatric considerations/ considerations for special populations • Follow-up and home care and rehabilitation		
VIII	8 (T)	Describe the etiology, psycho-dynamics, clinical manifestations, diagnostic criteria and management of patients with neurotic, stress related and somatization disorders	**Nursing management of patient with neurotic, stress related and somatisation disorders** • Prevalence and incidence • Classifications • Anxiety disorders – OCD, PTSD, Somatoform disorders, Phobias, Disassociative and Conversion disorders • Etiology, psychodynamics, clinical manifestation, diagnostic criteria/ formulations • Nursing Assessment: History, Physical and mental assessment • Treatment modalities and nursing management of patients with neurotic and stress related disorders • Geriatric considerations/ considerations for special populations • Follow-up and home care and rehabilitation	• Lecture and Discussion • Case discussion • Case presentation • Clinical practice	• Essay • Short answer • Assessment of patient manage-ment problems

MENTAL HEALTH NURSING - II

PLACEMENT: VI SEMESTER
THEORY: 1 Credit (40 Hours)
PRACTICUM: Clinical: 2 Credits (160 Hours)
DESCRIPTION: This course is designed to provide the students with basic understanding and skills essential to meet psychiatric emergencies and perform the role of community mental health nurse.
COMPETENCIES: On completion of the course, the students will be able to:

1. Apply nursing process in providing care to patients with substance use disorders, and personality and sexual disorders.
2. Apply nursing process in providing care to patients with behavioural and emotional disorders occurring during childhood and adolescence.
3. Apply nursing process in providing care to patients with organic brain disorders.
4. Identify and respond to psychiatric emergencies.
5. Carry out crisis interventions during emergencies under supervision.
6. Perform admission and discharge procedures as per MHCA 2017.
7. Explore the roles and responsibilities of community mental health nurse in delivering community mental health services.

COURSE OUTLINE

T – Theory

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/learning activities	Assessment methods
I	6 (T)	Describe the etiology, psychodynamics, clinical manifestations, diagnostic criteria and management of patients with substance use disorders	**Nursing management of patients with substance use disorders** ◆ Prevalence and incidence ◆ Commonly used psychotropic substance: classifications, forms, routes, action, intoxication and withdrawal ◆ Psychodynamics/ etiology of substance use disorder (Terminologies: Substance Use, Abuse, Tolerance, Dependence, Withdrawal) ◆ Diagnostic criteria/ formulations	◆ Lecture-cum-discussion ◆ Case discussion ◆ Case presentation ◆ Clinical practice	◆ Essay ◆ Short answer ◆ Assessment of patient manage-ment problems

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/learning activities	Assessment methods
			• Nursing Assessment: History (substance history), physical, mental assessment and drug and drug assay • Treatment (detoxification, antabuse and narcotic antagonist therapy and harm reduction, Brief interventions, MET, refusal skills, maintenance therapy) and nursing management of patients with substance use disorders • Special considerations for vulnerable population • Follow-up and home care and rehabilitation		
II	6 (T)	Describe the etiology, psychodynamics, clinical manifestations, diagnostic criteria and management of patients with personality, and sexual disorders	**Nursing management of patient with personality and sexual disorders** • Prevalence and incidence • Classification of disorders • Etiology, psychopathology, characteristics, diagnosis • Nursing assessment: history, physical and mental health assessment • Treatment modalities and nursing management of patients with personality, and sexual disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture-cum-discussion • Case discussion • Case presentation • Clinical practice	• Essay • Short answer • Assessment of patient management problems

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/learning activities	Assessment methods
III	8 (T)	Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of childhood and adolescent disorders including mental deficiency	**Nursing management of behavioural and emotional disorders occurring during childhood and adolescence** (Intellectual disability, autism, attention deficit, hyperactive disorder, eating disorders, learning disorder) ◆ Prevalence and incidence ◆ Classifications ◆ Etiology, psychodynamics, Characteristics, diagnostic criteria/ formulations ◆ Nursing Assessment: History, Physical, mental status examination and IQ assessment ◆ Treatment modalities and nursing management of childhood disorders including intellectual disability ◆ Follow-up and home care and rehabilitation	◆ Lecture-cum-discussion ◆ Case discussion ◆ Case presentation ◆ Clinical practice	◆ Essay ◆ Short answer ◆ Assessment of patient manage-ment problems
IV	5 (T)	Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of organic brain disorders.	**Nursing management of organic brain disorders** (delirium, dementia, amnestic disorders) ◆ Prevalence and incidence ◆ Classification ◆ Etiology, psychopathology, clinical features, diagnosis and Differential diagnosis ◆ Nursing assessment: history, physical, mental and neurological assessment	◆ Lecture-cum-discussion ◆ Case discussion ◆ Case presentation ◆ Clinical practice	◆ Essay ◆ Short answer ◆ Assessment of patient manage-ment problems

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/learning activities	Assessment methods
			• Treatment modalities and nursing management of organic brain disorders • Follow-up and home care and rehabilitation		
V	6 (T)	Identify psychiatric emergencies and carry out crisis intervention	**Psychiatric emergencies and crisis intervention** • Types of psychiatric emergencies (attempted suicide, violence/ aggression, stupor, delirium tremens and other psychiatric emergencies) and their managements • Maladaptive behaviour of individual and groups, stress, crisis and disaster(s) • Types of crisis • Crisis intervention: Principles, techniques and process • Stress reduction interventions as per stress adaptation model • Coping enhancement • Techniques of counseling	• Lecture-cum-discussion • Case discussion • Case presentation • Clinical practice	• Short answer • Objective type
VI	4 (T)	Explain legal aspects applied in mental health settings and role of the nurse	**Legal issues in mental health nursing** • Overview of Indian Lunacy Act and The Mental Health Act 1987 • (Protection of Children from Sexual Offence) POCSO Act • Mental Health Care Act (MHCA) 2017 • Rights of mentally ill clients • Forensic psychiatry and nursing • Acts related to narcotic and psychotropic substances and illegal drug trafficking	• Lecture-cum-discussion • Case discussion	• Short answer • Objective type

Unit	Time (Hrs)	Learning outcomes	Content	Teaching/learning activities	Assessment methods
			◆ Admission and discharge procedures as per MHCA 2017 ◆ Role and responsibilities of nurses in implementing MHCA 2017		
VII	5 (T)	◆ Describe the model of preventive psychiatry ◆ Describe Community Mental health services and role of the nurse	**Community mental health nursing** ◆ Development of community mental health services ◆ National mental health policy viz. National Health Policy ◆ National Mental Health Program ◆ Institutionalization versus Deinstitutionalization ◆ Model of Preventive psychiatry ◆ Mental Health Services available at the primary, secondary, tertiary levels including rehabilitation and nurses' responsibilities ◆ Mental Health Agencies: Government and voluntary, National and International ◆ Mental health nursing issues for special populations: Children, adolescence, women elderly, victims of violence and abuse, handicapped, HIV/AIDS, etc.	◆ Lecture-cum-discussion ◆ Clinical/ field practice ◆ Field visits to mental health service agencies	◆ Short answer ◆ Objective type ◆ Assessment of the field visit reports

6 CHAPTER Nursing Management of Patient with Schizophrenia and Other Psychotic Disorders

"A labyrinth of the mind, where courage meets complexity, and empathy becomes the compass guiding toward understanding and support."

Chapter Outline

- Prevalence and Incidence
- Etiology, Pathophysiology, Clinical Manifestations, Diagnostic Criteria/ Formulation, Classification
- Course and Prognosis, Investigations
- Treatment Modalities
- Nursing Management of Patients with Schizophrenia and Other Psychotic Disorders
- Geriatric Consideration
- Follow-up and Homecare and Rehabilitation

MEANING

The word 'Schizophrenia' was coined by the Swiss psychiatrist Eugen Bleuler in 1908. It is derived from the Greek words *skhizo* (split) and *phren* (mind).

Schizophrenia is a long-term mental health condition characterized by disturbances in thought (delusions), perception (hallucinations) and behavior (disorganized behavior) by a loss of emotional responsiveness and extreme apathy and noticeable deterioration in the level of functioning in everyday life.

Schizophrenia is a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality and relates to others.

Schizophrenia is characterized by disturbances in multiple modalities including thinking, perception, cognition, volition, affect and behavior.

PREVALENCE AND INCIDENCE

Prevalence includes both old and new cases while incidence refers to new cases arising from healthy individuals.

- According to Global burden of disease 2019, Schizophrenia affects approximately 24 million people or 1 in 300 people (0.36%) worldwide. This rate is 1 in 222 people (0.45%) among adults.
- According to the global burden of disease study 1990-2017, in 2017 there were 197.3 million people with mental disorders in India, comprising 14.3% of the total population of the country. Mental disorders contributed 4.7% (3.7–5.6) of the total disability-adjusted life-years (DALYs). The crude prevalence rate of schizophrenia was 0·3%.
- Schizophrenia affects approximately 1% of adults.
- In India the prevalence of schizophrenia is about 3/1000 individuals (Gururaj, Girish and Isaac, 2005).
- According to the National Mental Health Survey (2015-2016) conducted by NIMHANS, Bengaluru prevalence of schizophrenia in Indian population is 0.5% for current and 1.4% for a lifetime experience.
- Men are slightly more likely to be diagnosed and have an earlier onset than women.
- Onset is most often during late adolescence. The peak ages of onset are 15–25 years for men and 25–35 years for women. About two-thirds of cases are in the age group of 15–30 years.

- It is prevalent in all cultures across the world. About 15% of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50% of all mental hospital beds.

ETIOLOGY

The exact cause of schizophrenia is unknown. Several studies suggest that multiple factors are responsible for causation of schizophrenia **(Figure 6.1)**.

Biological Theories

Biological explanations include biochemical, neurostructural, genetic and perinatal risk factors.

Biochemical Theories

- Many studies hypothesize the functional increase of dopamine at the postsynaptic receptor.
- Other neurotransmitters probably involved are serotonin and alpha-adrenergic hyperactivity or glutaminergic and GABA hypoactivity.

Neurostructural Theories

- Research has found abnormal brain structure in people with schizophrenia.
- Computed tomography and magnetic resonance imaging (MRI) studies of brain structure show enlarged ventricles and mild cortical atrophy in some patients of schizophrenia.
- Positron emission tomography scan shows hypofrontality and decreased glucose utilization in the dominant temporal lobe.

Genetic Theories

- Schizophrenia can run in families.
- The disease is more common among people born of consanguineous marriages.
- Studies show that relatives of schizophrenics have a much higher probability of developing the disease than the general population **(Box 6.1)**.

Perinatal Risk Factors

Following factors are associated with an increased risk of developing schizophrenia in people whose genes make them more likely to get the disorder.

- Gestational diabetes
- Pre-eclampsia
- Abnormal fetal development and low birth weight
- Birth complications

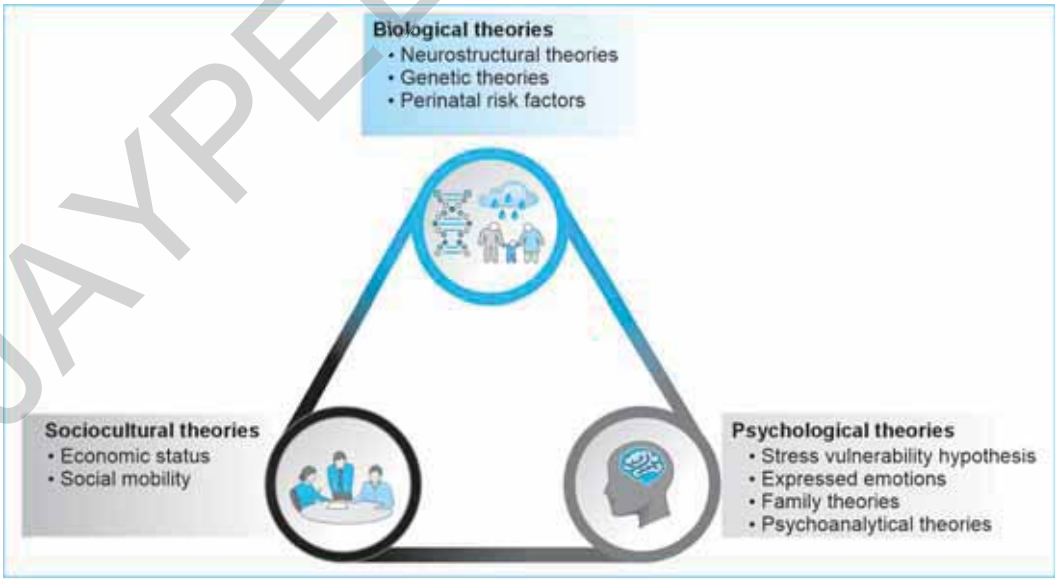

Figure 6.1: Etiology of schizophrenia

Box 6.1: Genetic risk of schizophrenia

- Concordance rate for monozygotic twins—46%
- Concordance rate for dizygotic twins—14%
- One parent has schizophrenia, the chance of the child developing schizophrenia—10–12%
- Both the parents have schizophrenia, the chance of the child developing schizophrenia—40%
- First degree relatives have schizophrenia, the chance of developing schizophrenia—8–10%
- Second degree relatives have schizophrenia, the chance of developing schizophrenia—3%
- Third degree relatives have schizophrenia, the chance of developing schizophrenia—2%
- General population—0.5–1% (no affected relative)

- Maternal malnutrition and vitamin deficiency.
- Winter births and urban residence.
- Viral infections, exposure to toxins like marijuana.

Psychological Theories

Psychological explanation includes stress vulnerability hypothesis, expressed emotions, family theories, and psychoanalytical theories.

Stress Vulnerability Hypothesis

- According to this theory increased number of stressful life events before the onset or relapse probably has a triggering effect on the onset of schizophrenia among genetically vulnerable individuals.
- Stressful life events can precipitate the disease in predisposed individuals.
- Higher the genetic vulnerability in a person, lessor the environmental stress needed to precipitate a relapse.

Expressed Emotions

Increased expressed emotions such as hostility, critical comments, emotional over-involvement of significant others in the family can lead to an early relapse.

Family Theories

- Several early theories have been advocated in the past but are currently of doubtful value. Some of these theories were unfortunately responsible for arousing a sense of unnecessary guilt in parents for causation of schizophrenia in their children.
- These include schizophrenic mother (cold, over protective and domineering), lack of real parents, dependency on mother, anxious mother, parental marital schism or skew (hostility between parents), double blind theory (parents convey two or more conflicting and incompatible messages at the same time).

Psychoanalytical Theories

- According to Freud there is regression to the oral stage of psychosexual development with the use of defense mechanisms of denial, projection and reaction formation.
- The individuals have poor ego boundaries, ambivalent relationships and arrested psychosexual development.

Sociocultural Theories

Sociocultural explanation includes economic and social mobility.

Economic Status

Some studies show that schizophrenia was found to be more common in people with very low socioeconomic status.

Social Mobility

Higher rates of schizophrenia have been found among some migrants.

PATHOPHYSIOLOGY

Abnormalities in neurotransmission provided the basis for theories on pathophysiology of schizophrenia.

- Neurochemical abnormality hypothesis argues that an imbalance of dopamine, serotonin, glutamate and GABA results in the psychiatric manifestations of schizophrenia.
- Hyperactivity of dopamine in certain neural pathways is thought to be responsible for psychotic symptoms.
- There are four neural pathways that are necessary to be considered in the pathophysiology and treatment of schizophrenia: mesolimbic, misocortical, tuberofundibular and nigrostriatal pathways.

- Overactivity of dopamine in mesolimbic pathway is thought to produce the positive symptoms of schizophrenia.
- Overactivity of dopamine in mesocartical pathway is believed to be responsible for the negative symptoms.
- Blockade of dopamine receptors in nigro-striatal pathway causes extrapyramidal side effects.
- Blockade of dopamine in tuberofundibular (TI) pathway leads to the adverse effect of hyperprolactinemia.
- Reduction of gray matter volume in temporal and parietal lobes as shown by PET and MRI scans, and differences in frontal lobes and hippocampus are both seen as potentially contributing factors to cognitive and memory impairment associated with schizophrenia.

CLINICAL MANIFESTATIONS

According to ICD-11, schizophrenia and other primary psychotic disorders are characterized by significant impairment in reality testing and alterations in behavior. They manifest in:

- Positive symptoms such as persistent delusions, persistent hallucinations, disorganized thinking, grossly disorganized behavior and experiences of passivity and control.
- Negative symptoms such as blunted or flat affect and avolition and psychomotor disturbances.
- Symptoms occurring with sufficient frequency and intensity to deviate from expected cultural or subcultural norms.
- Symptoms not arising as a feature of another mental and behavioral disorder.

Schizophrenia symptoms are classified into positive, negative and cognitive symptoms **(Figure 6.2).**

- **Positive symptoms** are those which cause an excess or distortion of normal function including:
  - **Delusions:** Delusions can be paranoid (beliefs of persecution), somatic (false beliefs about physical illness), grandiose (belief of self-importance and having special powers or abilities; belief that one is especially very powerful, rich, born with a special mission in life); delusion of reference (being referred to by others); delusion of control (being controlled by an external force).
  - **Hallucinations:** Most commonly auditory or visual characterized by experiences when there are no external stimuli.
  - **Disorganized speech and behavior:** Aggression, agitation, odd behavior.
  - **Thought disorders:** Thoughts can be blocked or withdrawn from the mind by others.
  - **Ideas of reference:** Occurs when a person believes that certain external phenomena such as TV, radio or newspaper articles are reporting about them or talking directly to them (ideas of reference can also be considered as delusions if there are beliefs that external happenings relate directly to the individual).
- **Negative symptoms** are those that lead to a decrease or loss of normal function including:
  - Lack of emotions or restricted range and intensity of emotions (affective flattening)
  - Poor or non-existent social functioning
  - Lack of motivation, lack of initiative, less energy, withdrawal from family, friends and social activities, slow movements (avolition)
  - Loss of pleasure or interest in life (anhedonia)
  - Reduced speech (alogia)
  - Ambivalence and poor self-care
  - It is common for people with schizophrenia to lack insight to such an extent that they do not believe they are ill
- **Cognitive symptoms** are nonspecific and hence must be severe enough for another individual to notice them. These include:
  - Problems in attention, concentration and memory.
  - Having trouble processing information to make decisions.

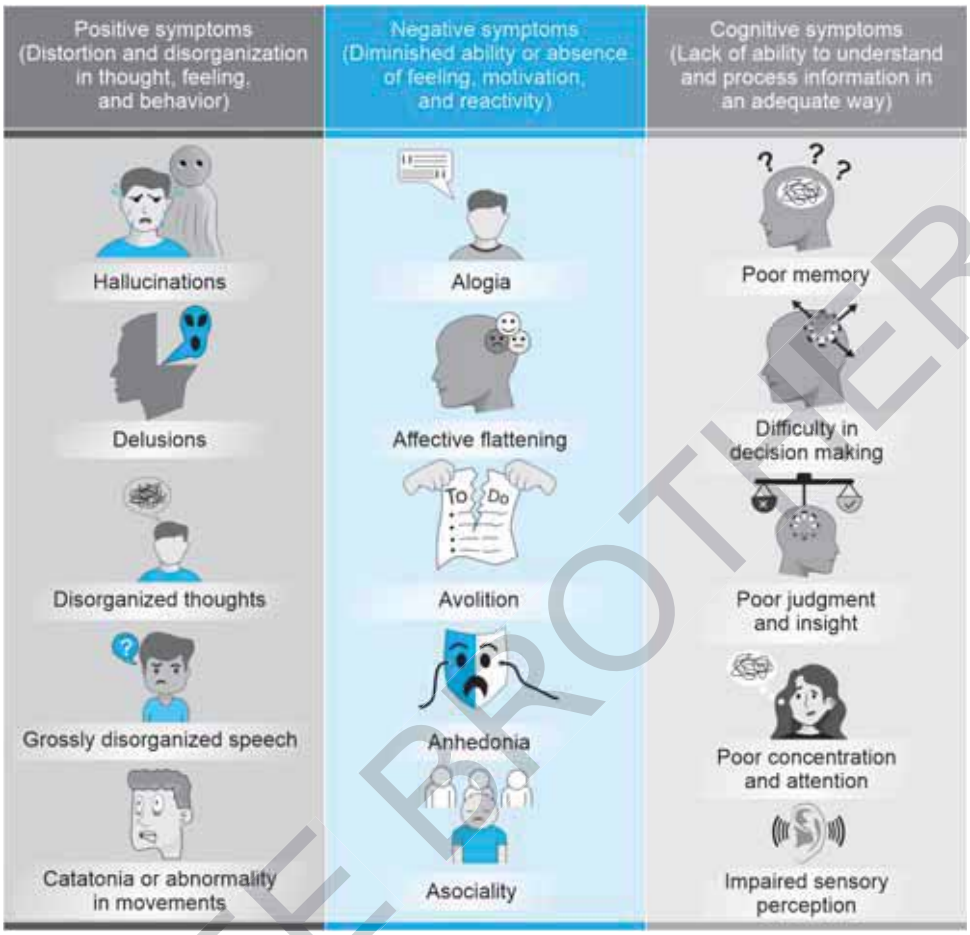

Figure 6.2: Positive, negative and cognitive symptoms of schizophrenia

- Having trouble using information immediately after learning it.

Eugene Bleuler (1857–1939) defined the main symptoms of the disease as Bleuler's 4A's: associations, affect, ambivalence and autism **(Box 6.2)**.

Kurt Schneider proposed the first rank symptoms of schizophrenia in 1959. The presence of even one of these symptoms is considered to be strongly suggestive of schizophrenia **(Box 6.3)**.

Predominant clinical features in acute schizophrenia are delusions, hallucinations and interference with thinking. Features of this kind are often called positive symptoms or psychotic features. While most of the patients recover from acute illness, some progress to the chronic phase during which time the main features are negative symptoms. Once the chronic syndrome is established few patients recover completely **(Box 6.4)**.

Box 6.2: Bleuler's four A's

- **Associative looseness:** Inability to think logically, stringing together of unrelated topics.
- **Affective disturbance:** Inability to show appropriate emotional responses (inappropriate), blunted or flattened affect.
- **Ambivalence:** It refers to contradictory or opposing emotions, attitudes, ideas or desires for the same person, thing or situation simultaneously.
- **Autistic thinking:** It is a thought process in which the individual is unable to relate to others or to the environment. Preoccupation with the self, with little concern for external reality.

Box 6.3: Schneider's first-rank symptoms of schizophrenia (SFRS)

- Hearing one's thoughts spoken aloud (audible thoughts or thought echo)
- Hallucinatory voices in the form of statement and reply (patient hears voices discussing him in the third person)
- Hallucinatory voices in the form of a running commentary (voices commenting on one's action)
- Thought withdrawal (thoughts cease and subject experiences them as removed by an external force)
- Thought insertion (subject experiences thoughts imposed by some external force on his passive mind)
- Thought broadcasting (subject experiences that his thoughts are escaping the confines of his self and are being experienced by others around)
- Delusional perception (normal perception has a private and illogical meaning)
- Somatic passivity (bodily sensations especially sensory symptoms are experienced as imposed on body by some external force)
- Made volition or acts (one's own acts are experienced as being under the control of some external force, the subject being like a robot)
- Made impulses (the subject experiences impulses as being imposed by some external force)
- Made feelings or affect (the subject experiences feelings as being imposed by some external force)

Box 6.4: Case vignette—Schizophrenia

Mr Ravi, a 24 year old male, studying BA final year, resides in village, came to psychiatric OPD with the following complaints. Talking and behaving strangely since 2 months, restless and hostile towards family members, abuses and assaults family members whenever he gets irritated, talking to self and muttering to self, unduly suspicious towards family members, decreased sleep, appetite, poor self-care and not attending college since 2 months. On enquiry he believes that people stare at him and watch his actions. He believes that few of his relatives are trying to harm and kill him. He also informed that he is hearing voices when no one is around, hears the conversations of people who are against him. He hears his own thoughts as if somebody is shouting from somewhere. At other times he can hear a running commentary of his own actions. Because of these experiences, he is scared to move around.

DIAGNOSTIC CRITERIA ACCORDING TO ICD-11

Mental status examination, psychiatric history and careful clinical observation form the basis for diagnosing schizophrenia. Rule out physical disorders, substance induced psychosis and primary mood disorders with psychotic features. Schizophrenia is diagnosed using International Classification of Diseases version 11 (ICD-11). Both DSM V and ICD-11 omit the traditional clinical subtypes of schizophrenia (paranoid, hebephrenic, simple etc.) and de-emphasize the importance of first rank schizophrenia symptoms due to their lack of utility and relevance in treatment selection. For a diagnosis to be made, the symptoms must have persisted for at least a month, symptoms must not have been a manifestation of another health condition or due to the effect of a substance or medication.

ICD-11 Diagnostic Requirements

At least two of the following essential symptoms must be present for a period of 1 month or more. At least one of the qualifying symptoms should be from item (a) through (d) below:

a. Persistent delusions (e.g., persecutory, grandiose, reference).
b. Persistent hallucinations (e.g., mainly auditory or any sensory modality).
c. Disorganized thinking (e.g., tangentiality and loose associations, irrelevant speech, neologism, incoherent, word salad).
d. Experiences of influence, passivity or control (i.e., an experience that one's feelings, impulses, actions or thoughts are not generated by oneself but are being placed in one's mind or withdrawn from one's mind by others or that one's thoughts are being broadcast to others).
e. Negative symptoms such as affective flattening, alogia or paucity of speech, avolition, asociality and anhedonia.
f. Grossly disorganized behavior that impedes goal-directed activity (e.g., bizarre or inappropriate emotional responses).
g. Psychomotor disturbances (e.g., catatonic restlessness, agitation, posturing, waxy

flexibility, negativism, mutism or stupor). If full symptoms of catatonia are present in the context of schizophrenia, the diagnosis of catatonia associated with another mental disorder should be assigned.

Additional Clinical Features

- Onset of schizophrenia may be acute or insidious.
- The prodromal phase (period of subclinical signs and symptoms preceding the onset of psychotic symptoms) can last from weeks to several months or even years during which comorbid disorders may also be commonly observed. The characteristic features of this phase may include loss of interest in activities, neglect of personal hygiene, sleep disturbances, anxiety/agitation or varying degree of depressive symptoms.
- Schizophrenia is frequently associated with significant distress and impairment in personal, family, social, educational, occupational or other important areas of functioning.

ICD-11 CLASSIFICATION

Schizophrenia or other primary psychotic disorders include the following:

- **6A20:** Schizophrenia
- **6A21:** Schizoaffective disorder
- **6A22:** Schizotypal disorder
- **6A23:** Acute and transient psychotic disorder
- **6A24**: Delusional disorder

Schizoaffective Disorders

In this disorder the patient has schizophrenia symptoms (e.g., delusions, hallucinations, disorganization in the form of thought, experiences of influence, passivity and control) and mood disorder symptoms (manic, mixed, or moderate or severe depressive episode) within the same episode of illness, either simultaneously or within a few days of each other. The symptoms are not a manifest of medical conditions or due to the effects of substance or medications.

Schizotypal Disorder

It is characterized by eccentric behavior, cognitive and perceptual distortions, unusual beliefs, inappropriate affect, paranoid ideas or other psychotic symptoms, hallucinations in any modality. These are not of sufficient intensity or duration to meet the diagnostic criteria of schizophrenia, schizoaffective or delusional disorder. The symptoms cause distress or impairment in personal, family, social, educational, occupational or other important areas of functioning. These symptoms are not a manifest of medical condition or due to the effects of substance or medications.

Acute and Transient Psychotic Disorder

It is characterized by acute onset of psychotic symptoms (maximal severity within 2 weeks) and may include delusions, hallucinations, disorganization of thought processes, confusion, and disturbances of affect and mood. Catatonia-like psychomotor disturbances may be present. Symptoms typically change rapidly, both in nature and intensity, from day to day, or even within a single day. The duration of the episode does not exceed 3 months, and most commonly lasts from a few days to 1 month. The symptoms are not a manifest of medical condition or due to the effects of substance or medications.

Delusional Disorder

It is characterized by delusions in various forms (persecutory, somatic, grandiose, jealous, erotomania, etc.) typically persisting for at least 3 months or longer, showing remarkable stability within individuals. Absence of clear and persistent hallucinations, severely disorganized thinking, experiences of influence, passivity or control or negative symptoms characteristic of schizophrenia are observed. Apart from behavior directly related to the delusional system, affect, speech and behavior are typically unaffected. The symptoms are not a manifest of medical condition or due to the effects of substance or medications. *(Source ICD-11, https://icd.who.int/en)*

COURSE AND PROGNOSIS

The classic course is one of exacerbations and remissions. In general, schizophrenia

Table 6.2: Prognostic factors in schizophrenias

Good prognostic factors	Poor prognostic factors
Abrupt or acute onset	Insidious onset
Later onset	Younger onset
Presence of precipitating factor	Absence of precipitating factor
Good premorbid personality	Poor premorbid personality
Paranoid and catatonic subtypes	Simple, undifferentiated subtypes
Short duration: <6 months	Long duration: >2 years
Predominance of positive symptoms	Predominance of negative symptoms
Family history of mood disorders	Family history of schizophrenia
Good social support	Poor social support
Female sex	Male sex
Married	Single, divorced or widowed
Outpatient treatment	Institutionalization

has been described as the most crippling and devastating of all psychiatric illnesses. Prognostic factors of schizophrenia are presented in **Table 6.2**.

INVESTIGATIONS

- No diagnostic test definitively confirms schizophrenia. Tests may be ordered to rule out disorders that cause psychosis including vitamin deficiencies, uremia, thyrotoxicosis and electrolyte imbalances.
- CT scan and MRI show enlarged ventricles, enlargement of the sulci on the cerebral surface and atrophy of the cerebellum.

TREATMENT MODALITIES

Schizophrenia requires long term treatment. Treatment with medications and psychosocial therapy can effectively control the symptoms. In some cases, hospitalization may be required.

Pharmacotherapy

An acute episode of schizophrenia typically responds to treatment with antipsychotic agents which are most effective in its treatment. Conventional antipsychotics are now used less frequently because of their only partial efficacy and adverse effects. Some non-compliant patients may receive fluphenazine or Haloperidol depot formulations. These are long-acting IM doses that release the drug gradually over several weeks **(Box 6.5)**.

Atypical antipsychotics control wider range of signs and symptoms than conventional agents do and cause few or no adverse motor affects **(Box 6.6)**.

Other drugs which are used in the treatment of schizophrenia are antidepressants, mood stabilizers, benzodiazepines, etc. *(Refer Appendix 27 for Drug Guide)*.

Electroconvulsive Therapy (ECT)

Indications for ECT in schizophrenia include:

- Drug resistant patients
- Schizophrenia patients with catatonia, aggression or suicidal behavior
- ECT combined with pharmacotherapy is a viable option for selected patients

Psychosocial Therapies

Commonly used psychosocial therapies are as follows:

Box 6.5: Conventional antipsychotics

- **Chlorpromazine:** 300–1500 mg/day PO; 50–100 mg/day IM
- **Fluphenazine decanoate:** 25–50 mg IM every 1–3 weeks
- **Haloperidol:** 5–100 mg/day PO; 5–20 mg/day IM
- **Trifluoperazine:**15–60 mg/day PO;1–5 mg/day IM

Box 6.6: Commonly used atypical antipsychotics

- **Clozapine:** 25–450 mg/day PO
- **Risperidone:** 2–10 mg/day PO
- **Olanzapine:** 10–20 mg/day PO
- **Quetiapine:** 150–750 mg/day PO
- **Ziprasidone:** 20–80 mg/day PO
- **Aripiprazole:** 10–15 mg/day PO
- **Paliperidone:**1.5–12 mg/day PO
- **Amisulpride:** 400–800 mg/day PO

- **Group therapy:** Social interaction, sense of cohesiveness, identification, and reality testing achieved within the group setting have proven to be highly therapeutic for these individuals.
- **Behavior therapy:** Behavior therapy is useful in reducing the frequency of bizarre, disturbing and deviant behavior, and increasing appropriate behaviors.
- **Social skills training:** Social skills training addresses behaviors such as poor eye contact, odd facial expressions and lack of spontaneity in social situations through the use of videotapes, role playing and homework assignments.
- **Cognitive therapy:** Used to improve cognitive distortions like reducing distractibility and correcting judgment.
- **Family therapy:** Family therapy typically consists of a brief family education about schizophrenia. It has been found that relapse rates of schizophrenia are higher in families with high expressed emotions (EE) where significant others make critical comments, express hostility or show emotional over-involvement. The significant others are therefore taught to lower expectations and family tensions apart from being given social skills training to enhance communication and problem solving.
- **Psychosocial rehabilitation:** This includes activity therapy to develop the work habit, training in a new vocation or retraining in a previous skill, vocational guidance and independent job placement.

NURSING MANAGEMENT

Nursing management for schizophrenia includes assessing symptoms, establishing rapport, enhancing communication, improving general and social functioning level, promoting medication compliance and educating family members.

Nursing Assessment

Data may be obtained from patient, family members, other people familiar with the patient and also from old records. Nursing assessment includes information regarding any previous incidence of mental illness or psychotic episodes.

- Observe behavior pattern, posturing, psychomotor disturbance, appearance, hygiene.
- Identify the type of disturbance the patient is experiencing.
- Ask the patient about feelings while thought alterations are evident.
- Note the effect and emotional tone of the patient and whether they are appropriate in relation to the thought or present situation.
- Assess for theme and content of delusional thinking. If the delusion is persecution oriented, assess the nature of threat and risk for violence.
- Assess speech patterns associated with delusions.
- Assess for ability to perform self-care activity, i.e., sleep pattern and interaction with other patients.
- Determine any suicidal intent or recent attempts that may have been made **(Table 6.3)**.

Nursing Diagnosis I

Disturbed thought process related to inability to trust, panic anxiety, possible hereditary or

Table 6.3: Objective signs and subjective symptoms of schizophrenia

Objective signs	Subjective symptoms
◆ Withdrawal behavior ◆ Hostility ◆ Inadequate or inappropriate communication/ speech ◆ Inadequate food and fluid intake ◆ Psychomotor agitation ◆ Catatonic rigidity ◆ Stereotype behavior ◆ Apathy ◆ Ambivalence ◆ Mutism ◆ Inability to trust others	◆ Hallucination ◆ Illusions ◆ Paranoid thinking ◆ Anhedonia ◆ Confusion ◆ Ideas of reference ◆ Thought blocking ◆ Retarded thinking ◆ Insomnia

biochemical factors evidenced by delusional thinking, extreme suspiciousness of others.

Objective: The patient will
- ❖ Eliminate pattern of delusional thinking
- ❖ Demonstrate trust in others
- ❖ Demonstrate decreased anxiety level
- ❖ Demonstrate improved reality orientation

Intervention: *See* **Table 6.4**.

Barriers to successful intervention
- ❖ Becoming anxious

Table 6.4: Nursing interventions for delusional behavior

Nursing interventions	Rationale
Assess the content of delusion without appearing to probe	Provides baseline data to plan accurate care
Initially clarify meanings, for example, "Who do you think is trying to hurt you?"	Provides baseline data to plan accurate care
Assess the intensity, frequency and duration of delusion	Provides baseline data to plan accurate care
Assess the context and environmental triggers for the delusional experience	Helps to reduce environmental triggering factors
Approach the patient with calmness, empathy and gentle eye contact	Non-verbal nursing approaches foster the development of trust between nurse and the patient
When patients are suspicious they may be afraid of everyone, everything and every interaction around them. The nurse must communicate clearly and directly with simple statements	This communication improves patient's understanding
Misinterpretations of patients are clarified, arguments are avoided	Arguing with a patient about delusion is ineffective, inappropriate and may strengthen patient's beliefs
Distract the patient from delusions that tend to exacerbate aggressive or potentially violent episodes. Promote activities that require attention to physical skills and will help the patient use time constructively	Engaging the patient in constructive activities increases the reality base and decreases the risk for violent episodes that are provoked by delusions
Careful monitoring is required if the delusions lead patients to harm themselves or others	Early intervention may prevent aggressive response to delusions
Discourage long discussions about their irrational thinking. Instead talk about real events and real people	Discussions that focus on false ideas are purposeless and useless and may even aggravate the condition
Following interventions will help highly suspicious patients: ◆ Use the same staff as far as possible ◆ Be honest and keep all the promises ◆ Avoid physical contact in the form of touching the patient ◆ Avoid laughing, whispering or talking quietly where the patient can see but cannot hear what is being said ◆ Avoid competent activities ◆ Use assertive, matter-of-fact yet friendly approach	Promotes trust, prevents the patient from feeling threatened
Encourage the patient to express feelings as much as possible	Provides relief from stress
Patient's participation is encouraged in providing care but not forced	This increases feelings of self-worth and facilitates trust
Educate the patient and family or significant others about patient's symptoms, importance of medication compliance, and follow-up visits	This will facilitate learning and increase knowledge base, ensure the patient's continued treatment and prevent relapse after discharge from the hospital

- Focusing on delusions
- Attempting to prove the patient wrong
- Setting unrealistic goals

Nursing Diagnosis II

Ineffective health maintenance related to inability to trust, extreme suspiciousness evidenced by inadequate food and fluid intake, difficulty in falling asleep.

Objectives: The patient will

- Maintain adequate nutrition, hydration and elimination
- Maintain adequate sleep and rest
- Take medication as administered

Interventions: See **Table 6.5**.

Nursing Diagnosis III

Self-care deficit related to withdrawal, regression, panic anxiety, cognitive impairment, inability to trust evidenced by difficulty in carrying out tasks associated with hygiene, dressing, grooming, eating, sleeping and toileting.

Objectives: The patient will

- Demonstrate increased interest in self-care
- Complete daily activities with minimum assistance
- Demonstrate adequate personal hygiene skills

Interventions: See **Table 6.6**.

Table 6.5: Nursing interventions to improve health

Nursing interventions	Rationale
Assess for malnutrition and dehydration	If patient's delusions are related to food they may refuse to eat because the patient believes that the food is poisoned
Monitor food and fluid intake	Patient's physiological problems are first priority. The patient may be unaware of or may ignore his or her needs for food and fluids
Creative approaches may need to be followed with patients who are not eating e.g., allowing them to take packed foods, fruits, eggs, etc.	To ensure patient's nutritional needs are met
Provide less stimulating environment (dim light, comfortable bed, less noise, etc.) to suspicious patients as they find it difficult to fall asleep due to nightmares or severe anxiety	Patient may feel more comfortable in less stimulating environment
Administer sedatives if needed	To facilitate normal sleep
Prevent day time naps by involving the patients actively in physical exercises or day treatment programs. Example, referral to rehabilitation programs, job training programs, sheltered workshops, etc.	To facilitate normal sleep pattern
If the patient is suspicious or is reluctant to take medications, allow the patient to open the sealed medication packet	Patient has an opportunity to see medications sealed in packages which may reduce suspicion
If toileting needs are not being met, establish a structured schedule for the patient	A structured schedule will help the patient establish a pattern so that he can develop the habit of toileting independently
Monitor patient's elimination patterns. If constipation occurs use medications to establish regularity	Constipation occurs frequently with use of major tranquilizers, decreased food and fluid intake and reduced level of activity

Table 6.6: Nursing interventions to improve self-care activities

Nursing interventions	Rationale
Assess patient's ability to meet self-care activities	Provides baseline data
Provide assistance with self-care needs as required. Some patients who are severely withdrawn may require total care	Patient's safety and comfort are nursing priorities. Good physical grooming can enhance confidence in social situation
Develop a structured schedule for patient's routine for hygiene, toileting, and meals	A structured schedule will help the patient establish a pattern so that he can develop a habit
Encourage the patient to perform as many activities as possible independently	Independent accomplishment enhances self-esteem and promotes repetition of desirable behavior
Praise the patient for completing activities of daily living and initiating self-care activities	Positive reinforcement enhances self-esteem and promotes repetition of desirable behavior
Encourage wearing appropriate clothes for the setting	Appropriate clothing enhances confidence in social situations
Role model appropriate behavior and explain tasks in short simple steps	Short simple steps and role modeling are easier for the patient to perform activities
Allow the patient enough time to complete any task	It may take the patient longer to dress or comb his or her hair because of lack of concentration and short attention span
Withdraw assistance gradually and supervise the patient's grooming or other self-care skills	It will improve patient's independence

Nursing Diagnosis IV

Potential for violence, self-directed or at others, related to command hallucinations evidenced by physical violence, destruction of objects in the environment or self-destructive behavior.

Objectives: The patient will

- Not injure others or destroy property or self
- Verbalize feelings of anger or frustration
- Express lesser feeling of agitation, fear or anxiety

Interventions: See **Table 6.7**.

Table 6.7: Nursing interventions for violent behavior

Nursing interventions	Rationale
Maintain low level of stimulation (low lighting, low noise, few people, etc.) in patient's environment	Anxiety levels rise in a stimulating environment and may trigger aggression
Observe patient's behavior frequently	Close observation is necessary so that interventions can be provided to ensure patient's or other's safety
Remove all dangerous objects from patient's environment	To prevent the patient from using them to harm self or others in an agitated state
Provide a structured environment with scheduled routine activities of daily living	Lack of structure and unexplained changes usually increase agitation and anxiety. Structure enhances patient's security
Be alert for signs of increasing fear, anxiety or agitation so that we may intervene as early as possible and prevent harm to the patient or others	Earlier the intervention, easier it is to calm the patient and prevent harm
Do not use physical restraints or techniques without sufficient reason	Patient has the right to fewest restrictions possible within the limits of safety
Talk to the patient in a low calm voice	Using a low voice may help to calm the patient
Have sufficient staff available to indicate a show of strength to the patient if necessary	This provides the patient an evidence of control over the situation and physical security for the staff
Administer tranquilizers as prescribed.	If the patient is not calmed by 'talking down', use medications as prescribed

Contd…

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