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A Guide to Mental Health & PSYCHIATRIC NURSING

As per the Revised INC Syllabus for BSc Nursing

6th Edition Revised Reprint

R Sreevani

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Contents

Chapter 1: Introduction 1

- Perspectives of Mental Health and Mental Illness 1
- Evolution of Mental Health Services and Treatment 5
- Evolution of Mental Health Nursing 10
- Mental Health Team or Multidisciplinary Team 13
- Nature of Mental Health Nursing 15
- Scope of Mental Health Nursing 15
- Roles and Functions of Mental Health Nurse in Various Settings 21
- Factors Affecting the Level of Nursing Practice 24
- Concepts of Normal and Abnormal Behavior 25

Chapter 2: Principles and Concepts of Mental Health Nursing 31

- Definitions: Mental Health Nursing 31
- Classification of Mental Disorders 32
  - ICD-11 32
  - DSM-5 32
- Review of Personality Development 33
- Defense Mechanisms 36
- Etiology: Biopsychosocial Factors 38
- Psychopathology of Mental Disorders 41
- Review of Structure and Functions of Brain, Limbic System and Abnormal Neurotransmission 49
- General Principles of Mental Health Nursing 58
- Ethics and Responsibilities 60
- Practice Standards for Psychiatric Mental Health Nursing (Indian Nursing Council Practice Standards) 63
- Categories of Psychiatric Mental Health Nursing Standards 64
- Conceptual Model and the Role of a Nurse 66
  - Existential Model 66
  - Psychoanalytical Model 66
  - Behavioral Model 68
  - Interpersonal Model 69
  - Nursing Model 60
- Preventive Psychiatry and Rehabilitation 71

Chapter 3: Mental Health Assessment 80

- History Taking 80
- Mental Status Examination (MSE) 83
- Physical Examination 84
- Mini-Mental Status Examination 84
- Neurological Examination 84
- Investigations in Psychiatry 89
- Psychological Tests 90

Chapter 4: Therapeutic Communication and Nurse–Patient Relationship 94

- Therapeutic Communication 94
  - Characteristics 94
  - Techniques 94
  - Barriers 96
- Interpersonal Relationships 97
  - Types of Relationships 97
- Therapeutic Nurse–Patient Relationship 98
- Review of Techniques of IPR: Johari Window 100
- Therapeutic Nurse-Patient Relationship 102
- Elements of Nurse-Patient Contract 103
- Therapeutic Impasses and Its Management 107
- Process Recording 108

Chapter 5: Therapeutic Modalities and Therapies Used in Mental Disorders 113

- Psychopharmacology 113
  - Core Concept 114
  - General Guidelines on Drug Administration in Psychiatry 116
  - Patient Education Related to Psychopharmacology 116
- Antipsychotics 117
  - Classification of Antipsychotic Drugs 117
- Antidepressants 123
- Lithium and Other Mood Stabilizing Drugs 126
- Anxiolytics (Antianxiety Drugs) and Hypnosedatives 130
- Antiparkinsonian Agents 132
- Miscellaneous Drugs 132
- Electroconvulsive Therapy 134
- Repetitive Transcranial Magnetic Stimulation (rTMS) 137
- Ketamine Therapy 138
- Psychological Therapies 140
  - Psychotherapy 140
  - Behavioral therapy 143
  - Cognitive therapy 145
- Psychosocial Therapies 147
  - Group Therapy 148
  - Family Therapy 150
  - Therapeutic Community 153
  - Recreational Therapy 155
  - Music Therapy 156
  - Dance Therapy 156
  - Occupational Therapy 157
- Role of a Nurse in Psychological Therapies 158
- Complementary and Alternative Therapies in Psychiatry 158
  - Acupuncture 159
  - Ayurvedic Medicine 160
  - Homeopathic Medicine 160
  - Naturopathy 160
  - Meditation 160
  - Relaxation Therapies 160
  - Spiritual Healing and Prayer 161
  - Herbal Therapies 161
  - Aromatherapy 161

- Special Diet Therapies, Mega Doses of Vitamins or Minerals 161
- T'ai chi and Qi Gong 162
- Yoga 162
- Massage 162
- Biofield Therapies 162
- Bioelectromagnetic-based Therapies 163
- Light Therapy 163
- Psychiatric Disorders and Related CAM Therapies 163
- Psychiatric Nurse and CAM 164

❍ Considerations for Special Population 165

Chapter 6: Nursing Management of Patient with Schizophrenia, and Other Psychotic Disorders 174

❍ Prevalence and Incidence 174
❍ Etiology 175
❍ Pathophysiology 176
❍ Clinical Manifestations 177
❍ Diagnostic Criteria According to ICD-11 179
❍ Classification 180
- Schizoaffective Disorders 180
- Schizotypal Disorder 180
- Acute and Transient Psychotic Disorder 180
- Delusional Disorder 180

❍ Course and Prognosis 180
❍ Investigations 181
❍ Treatment Modalities 181
❍ Nursing Management of Patients with Schizophrenia and Other Psychotic Disorders 182
❍ Geriatric Considerations 189
❍ Considerations for Special Population 189
❍ Follow-up, Homecare and Rehabilitation for Schizophrenia Patient 189

Chapter 7: Nursing Management of Patient with Mood Disorders 195

❍ Prevalence and Incidence 195
- ICD-11 Classification of Mood Disorders 195

❍ Manic Episode 196
- Etiology 196
- Pathophysiology of Mania 197
- Clinical Features 197
- Diagnosis 199
- Treatment Modalities 199
- Nursing Management for Mania 200

❍ Depressive Episode 205
- Etiology of Depression 206
- Clinical Features 207
- Diagnosis 208
- Treatment Modalities 209
- Nursing Management of Major Depressive Episode 210

❍ Course and Prognosis of Mood Disorders 214
❍ Recurrent Depressive Disorder 214
❍ Cyclothymia 214
❍ Dysthymia 215

- Geriatric Considerations 215
- Considerations for Special Population 215
- Follow-up, Homecare and Rehabilitation 215

Chapter 8: Nursing Management of Patient with Neurotic, Stress-related and Somatization Disorders 220

- Prevalence and Incidence of Anxiety Disorders 220
- Etiology of Anxiety Disorders 221
- ICD-11 Classification of Anxiety Disorders 222
- Generalized Anxiety Disorder (6B00) 222
  - Clinical Features 222
  - Course 223
  - Diagnosis 223
  - Treatment Modalities 223
- Panic Disorder 224
  - Clinical Features 224
  - Course 225
  - Diagnosis 225
  - Treatment Modalities 225
- Phobic Anxiety Disorder 226
  - Types 226
  - Signs and Symptoms 227
  - Course 227
- Separation Anxiety Disorders 229
- Selective Mutism 229
- Diagnosis 230
- Treatment for Anxiety Disorders 230
- Nursing Management for Anxiety or Fear-related Disorders 231
- Obsessive-compulsive Disorder 233
  - ICD-11 Classification 234
  - Etiology 234
  - Symptoms 235
  - Course and Prognosis 236
  - Treatment 236
  - Nursing Management 237
- Post-traumatic Stress Disorder 238
  - Causes 238
  - Signs and Symptoms 239
  - Course and Prognosis 240
  - Treatment 240
  - Nursing Interventions 240
- Dissociative Disorders 241
  - Etiology 241
  - Classification 242
- Dissociative Neurological Symptom Disorder 242
  - Dissociative Motor Disorders 242
  - Dissociative Convulsions 242
  - Dissociative Sensory Loss and Anesthesia 242
  - Dissociative Amnesia 243
  - Dissociative Fugue 243
  - Possession and Trance Disorders 243
  - Dissociative Identity Disorders 243

- Depersonalization and Derealization Disorders
- Diagnosis 243
- Treatment Modalities 243
- Nursing Management 244

❍ Somatoform Disorders 245
- Signs and Symptoms 245
- Diagnoses 245
- Treatment Modalities 245
- Nursing Interventions 246

❍ Geriatric Considerations 246
❍ Considerations for Special Population 246
❍ Follow-up, Homecare and Rehabilitation 246

Chapter 9: Nursing Management of Patients with Substance Use Disorders 252

❍ ICD-11 Classification 253
❍ Commonly Abused Substances 253
❍ Etiological Factors for Substance Use Disorders 254
❍ Signs of a Substance Abuse 255
❍ Consequences of Substance Abuse 256
❍ Disorders Due to Use of Alcohol (6C40) 256
- Prevalence and Incidence 257
- ICD-11 Classification 257
- Complications of Alcohol Abuse 259
- Diagnosis 260
- Treatment 260
- Agencies Concerned with Disorders Due to Alcohol Use 263
- Nursing Management 264

❍ Disorders Due to Use of Cannabis (6C41) 267
❍ Disorders Due to Use of Opioids (6C43) 268
❍ Disorders Due to Use of Sedatives, Hypnotics or Anxiolytics (6C44) 268
❍ Disorders Due to Use of Cocaine (6C45) 269
❍ Disorders Due to Use of Stimulants Including Amphetamines, Methamphetamine (6C46) 269
❍ Disorders Due to Use of Caffeine (6C47) 270
❍ Disorders Due to Use of Synthetic Cathinones (6C48) 270
❍ Disorders Due to Use of Hallucinogens (6C49) 270
❍ Disorders Due to Use of Nicotine (6C4A) 271
❍ Disorders Due to Use of Volatile inhalants (6C4B) 271
❍ General Nursing Interventions for a Patient with Acute Drug Intoxication 272
❍ Prevention of Substance Use Disorder 272
❍ Laws Related to Substance Abuse 274
❍ Special Considerations 274
❍ Follow-up and Homecare 274

Chapter 10: Nursing Management of Patient with Personality and Sexual Disorder 280

❍ Personality Disorder 280
- Meaning 280
- Incidence 280
- Classification 280
- Etiology 281

- Clinical Features of Paranoid Personality Disorder 282
  - Schizoid Personality Disorder 282
  - Schizotypal Disorder 283
  - Antisocial (Dissocial) Personality Disorder 283
  - Histrionic Personality Disorder 283
  - Narcissistic Personality Disorder 283
  - Borderline Personality Disorder 283
  - Anxious Personality Disorder 283
  - Dependent Personality (Submissiveness) 283
  - Obsessive-compulsive (Anankastic) Personality Disorder
- Treatment Modalities 285
  - Nursing Interventions for Patients with Personality Disorders 285
  - Nursing Interventions for Antisocial Personality Disorder 286
  - Nursing Interventions for Borderline Personality Disorder 286
  - Geriatric Considerations 286
  - Follow-up, Homecare and Rehabilitation for Personality Disorders 287
- Sexual Disorders 287
  - ICD-11 Classification 287
- Treatment 288
- Nursing Intervention 288

Chapter 11: Nursing Management of Behavioral and Emotional Disorders Occurring During Childhood and Adolescence 292

- Classification (ICD-11) 293
- Disorders of Intellectual Development (Mental Retardation/Mentally Challenged Individuals) 293
  - Definition 293
  - Epidemiology 294
  - Etiology 294
  - Classification 295
  - Behavioral Manifestations 295
  - Diagnosis 297
  - Prognosis 297
  - Treatment Modalities 298
  - Prevention 298
  - Care and Rehabilitation 299
  - Nursing Management 299
- Developmental Speech or Language Disorders (6A01) 301
  - Causes 301
  - Symptoms 301
  - Diagnosis 301
  - Treatment 301
- Autism Spectrum Disorder (6A02) 301
  - Meaning 301
  - Epidemiology 301
  - Etiology 302
  - Clinical Picture 302
  - Course and Prognosis 304
  - Diagnosis 304
  - Treatment 304
  - Nursing Management 305
  - Prevention 306

- Developmental Learning Disorder (6A03) 306
  - Causes 306
  - Symptoms of Learning Disorders 306
  - Treatment 307
- Developmental Motor Co-ordination Disorder (Dyspraxia)(6A04) 307
  - Causes 307
  - Symptoms 307
  - Treatment 307
- Attention-deficit Hyperactivity Disorder (ADHD) (6A05) 307
  - Etiology 308
  - Clinical Features 308
  - Types 309
  - Diagnosis 309
  - Treatment 309
  - Nursing Intervention 310
- Conduct Disorders (6C91) 310
  - Etiology 311
  - Clinical Features 312
  - Diagnosis 312
  - Treatment 313
  - Nursing Interventions 313
- Elimination Disorders 314
  - Non-organic Enuresis (6C00) 314
  - Non-organic Encopresis (6C01) 315
- Anorexia Nervosa (6B80) 315
  - Etiology 315
  - Clinical features 315
  - Complications 317
  - Course and prognosis 317
  - Diagnosis 317
  - Treatment 317
  - Nursing interventions 317
- Bulimia Nervosa (6B81) 318
  - Etiology 318
  - Clinical Features 318
  - Complications 318
  - Diagnosis 319
  - Treatment Modalities 319
  - Nursing interventions 319
- Follow-up, Homecare and Rehabilitation for Childhood Psychiatric Disorders 320

Chapter 12: Nursing Management of Organic Brain Disorders 324

- Classification of Neurocognitive Disorders 324
- Delirium (Acute Organic Brain Syndrome) 324
  - Incidence 324
  - Etiology 325
  - Clinical Features 325
  - Course and Prognosis 326
  - Investigations 326
  - Treatment 326
  - Nursing Interventions 326
- Organic Amnestic Syndrome 327
  - Etiology 327

- Clinical Features 327
- Management 327

❍ Dementia (Chronic Organic Brain Syndrome) 328
- Incidence 328
- Causes 328
- Pathophysiology 328
- Stages of Dementia 329
- Warning Signs of Alzheimer's Dementia 330
- Clinical Features (for Alzheimer's Type) 331
- Course and Prognosis 331
- Diagnosis 331
- Treatment Modalities 332
- Nursing Management 332

❍ Follow-up, Homecare and Rehabilitation 335

❍ Geriatric Considerations 335

Chapter 13: Psychiatric Emergencies and Crisis Intervention 340

❍ Types of Psychiatric Emergencies and their Management 340
- Attempted Suicide 341
- Violence/Aggression 344
- Stupor 345
- Substance Intoxication and Withdrawal 345
- Panic Attacks 345
- Hysterical Attacks 346
- Victims of Disaster 346
- Rape Victim 347
- Neuroleptic Malignant Syndrome 347
- Serotonin Syndrome 347
- Drug Toxicity 347

❍ Maladaptive Behavior 348

❍ Crisis 350
- Characteristics of Crisis 351
- Types of Crises 351
- Signs and Symptoms of Crisis 352
- Phases/Stages of Crisis 352
- Process of Crisis (Resolution of Crisis) 353
- Crisis Intervention 354
- Modalities of Crisis Intervention 357

❍ Stress Reduction Interventions 358
- Components of Stress 358
- Stress Reduction Strategies 358

❍ Coping 360
- Meaning of Coping 360
- Types of Coping Styles 360
- Enhancing Coping Strategies 362

❍ Counseling 362
- Principles of Counseling 362
- Techniques of Counseling 363

Chapter 14: Legal Issues in Mental Health Nursing 369

❍ Overview of Indian Lunacy Act 1912 and the Mental Health Act 1987 369

❍ Mental Health Care Act (MHCA) 2017 370
- Reasons for Enactment 370

- Key Features of MHCA 370
- Description of the Act 371

❍ Protection of Children from Sexual Offence (POCSO) Act 377
- Key Features of the Act 377
- General Principles of the Act 377
- Categories of Sexual Offences Under this Act 378

❍ Rights of Mentally Ill Patients and Nurse's Responsibilities 378
❍ Civil Rights of the Mentally Ill 379
❍ Nurse's Implications for Protecting Patient's Rights 379
❍ Forensic Psychiatry 380
- Criminal Forensic Psychiatry 380
- Civil Forensic Psychiatry 380
- Legal Forensic Psychiatry 380

❍ Legal Responsibilities of a Nurse 383
- Nursing Malpractice 383
- Confidentiality 383
- Informed Consent 384
- Substituted Consent 384
- Record Keeping 384
- Specific Problems in Mental Hospitals 384

❍ Acts Related to Narcotic and Psychotropic Substances and Illegal Drug Trafficking 385
❍ Admission and Discharge Procedures as per MHCA 2017 386
❍ Roles and Responsibilities of Nurses in Implementing MHCA 2017 387

Chapter 15: Community Mental Health Nursing 394

❍ Development of Community Mental Health Services in India 394
❍ National Mental Health Policy vis-a-vis National Health Policy 399
❍ National Mental Health Programme 401
❍ District Mental Health Programme (DMHP) 402
❍ Institutionalization vs Deinstitutionalization 404
❍ Models of Preventive Psychiatry 406
- Primary Prevention 407
- Secondary Prevention 408
- Tertiary Prevention 408

❍ Mental Health Services Available at Primary, Secondary and Tertiary Level including Rehabilitation and Nurses' Responsibilities 409
❍ Other Mental Health Services Available for Psychiatric Patients 410
- Partial Hospitalization 410
- Quarter Way Homes 411
- Half-way Homes 411
- Self-help Groups 412
- Suicide Prevention Centers 413

❍ Rehabilitation Services in India 413
❍ Mental Health Agencies 414
- Government and Voluntary 414
- National and International 414

❍ Community Mental Health Nursing 418
❍ Tips for Working in the Community 420
❍ Misconceptions about Mental Illness 422
❍ General Attitude Towards the Mentally-ill 422
❍ Mental Health Nursing Issues for Special Population 423

– Children 423
– Adolescents 423
– Women 424
– Elders 427
– Victims of Violence and Abuse 428
– Handicapped 430
– HIV/AIDS Patients 430

Appendices **437**

- *Appendix 1:* The Main Categories in ICD-11 437
- *Appendix 2:* History Taking Format in Psychiatric Nursing 441
- *Appendix 3:* Mental Status Examination Format 445
- *Appendix 4:* Mental Status Examination of Uncooperative Patient 449
- *Appendix 5:* Neurological Examination Format 451
- *Appendix 6:* Physical Examination Format 453
- *Appendix 7:* Glasgow Coma Scale 454
- *Appendix 8:* Process Recording Format 455
- *Appendix 9:* Mini-Mental Status Examination (MMSE) Format 456
- *Appendix 10:* Alcoholism History Collection Format 458
- *Appendix 11*: Child and Adolescent Psychiatry Assessment Format 460
- *Appendix 12:* Geriatric History Collection Format 462
- *Appendix 13:* Nursing Care Plan Format in Psychiatric Nursing 464
- *Appendix 14:* Case Study/Case Presentation Format in Psychiatric Nursing 465
- *Appendix 15:* ECT History Collection Format 467
- *Appendix 16:* Psychotherapy Format 469
- *Appendix 17:* Occupational Therapy Format 470
- *Appendix 18:* Behavior Therapy Format 471
- *Appendix 19:* Recreation/Play Therapy Format 472
- *Appendix 20:* Group Therapy Format 473
- *Appendix 21:* Health Education Format 474
- *Appendix 22:* Drug Book Format 475
- *Appendix 23:* Psychiatric OPD Logbook 476
- *Appendix 24:* Admission Procedure Format 477
- *Appendix 25:* Discharge Procedure Format 478
- *Appendix 26:* Objective Structured Practical/Clinical Examination (OSPE/OSCE) 479
- *Appendix 27:* Drug Guide 490
- *Appendix 28:* Abbreviations 521

Glossary *525*

Bibliography *537*

Index *539*

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.

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- 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

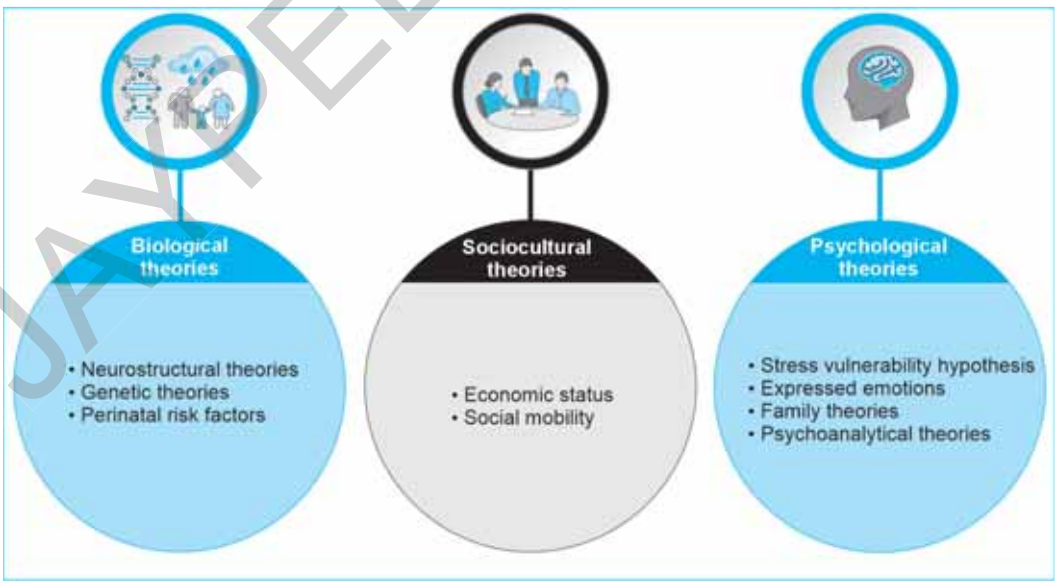

Figure 6.1: Etiology of schizophrenia

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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.

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- 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.

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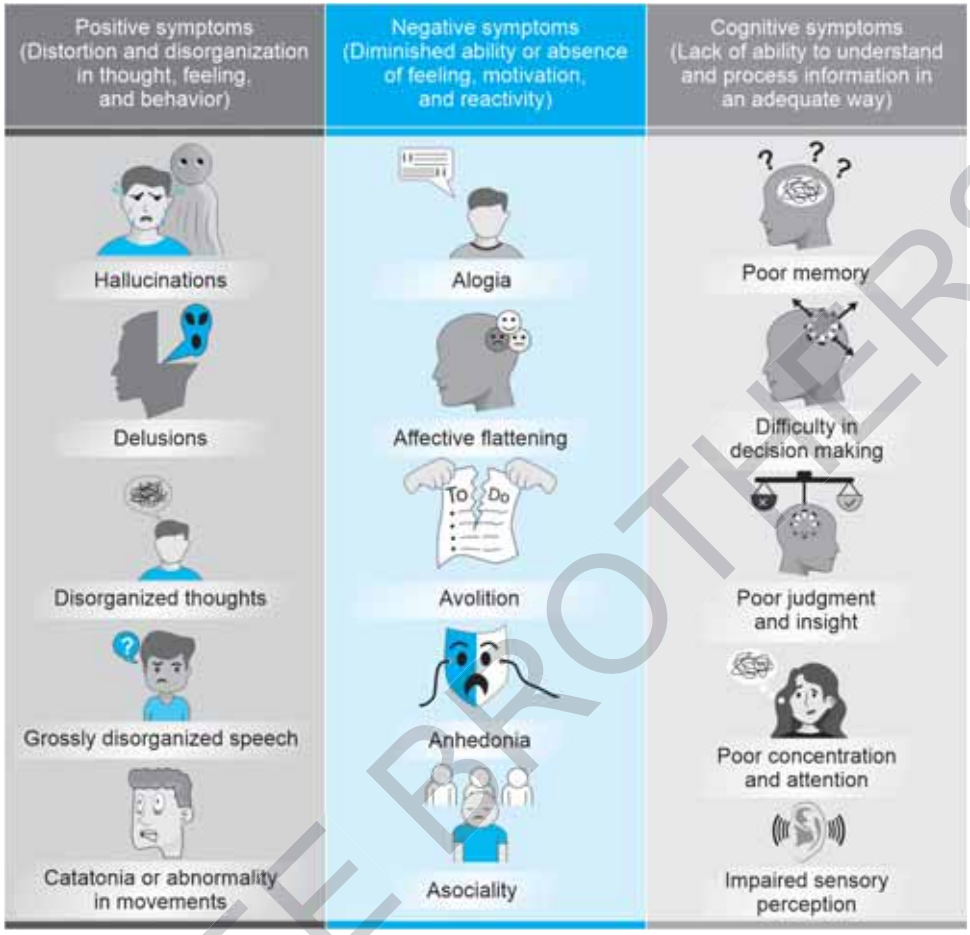

Figure 6.2: Positive, negative and cognitive symptoms of schizophrenia

- 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:** Contradictory or opposing emotions, attitudes, ideas or desires for the same person, thing or situation simultaneously.
- **Autistic thinking:** 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.

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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

UNDER PEER REVIEW

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

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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. Medications and psychosocial therapy can control the symptoms effectively. 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 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

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- **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

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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

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- 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

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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

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R Sreevani PhD (Psychiatric Nursing) presently working as a Professor and Head, Department of Psychiatric Nursing, Dharwad Institute of Mental Health and Neurosciences (DIMHANS), Dharwad, Karnataka, India, was awarded PhD in Psychiatric Nursing under National consortium for PhD in Nursing from Rajiv Gandhi University of Health Sciences (RGUHS), Karnataka. She secured her Masters Degree in Psychiatric Nursing from National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka, which is world-renowned as a center for mental health, neurosciences and allied fields. She has the distinction of graduating from College of Nursing, Kurnool, Andhra Pradesh, India, with top rank and securing 4 Gold Medals instituted by student welfare bodies.

She is a certified Body-Mind-Spirit practitioner from Hong Kong University, Hong Kong. She also has a Postgraduate Diploma in Nutrition and Dietetics Management from Institute for Social Sciences and Research, Vellore, Tamil Nadu, India.

Well known for authoring *Applied Psychology for Nurses* and *Basics in Nursing Research and Biostatistics*, she has also authored *Applied Sociology for Nurses* and *Health/Nursing Informatics & Technology* besides authoring many other books published by M/s Jaypee Brothers Medical Publishers, New Delhi. She has published many Research Articles in National and International journals; organized Workshops; presented Scientific Papers and been a resource person in National and International Conferences/Workshops. She is also a principal investigator in National and International funding projects.

She is a nominated member of the Central Mental Health Authority under the Mental Healthcare Act, 2017, and also a fellow of the Indian Society of Psychiatric Nurses. She has been conferred with the National Florence Nightingale Award 2015 for her noteworthy contribution to the field of nursing education.

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