AMALA COLLEGE OF NURSING
AQAR (2022-2023)

CRITERION 2 – TEACHING- LEARNING AND EVALUATION

Key Indicator 2.3 – Teaching- Learning Process

Metric No. 2.3.1. - Student-centric methods are used for enhancing learning experiences by:

SUBMITTED TO

National Assessment and Accreditation Council

CASE PRESENTATION

CLINICAL PRESENTATION OF MRS. SEENATH WITH SCHIZOPHRENIA

Presented on 11/11/22

Submitted to,
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Presented on 11/11/22

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14/11/22

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AMALA NAGAR, THRISSUR

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HISTORY COLLECTION

I. IDENTIFICATION DATA

Name : Mrs. Seenath.
Age : 47 years
Father/spouse : Mr. Sainudheen.
Address : Tharaparambil
Kecheri, Thrissur.
Education : 9th Standard
Occupation : Housewife
Income : Nil
Languages : Malayalam, Arabic, English
Marital status : Married
Religion : Muslim

INFORMANT DETAILS

Name : Mrs. Faigiza
Age : 26 years
Relationship with patient - Daughter
Duration of stay : 28 years
Information : Relevant and adequate

II. PRESENTING CHIEF COMPLAINTS

Patient Version.
Patient says. "I have no disease or health problems"

Informant Version

On admission

Decreased sleep x 1 week
Aggressive behaviour x 1 week
Not following instructions x 4 days
Suspecting harm from others x 1week
over religiosity x 4 years.
irritability to specific colours and persons x2 week

Present problems

sleep disturbances
Aggressiveness
suspecting harm from others.
Sad facial expressions

HISTORY OF PRESENT ILLNESS

Mrs. Seendth 47 years old female gal admitted in Ansar hospital on 20/10/22 at 6.45pm involuntarily with her sister and daughter by walking. The specific reason for the admission was decreased sleep since one week aggressive behaviour since one week, Not following commandments since 4 days, suspecting harm from others since 1 week and irritability to specific colours and persons 2week and over religiosity since 4 years

The patient was last well since 2 weeks before admission. The precipitating factor for the disease is the, non compliance to medication regimen. The symptoms like decreased sleep since one week, not following instructions aggressive behaviour, irritability to red colour and some family members and neighbours over religiosity. Suspecting harm from others. Reduced food intake and loss of awareness in between activities. The time of onset of current episode is in middle age. The mode of onset is insidious. The course of disease is improving and the intensity is decreasing. The perpetuating factor is loneliness in house in day time. The predisposing factor is the presence of mental disorder in brother. She has no negative history such as drug use, head injury or other organic cause.

The effect of the symptoms on self is giving rise to distress. The mental function like concentration is impaired, she has delusional thoughts and other functions such as attention and memory is intact. The biological function such as sleep is decreased. she has normal appetite bowel and bladder habits and sexual functions. The social functioning such as ability to work and family relationships are normal. She has difficulty in initiating new social relationships. She has good relationship with spouse and other family members. She has no legal problems, arrest, ongoing cases in the family.

At present patient is taking medications like T. Stelopin 25mg TID, T. Haldase 1.5mg TID, T. pacitane - 2mg 1-1-0, and T. [illegible] 2mg 0-0-1. Client has not undergone any electro convulsive therapy, psychotherapy

family therapy on rehabilitation.

PAST PSYCHIATRIC AND MEDICAL HISTORY

Past psychiatric history.

Mrs. Seenath has previous 2 episodes of illness and 1 hospitalization.

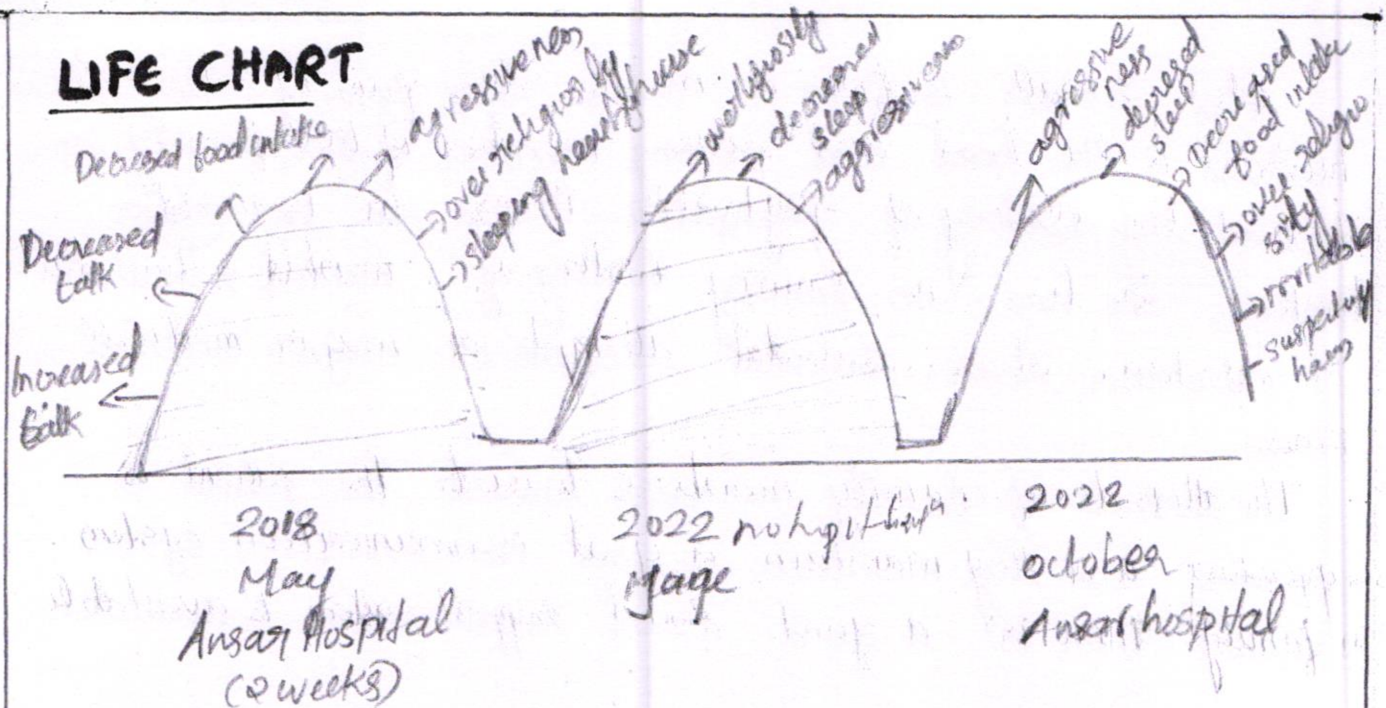
In 2018 patient had the first episode of disease, the precipitating factor for the first episode was the financial crisis and loss of own house. Patient had symptoms such as over religiosity, increased talk, suspecting harm from others, Not taking food, sleeping in the neighbouring houses, aggressiveness she was consulted in Ansar hospital and was admitted in the hospital for 2 weeks. and her symptoms were reduced. [illegible]

The second episode happened in 2022 June, the precipitating factor for the disease was not taking medication. She was consulted the doctor and did not admitted in the hospital. There were no side effects from the treatment. Patient has no history of substance use or suicidal tendancies or attempts

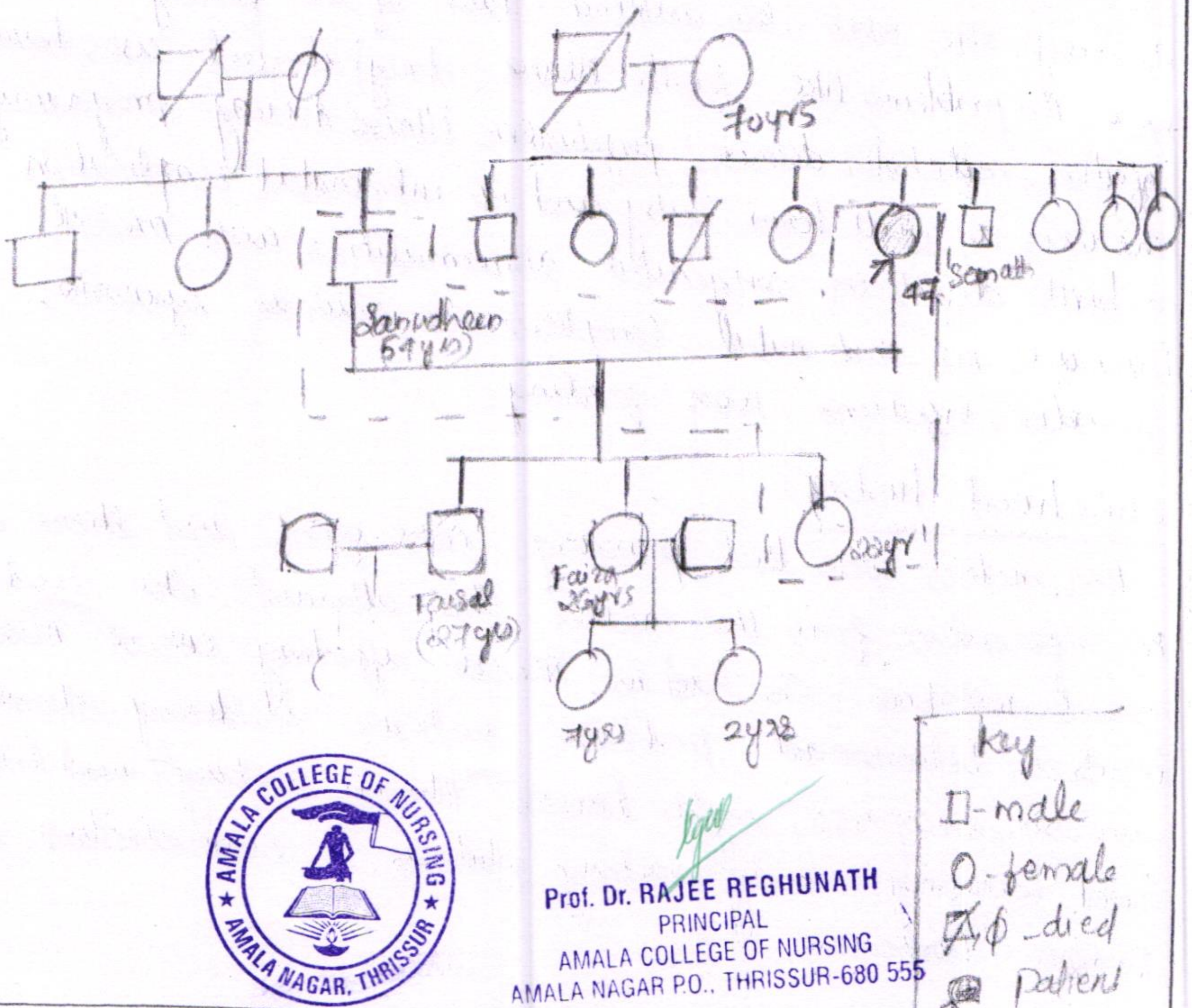
Past Medical history.

Patient has no history of surgical procedures, accidents head injury, convulsions, unconsciousness or diseases such as diabetes, hypertension, CAD, venereal disease, HIV or any other diseases

LIFE CHART



FAMILY HISTORY



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Mrs. Seenath is from a middle class family, Her husband is the head and earning member of the family. She had the history of psychiatric illness in her elder brother. She has no family history of mental retardation or substance abuse, suicidal attempts or major medical illness.

The attitude of family members towards the patient is supporting and they maintain a good communication system in family. There is a good social support system is available.

PERSONAL HISTORY

Perinatal history

Mrs. Seenath was born in 1975 may by normal vaginal delivery. She was the wanted child of the family. There were no problems like febrile illness, drug/alcohol use, trauma infection, metabolic disease, psychiatric illness during pregnancy. She was a full term baby and no intranatal complication or birth defects or congenital abnormalities were present. There was no post natal complications such as cyanosis, jaundice, infections, poor feeding.

Childhood history.

Her mother was the primary care giver. and there were no seperations from the mother. She attained the develop mental milestones. She had no illnesse affecting cns or neurotic traits or behavioural problems such as stuttering, stammering enuresis, encopresis, night terrors, thumb sucking / nail biting head banging, body rocking, phobias, somnabulism, bad temper tantrums.

She has no emotional problems such as anxiety and inferiority or any sibling rivalry. She had good relationship with peer groups. She had no behavioural problems such as anti social, conduct problems, running away from home or alcohol / drug experimentation.

Education history

Mrs. Seenath started the formal education in her 5th years. She was average in education and participated in extra-curricular activities such as sports. She had good relationships with peers and teachers. She has no school phobia absenteeism, learning difficulties, impulsiveness, and antisocial behaviours. She discontinued her education in 9th standard. The reason for discontinuation was the failure in 9th standard.

Occupational history

Mrs. Seenath is a housewife. She had no other occupations.

Menstrual and obstetrical history

The patient had menarche at 13th years and normal development of secondary sexual characteristics. She had normal reaction to the changes. She had no physical or psychological symptoms during the menstruation. She has three children, two daughters and one son. All the children were born by normal vaginal delivery. There were no complications during the pregnancy period or in delivery.

Sexual and Marital history

Mrs. Seenath married at the age of 20; it was an arranged marriage. She has good relationship with the spouse. She is maintaining her duties and responsibilities as a mother. She is getting support from the spouse. She is satis-

fred in her marital relationship.

Premorbid personality.

→ Attitude to self:

Patient was confident. Patient says I was confident in my activities. and she was aware about her strength and abilities. She discontinued her education in 9th standard due to the failure of 9th standard examination. She was good in sports and participated in sub-district level competitions. The ambition of her life is to build a own house and to live peacefully with her children

- Relations.

She maintained good interpersonal relationships in family. She is introverted. She faces difficulty in creating new relationship due to shy. She has healthy relationships with opposite sex. She is able to tolerate criticisms.

- work, leisure:

She had good acceptance of responsibility and perseverence. She has no special hobbies. She is interested in doing religious activities.

- Predominant mood is optimistic, and it is stable. She has poor tolerance to stress full events

- Religious beliefs and moral attitudes.

She is from Muslim religion. She used to participate in religious customs and prayers.

- Fantasy life

No fantasy life

- Habits

Sleep: She has reduced sleep. She wakeup in early morning to do prayers. She has normal eating patterns and excretory functions. She has no history of substance abuse.

MENTAL STATUS EXAMINATION

Name of the patient : Mrs. Seenath.
ward no. : A
Date : 4/11/22
Time : 10-30am

A. GENERAL APPEARANCE AND BEHAVIOUR

Level of consciousness : consious
Facial expression : ~~Anxious~~ Blunted
Level of grooming : Moderately kempt
Level of cleanliness : Adequate
Social behaviour : Normal.
Cooperativeness : cooperative
Eye to eye contact : Maintained.
Rapport : Build Spontaneously
Comprehension : intact

PHYSICAL FEATURES

Look : Looking one's age.
weight : Normal -
Any physical deformity : Absent

B. PSYCHOMOTOR ACTIVITY/MOTOR BEHAVIOUR

Quantity : Normal
Reaction time : Spontaneous
Posturing : open

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Gesturing : Normal

Abnormal involuntary movements : Tremors, restlessness, akathesia etc
Absent, No extrapyramidal symptoms

Catatonic phenomena : Absence of automatic obedience negativism, excessive cooperation, stereotype, waxy flexibility, echopraxia.

Conversion and dissociative signs : Absence of pseudo seizures and possession status.

Compulsive acts or rituals or habits : Absent

Hallucinatory behaviour : Absent

C. SPEECH

Initiation / spontaneity : Spontaneous
Reaction time : Normal
Rate : Slow
Productivity : Normal
Volume : Decreased
Tone : low pitched.
Relevance : Relevant
Coherance : Coherent
Other speech problems : Absence of echolalia, perseveration, neologism, verbigeration and alogia.

D. THOUGHT

STREAM :- Flight of ideas, loose thoughts, logorrhea pressure of speech, retarded thinking, mutism thought block, perseveration, verbigeration circumstantiality, tangentiality is absent

FORM :- Normal.

Absence of autistic thinking, illological thinking incoherence, neologism, word salad, ambivalance, over inclusion clang association, intellectualization.

CONTENT OF THOUGHT

DELUTIONS

1) Question: Do you believe that some body is trying to follow harrased, cheated conspired against you.?
Answer: Yes, My enemies are trying to attack me
Inference: Persecutory delusions are present

2) Question: Do you believe that you have any special abilities, power, knowledge, identity?
Answer: Yes. I have some Abilities recieved from God.
Inference: Delusion of grandeur is present.

3) Do you believe that all that happening around you are directed to you.?
Answer: Yes, Others are speaking about me.
Inference: Delusion of reference is present

4) Question: Do you believe some body or external forces control your thoughts, feeling or impulses.
Answer: Yes. Some forces are controlling my thoughts and activities
Inference: Delusion of control is present

5 Other delusions - hypochondriacal delusions, nihilistic delusion delusion of infidelity, delusion of control, bizzare delusions delusion of love, delusion of guilt are absent

Over valued ideas : Absence.

Preoccupations : Absence of worthlessness, hopelessness, shame, guilt, hypochondriacal, deathwishes suicidal or homicidal ideations.

Obsession : Absent

Phobias : Absent

Fantasy : Absent

POSSESSIONS

1) Question : Do you feel your thoughts are being inserted in your passive mind ?

Answer : ~~Yes~~ No.

Inference : Thought insertion is present.

2 Question : Do you believe that your thoughts are being escaped from your mind ?

Answer : ~~No~~ Yes.

Inference: Thought withdrawal is absent

3) Question : Do you feel that your thoughts are being escape from your mind and can be known to others

Answer : Yes. My enemies can know my thoughts

Inference: Thought broad casting is present

E. MOOD AND AFFECT

MOOD
Quality - worried.
Subjective Mood -
Question : what do you feel now?
Answer : I have no problems, I am happy.
Persistence : days
Stability of mood : Stable
other abnormalities , anhedonia, delusional mood are absent

Objective mood :
Quality - anxious
Stability of mood - stable.

AFFECT
Quality : Blunted
Appropriateness and congruence to thought : Not appropriate

Range - blunted.
Mobility - Decreased.
Persistence - No affective incontinence.

PERCEPTION

Sensory distortion
change in size - Absence of macropsia or micropsia
change in Quality - absence of hyperesthesia or hypesthesia

Sensory deceptions
→ Illusion -
Question : Do you often misinterpret object and environment or surrounding?
Answer : Absent
Inference : No Delusion present

Hallucination

1) Question - Do you hear or see things that can not see or hear by others?
Answer: Yes, I can hear voices speaking to me.
Inference: Presence of 2nd person auditory hallucination

2. Question: Do you feel that any tactile sensation with any imaginary object?
Answer: Absent
Inference: Absence of tactile hallucination.

3) Other hallucinations - Absent

Somatic passivity:
Question: Do you feel that sensation imposed in your body by some external force?
Answer: No
Inference: Absence of somatic passivity.

Depersonalization: Absent

Derealization: - Absent

Other abnormal perceptions:
Absence of déjà vu, déjà pensé, déjà entendu, Jamais vu etc.

G. COGNITIVE FUNCTIONS

ATTENTION

DIGIT SPAN TEST

DIGIT	FORWARD	BACKWARD	INFERENCE
Can you tell digit forward and backward			
1,4	✓	✓	Client answered five digits forward and backward. So attention is intact
2,5,8	✓	✓	
9,2,5,1	✓		
6,2,5,3,7	✓	✓	

CONCENTRATION

Question	Answer	inference.
• Can you substract 7 from 100, 5 times.	100 − 7 = 93 93 − 7 = 88 88 − 7 = 81	Client answered 3 series of substraction correctly and name of days of week and he did not answered the months of a years. So the concentration is impaired.
• Name the months backward	Not answered	
• Name of the days of weeks back ward	Answered.	

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ORIENTATION

Question	Answer	Inference
Time: what is the time now?	10.30 am	Oriented to time
Place: where are you now?	I am in Ansar hospital.	Oriented to place
Person: Do you know whom am I?	you are a nurse.	Oriented to person

MEMORY

Question	Answer	Inference
Immediate Memory:		
Can you recollect thes words (Pen, penal, book, eraser, Bottle)	Answered (Pen, Book, Bottle pencil, eraser)	Immediate memory is intact
Recent Memory		
what was your breakfast today?	Pathiri and egg curry	Recent memory is intact
Remote Memory		
Can you tell your date of marriage	Not remembering exact date.	Remote memory is impaired

INTELLIGENCE

Question	Answer	Inference.
General information		
-who is the chief minister of Kerela?	Pinarayi Vijayan.	General information is good.
-which is the capital of India	Delhi	

Arithmatic Ability		
Addition - 8+7	15	Arithmetic ability is good
Substraction : 10-2	8	
Multiplication : 8x7	56	
Division -28÷4	7	
Vocabulary		
can you tell 5 flowers name.?	Rose, Jasmine, Lilly lotus, Sunflower	Vocabulary is good.

ABSTRACT THINKING

Question	Answer	Inference.
Similarities and dissimilarities between objects. → Can you tell the similarities of chair and table?	Both are used to sit we can lean on chair But not in stool.	Abstract thinking is intact, since, explained similarities and dissimilarities of familiar objed and interpreted the proverb.
Interpretation of proverb. - All glitters are not gold.	All those who look good may not be good	

JUDGEMENT

Question	Answer	Inference
Personal Judgement → what is your future plan.?	I want to go home and live peacefully with my family members	Personal judgement is intact
- Soual Judgement what will do if you go for a marriage	I will enjoy and talk coith others	Social judgement is intact
→ Test what will you do if you see one falls infront of you?	I will go and help him to get up	Test judgement is good.

INSIGHT

Question. what is the reason for your admission?

Answer: I have ~~no~~ problems.

Inference: grade I insight. complete denial of illness.

GENERAL OBSERVATION

→ Sleep - Patient has disturbed sleep pattern., early morning awaking is present.

→ Episodic disturbance - Aggressive behaviour is present she has no epilepsy, hysterical, impulsive, destructive behaviours

→ Attitude and beliefs.

she completly denies the presence of illness. She is not interested to do treatments. She says that she has no need of the treatment.

SUMMARY AND DIAGNOSIS FORMULATION

Mrs. Seenath, 47 years old female got admitted with complaints of ~~roaming~~ around, aggressive behaviour, not following instructions, decreased sleep, over religiosity etc, since 1 week.

On mental status patient is conscious, moderately kempt with anxious flawed expression, maintained eye to eye contact on general appearance. She had normal psychomotor activities. On the assessment of thought it was found patient has delusion of persecution, grandeur, reference and control. and possessions - abnormalities like thought ~~withdrawal~~ and broadcasting is present She has worried mood and blunted affect. she has abnormal perception like auditory hallucinations on the assessment of the cognitive function, patient has intact attention, abstract thinking, intelligence etc. Concentration and remote memory is impaired. Patient has level-1 insight, ie complete denial of illness is present.

On the basis of mental status examination and ICD-10 criteria, I suggest my patient having schizophrenia with symptoms such as, abnormal thought process, delusion and possessions, like thought withdrawal, thought broad casting and sensory perception abnormalities like, auditory hallucinations, blunted affect, social withdrawal decreased sleep, irritability etc.

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PHYSICAL EXAMINATION

GENERAL APPEARANE

Consciousness - conscious
Nourishment - Moderately nourished
Health - unhealthy
Body build - Moderately built
Activity - Normal
Height - 164cm
weight - 62 kg
BMI - 23.0 kg/m²

VITAL SIGNS

Temperature - 98.8°F
Pulse - 82bpm
Respiration - 24bm
Blood pressure - 130/80mmHg

INTEGUMENTARY SYSTEM

SKIN - colour - Brown
Edema - Absent
Lesions - Absent

NAIL
Nail beds - pink, intact
Nail plates - flat

Hair
colour - Black
Grooming - well groomed

HEAD

Shape - Normocephalic
Scalp - clean
face - symmetrical

EYES

Sclera - white
Conjuctiva - Pink
Vision - Normal

EARS

Pinna - Normaly placed
Hearing - Normal

NOSE

Nasal septum - midline
Smell - Present

MOUTH AND PHARYNX

Lips - Pink
Tongue - midline
Teeth - Normal
Breath odour - No halitosis

NECK

Range of motion - Possible
Trachea - midline
Jugular veins - Not distended

RESPIRATORY SYSTEM

Inspection

Respiratory support - Room air
Thorax - symmetrical, Normal expansion

Palpation - No masses identified.

Percussion - Resonant sound

Auscultation - Normal breathsound (Vesicular, bronchovesicular)

CARDIOVASCULAR SYSTEM

Inspection - No surgical scars, visible pulsations

Palpation - No masses

- Apical pulse - felt

Heart rate - 95 bpm

Auscultation - S1 and S2 heard

GASTROINTESTINAL SYSTEM

On observation - No discolouration, scars, lesions

Auscultation - Bowel sounds are present

Percussion - Tympani

palpation - No masses, are identified.

Appetite - Normal

Bowel movements - Normal.

MUSCULOSKELETAL SYSTEM

Postural curves - Normal, cervical, thoracic and lumbar curvature

muscle strength - Normal

muscle tone - Normal

upper extremity.

Range of motion - possible

Symmetry - symmetrical

Joint - Normal

Deformities - Absent

Lower extremities

Range of motion - possible

symmetry - symmetrical

Edema - Absent

Reflexes - Normal. present

Edema - Absent

GENITOURINARY SYSTEM

Lesions - Absent
Infection - Absent
Voiding - Normal

RECTUM AND ANUS

Subjective complaints - absent
Perianal skin integrity - Normal
Bowel elimination pattern - Normal

SUMMARY

Mrs. Seenath 47 years old female got admitted in Amala Medical Rehabilitation hospital with complaints of not taking food, aggressiveness, medication skips, Not following commandments etc. On head to toe examination it was found, patient is weak, anxious, and drowsy. She has normal body functions. No abnormalities are identified.

INVESTIGATIONS

Sl.No	Name of investigation	Patient value	Normal value	Remark
1	Hemoglobin	11g/dL	12-16g/dL	Decreased
2	WBC	9700cells/cu	4500-11000/cu	Normal
3	Monocytes	4.6	2-8%	Normal
4	Neutrophils	63.6 %	40-60%	Increased
5	Basophils	0.4	0.5-1%	Normal
6	Lymphocytes	28.4	20-40%	Normal
7	Serum uric	21.5 mg/dL	6-24mg/dL	Normal
8	Serum Creatin	0.8 mg/dL	0.7-1.2mg/dL	Normal
9	GRBS	150mg/dL	~~240~~ mg/dL	Slightly increased

MEDICATIONS

Sl.No	Name of the medication	Dose	Route	Frequency	Action
1	T. Sizopin	25mg	P/o	1-1-1	Atypical antipsychotic
2	T. Halidaw	1.5mg	P/o	1-1-1	Conventional antipsychotics
3	T. Pacitane	2mg	P/o	1-1-0	Antiparkinson's agent
4	T. Ativan	2mg	P/o	1-1-0	Anxiolytic agent

DRUG FILE

Name	Dose	Mechanism of action	Indications	Side effects	Nurses responsibilities
Trihexy-phenidyl hydrochloride Trade name Pantane	2mg Route oral Frequency 1-1-0	Synthetic tertiary amine anticholinergic agent. It act by blocking excess acetylcholine at certain cerebral synaptic sites. Relaxes smooth muscles by direct effect and atropin like blocking action on parasympathetic nervous system	→ Parkinson's disease → Drug induced extrapyramidal symptoms → Huntington's chorea - spasmodic torticollis contraindications - Narrow angled glaucoma. - Hypersensitivity - cardiac disease - Hypertension - Kidney or liver disease - obstructive diseases of GI or genito-urinary tract	- Dry mouth - constipation - Blurred vision - mydriasis - photophobia - Angle closure glaucoma - Dreiness - nervousness - agitation - Delirium - Psychotic manifestations - Euphoria - Tachycardia - Palpitations - Hypersensitivity reactions	- Be aware that incidence of severity of adverse effects may be minimized by dosage reduction. - older adults appear more sensitive to adult dosage - Assess and report severe ANS stimulation - Monitor daily Intake and output if patient develope urinary hesistancy or retension - monitor intraocular pressure in regular intervals. - Provide close follow up care Tolerence may develop; necessitating dosage adjustment or use of combination therapy

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Name	Dose	Mechanism of action	Indication	Side effects	Nurses responsibility
Lorazepam	2mg	Lorazepam is a benzodiazepam it exerts effect by binding at receptors on Postsynaptic GABA A ligand gated chloride channel neuron at several sites within the central nervous system. Enhances the inhibitory effects of GABA exerting tranquilizing effect on mind and body.	- Anxiety disorders - status epilepticus - Preanesthetic agent - insomnia due to anxiety - Acute panic attacks	- Anterograde amnesia - Drowsiness - sedation - Dizziness - weakness - unsteadiness - Disorientation - Depression - Hypertension - Blurred vision - Diplopia - Nausea - Vomiting - abdominal discomfort	- Supervise ambulation of older adults for at least 8 hours to prevent falling and injury - Supervise patients who exhibits depression with anxiety closely the possibility of suicide thusts - Do not engage in hazardous activities or driving for at least 1-2 days - Do not drink large volumes of coffee - Do not consume alcohol at least 1-2 days. after injection and avoid when taking a tablet - Do not self medicate with OTC drugs, seek physician guidance.
Trade name	Route		contraindication		
Ativan	oral		- Sensitivity to benzodiazepines - acute narrow angle glaucoma - Psychosis - coma - children < 12yr		
	Frequency				
	0-0-1				

Name	Dose	Mechanism of action	Indication	Side effects	Nurses Rx
Teadenanc Halidase	1.5 mg	It exerts antipsychotic effect through D_2 dopamine receptor antagonism, particularly within mesolimbic and mesocortical systems of brain. So it reduces the over production of the dopamine.	→ schizophrenia - Psychosis - Mania - Severe behavioural problems - Tourette syndrome - depression - Delirium, dementia	-Blurred vision - constipation - orthostatic hypotension - Dry mouth - Peripheal edema - Difficulty in swallowing - dizziness - decreased sleep - Extrapyramidal symptoms. - Photosensitivity - Decreased sexual function - Drowsiness - lethargy	- Assess patient behaviour and emotional status - Not recommend for children younger than 3 years. - Decreased dosage is recommended for the elderly, who are more susceptable for EPS - Give Haloperidol cautiously with patients who have cardiovascular disease, hepatic or renal dysfunction. or history of seizures. - The therapeutic Serum level for haloperidol is 0.2-1mg/ml - Do not stop the medication upsuddly - Urge the patient to avoid alcohol during therapy
Generic name	Route		Contraindications - Pregnancy - Breast feeding - Heart diseases - Hyperthyroidism - CNS depression Parkinson's disease - Angle closure glaucoma - myelosuppression		
Haloperidol	Oral				
	Frequency				
	TID				

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	Frequency	
	TID	

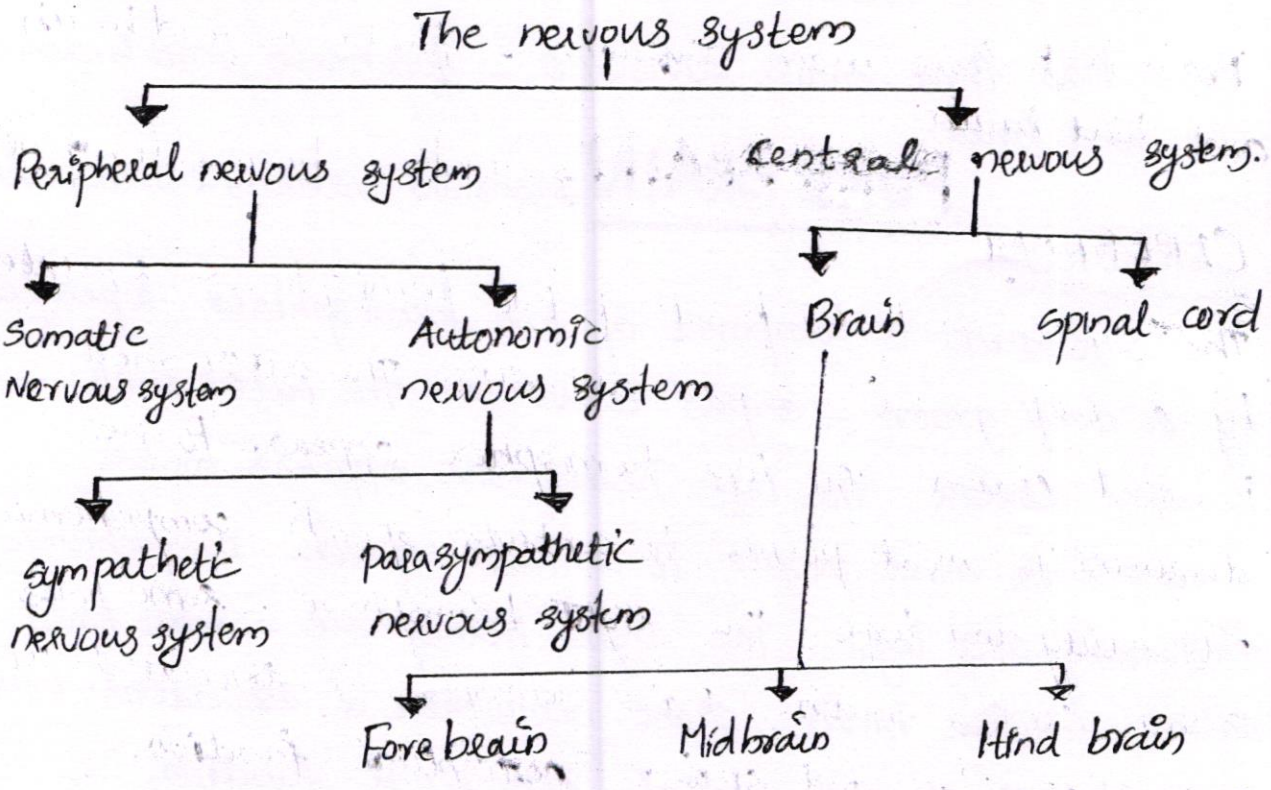
Name	Dose	Mechanism of Action	Indication	Side effects	Nurses Responsibility
Clozapine	25 mg	The mechanism by which clozapine exerts it's effect involves blocking of 5-HT_{2A}/ $5HT_{2C}$ serotonin receptors and D_1 & D_4 dopamine receptors with the highest affinity for D_4 dopamine receptor. As serotonine and D_4 dopamine antagonist it is able to elicit antipsychotic effects without inducing any extra-pyral motor symptoms	→ Schizophrenic - Schizo affective disorder - Severe OCD - Bipolar disorder - dementia - related behavioural disorder	CVS - Orthostatic hypotension. - ECG changes - Pericarditis GI Nausea, dry mouth constipation, hyper salivation Hematologic Agranulocytosis. CNS Seizures. Sedation neuroleptic malignant syndrome, dystonic reactions Metabolic Hyperglycemia diabetes mellitus Urogenital Urinary retention	- Assessment → Obtain baseline WBC and absolute neutrophil count must be checked before initiation of therapy every week for first 6 months - Monitor diabetics for loss of glycemic control - monitor, seizure activity, recurrence of psychotic symptoms - monitor cardiovascular and respiratory status. Patient education → Do not engage in any hazardous activity until response to drug is known. Drowsiness and sedations are common adverse effect. → Take the drug exactly as ordered. - Report immediately if unexplained fatigue, shortness of breath, sudden weight gain edema is present

Trade name	Route	Contraindication
Sizopin	Oral	- Severe CNS depression - Blood dyscrasia - History of bone marrow depression - Uncontrolled epilepsy - Severe agranulocytosis - Renal failure
	Frequency	
	TID	

ANATOMY AND PHYSIOLOGY OF NERVOUS SYSTEM

INTRODUCTION - NERVOUS SYSTEM.

The nervous system is the major controlling, regulatory and communicating system in our body. It is the center of all mental activity, including thought, learning and memory. The nervous system is composed of two major divisions - the central nervous system and the peripheral nervous system.



- Thalamus
- Hypothalamus
- Limbic system
- Cerebral cortex

- Medulla
- Pons
- Cerebellum.

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CENTRAL NERVOUS SYSTEM

The central nervous system comprised of brain and spinal cord. The three broad functions of the CNS are to take in sensory information, process information and send out motor signals

- Act as integrating and command centers of the nervous system.

BRAIN

Brain has three main divisions - forebrain, mid brain and hind brain.

FORE BRAIN → consists cerebrum & diencephalone

CEREBRUM

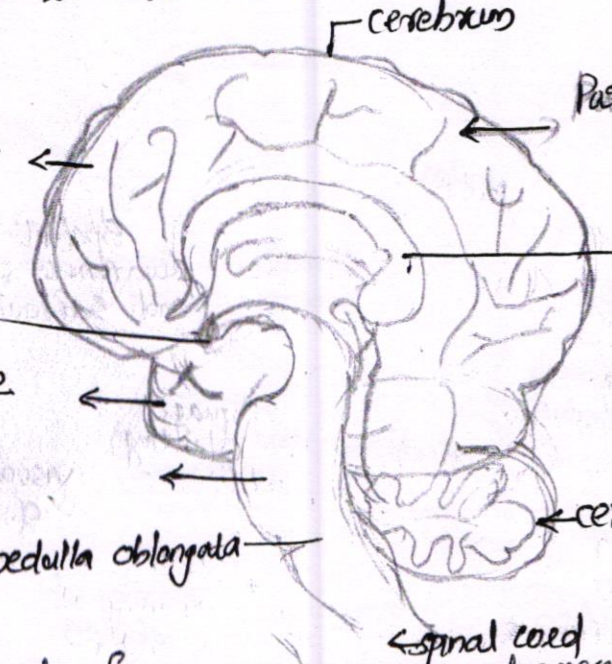
The cerebrum is composed of two hemispheres separated by a deep groove – corpus callosum. The outer shell is called cortex. The left hemisphere appears to be dominant in most people. It controls speech, comprehension rationality and logic. The right hemisphere - some times called creative brain., Right hemisphere is associated with affect, behaviour and spatial perceptual function.

Each hemisphere is devided into lobes,

LOBES

FRONTAL LOBE: controls voluntary movements, including movements that permits speaking, thinking, and judgement formation. It also play role in emotional experience, - as evidenced by changes in mood and character

after damage to this area.



The alterations include, fear, aggressiveness, depression, euphoria etc.

PARIETAL LOBES.

The parietal lobes control perception and interpretation of most information (touch, pain, taste and body position) Language interpretation is associated with left hemisphere of parietal lobe. It contains association fibers linked to primary sensory areas, through which, sensory peripheral information is interpreted.

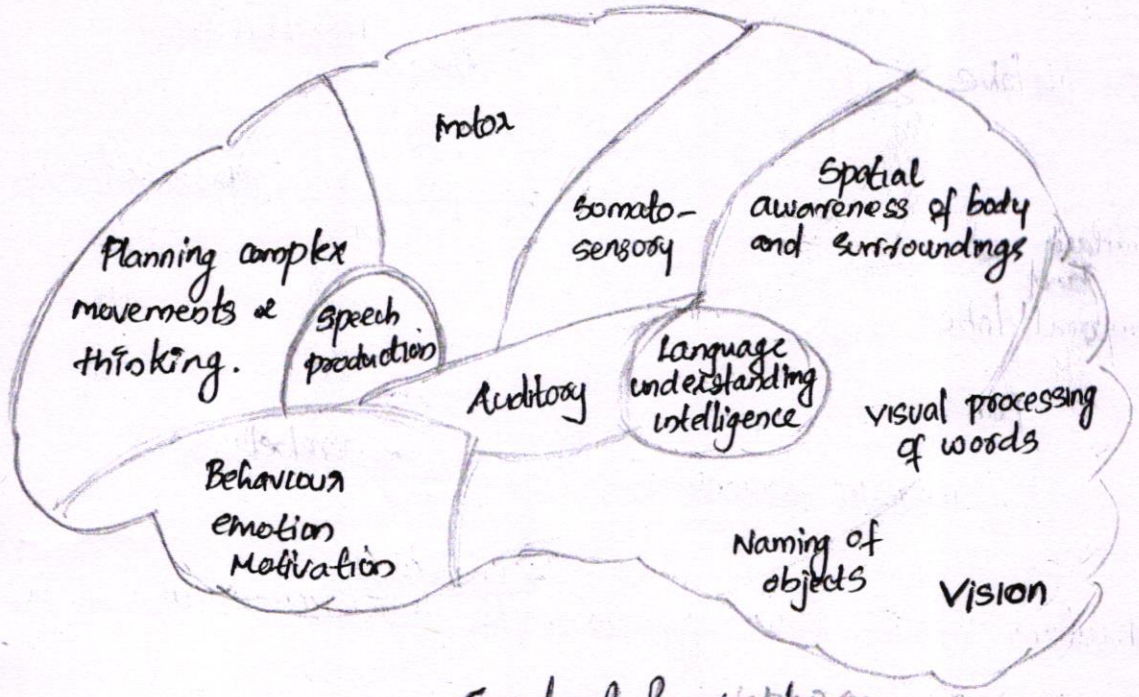
TEMPORAL LOBES

It's involved in auditory function, short term memory. role in expression of emotion through an interconnection with limbic system. The sense of smell has connection with temporal lobes, as the impulses are carried by olfactory nerves end in the area of brain Temporal lobe along with parietal lobe involved in language interpretation.

OCCIPITAL LOBES:

Primary area of visual reception and Interpretation. visual interpretation, which gives individuals the ability to judge spatial relationships such as distance and to see in 3 dimension is also processed in this area. Language interpretation is influenced by occipital lobes through association with visual experience

LOCALIZATION OF MENTAL FUNCTIONS IN BRAIN



Cerebral hemispheres

Left hemisphere

- Logic
- Analysis
- Mathematics
- Language
- Facts
- Thinking words
- Words of songs.
- Computation.
- Positive emotions.

Right Hemisphere.

- Creativity
- Imagination
- Holistic thinking.
- Intuition
- Arts
- Rhythm.
- Non-Verbal feelings
- Visualization
- Tune of songs
- Day dreaming.

THALAMUS

consists of large masses of gray matter situated either sides of lateral part of 3rd ventricle.

→ Thalamus is sensory relay for the brain.

→ All our senses, with the exception of the smell are routed through the thalamus before being directed to other areas of the brain for processing.

→ It has control over the autonomic nervous system.

→ It plays role in control of sleep and alertness.

- provides crude awareness.

HYPOTHALAMUS

Hypothalamus lies below the thalamus. It exerts a key influence on all kinds of emotion as well as motivational behaviour. The main functions are,

→ maintains daily physiological cycles.

→ controlling appetite

→ Releasing hormons

→ Managing sexual behaviour

→ Regulating emotional responses.

→ Regulating body temperature.

→ control over the activities of pituitary gland.

LIMBIC SYSTEM

The limbic system consists of structures in the thalamus hypothalamus and cerebrum, which forms a ring around the lower part of forebrain. Major structures within the system includes, the olfactory bulb, the septal nuclei, the hippocampus, the amygdale and the cingulated gyrus of cerebral cortex. The limbic system is also called the emotional brain.

HIPPOCAMPUS

There are two hippocampi, These are mainly associated as being memory centres of brain.

→ Episodic memmories are formed in the hippocampus, and then filled away into long term storage throughout other parts of the cerebeal cortex.

→ It plays role in spatial navigation, learning and emotions.

AMYGDALE

Main function is in emotional responses including, feelings of happiness, fear, anger and anxiety.

→ Formation of new memories.

→ Linked with fight or flight responses as stimulating activity in amygdale can influence body's automatic fear response.

BASAL GANGLIA

It is a group of structures situated at the base of the forebrain and top of the mid brain.

→ Regulates voluntary movements (eye movements, balance, as well as posture.

→ Involved in cognitive and emotional behaviours and having role in rewards and reinforcements.

CINGULATE GYRUS

Helpful in regulating emotions, behaviour and pain as well as being responsible for controlling autonomic motor function.

Limbic system controls feeding, fighting & feeling.

MID BRAIN

Lies on the top of the brain stem. Involved in auditory and visual processing.

→ Responsible for eye movement.

→ Concerned with relaying messages, particularly with those related to hearing and sight to higher brain centres.

HIND BRAIN

Composed of medulla, pons, and cerebellum.

MEDULLA OBLONGATA

It is continuous above with the pons and below with spinal cord. The vital centres, (respiratory and vasomotor) are situated in medulla.

→ Medulla controls many functions outside of consious control, such as breathing, blood pressure, blood flow and heart rate.

→ Involved in involuntary reflexes [coughing, sneezing etc]

PONS

The pons lies between the mid brain and medulla On each side it is connected to the cerebellum.

→ It serves as coordination centre for signals which flow between two hemispheres and spinal cord.

→ Associated with autonomic functions such as breathing taste, sleeping etc.

→ Also involved in analyzing sensory data.

CEREBELLUM

→ Main role is to monitor and regulate behaviour particularly movements and balance.

→ Involved in motor learning, sequence learning, reflex memory, mental function and emotional processing.

SPINAL CORD

Spinal cord is the part of central nervous system, which lies within the vertebral canal. It begins as the continuation of the Medulla oblongata. It is covered by three meningeal layers.

→ Responsible for communication between brain and rest of the body

→ Works as an organ for effective reflex actions like withdrawal of hand when something is hot. These reflex actions are automatic in nature.

PERIPHERAL NERVOUS SYSTEM

The nerve tissues lying outside the bony case of central nervous system come in the region of peripheral nervous system. It consists of nerves which helps in passing the sense impression to central nervous system, as well as in carrying the orders of cns to the muscles. It is sub divided into somatic system and autonomic system.

Somatic nervous system.

→ consists of sensory nervous system and somatosensory system. It is both sensory and a motor system.

Autonomic system.

→ It is only a motor system consisting of two divisions.

1. Sympathetic nervous system

It is connected to the spinal cord and carries messages

to the muscles and glands., particularly in situations of stress to prepare for an emergency.

2. Parasympathetic nervous system.

It is connected to brain and lower parts of the spinal cord. It tends to be active when we are calm and relaxed. The messages conveyed by the nerve fibers of this system directs the organs to do just opposite of what the sympathetic system has done.

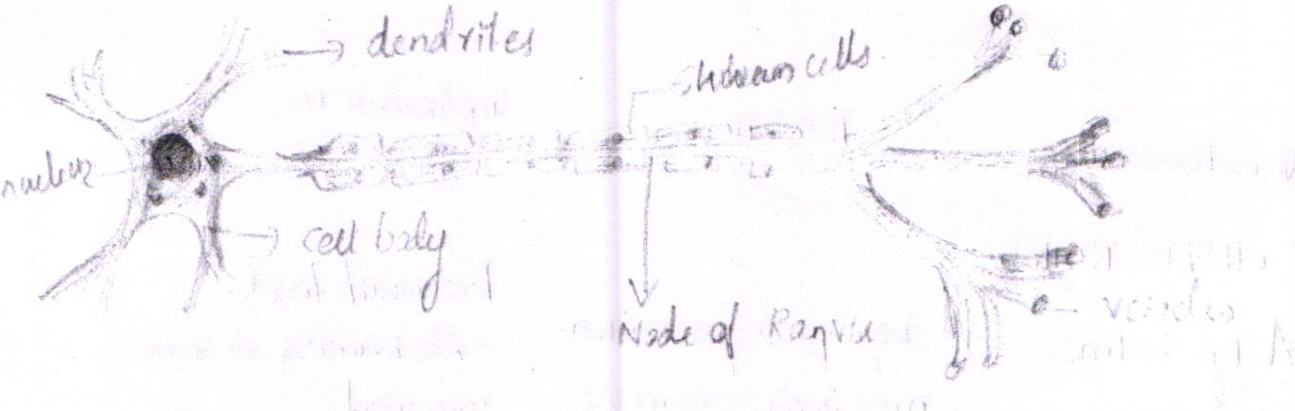
The sympathetic and parasympathetic divisions of autonomic nervous system work in close co-ordination for maintaining the equilibrium of body function.

NEURONS

The nerve cells along with branches called neurons. These are the basic elements of the nervous system. A neuron has a nucleus cell body and cell membrane to enclose the whole cell. There are tiny fibers extending out from the cell body called dendrites

FUNCTIONS

- Main role is the receive message through electrical impulses from the sense organs or adjacent neurons and carry them to the cell body. The message from cell body further carried the length of the nerve fiber known as axons



Neurotransmitters are often referred to as body's chemical messengers. They are the molecules used by the nervous system to transmit messages between neurons or from neurons to muscles. Communication between two neurons happens in

in the synaptic cleft. Here the electrical signals that have travelled along the axon are converted into chemical ones through the released neurotransmitters, causing a specific response in the receiving neuron. A neurotransmitter influences a neuron in one of the three ways. Excitatory, inhibitory or modulatory. An excitatory transmitter promotes the generation of action potential in the receiving neurons, while inhibitory neuro transmitter prevent the generation of the action potential in the receiving neuron.

There are about a dozen known small molecule neurotransmitters and more than 500 different neuropeptides and these chemical are involved countless functions related to nervous system as well as controlling body functions

Neurotransmitters	Function	Implication in
I. CHOLINERGICS Acetylcholine	Sleep, pain perception movements, memory learning, sleep	Decreased level, - Alzheimers disease. Increased, Depression.
II MONOAMINES Norepinephrine	Mood, cognition, perception, locomotion, cardiovascular functioning sleep and arousal	Decreased levels - Depression Increased levels. Mania, anxiety levels Schizophrenia

Dopamine	movement and coordination emotions, release of prolactine, voluntary, Judgement	Increased levels - mania, anxiety states, schizophrenia Decreased levels Parkinsonism and depression
Serotonin	Sleep, arousal, libido appetite, mood, aggression perception, coordination judgement.	Decreased levels - Depression Increased levels anxiety states.
Histamine	Control of gastric secretion smooth muscle contraction cardiac stimulation. stimulation of sensory nerve endings. and alertness	Decreased levels - Depression
III - AMINOACIDS		
Gamma amino butyric acid (GABA)	Slow down of body activity	Decreased levels - anxiety disorder schizophrenia and various forms of epilepsy.
Glycine	Recurrent inhibition of motor neurons	Increased levels - glycine encephalopathy Decreased levels correlated with Spastic motor movement

Glutamate and Aspartate	Relay of sensory information and the regulation of various motor and spinal reflexes	increased levels - Huntigtons disease Temporal lobe epilepsy
NEUROPEPTIDE Endorphine	Modulation of pain and reduced peristalsis	Modulation of dopamine activity by opioid peptides may indicate similar to symptoms of schizophrenia.
Substance P	Regulation of pain	Decreased level: Huntigton disease and Alzheimers disease increased levels, Depression
Somatostatin	Inhibit release of norepinephrine, stimulate release of sterotonine, dopamine and acetylcholine	Decreased Level: Alzhiemers disease Increased levels. Hunhgton disease

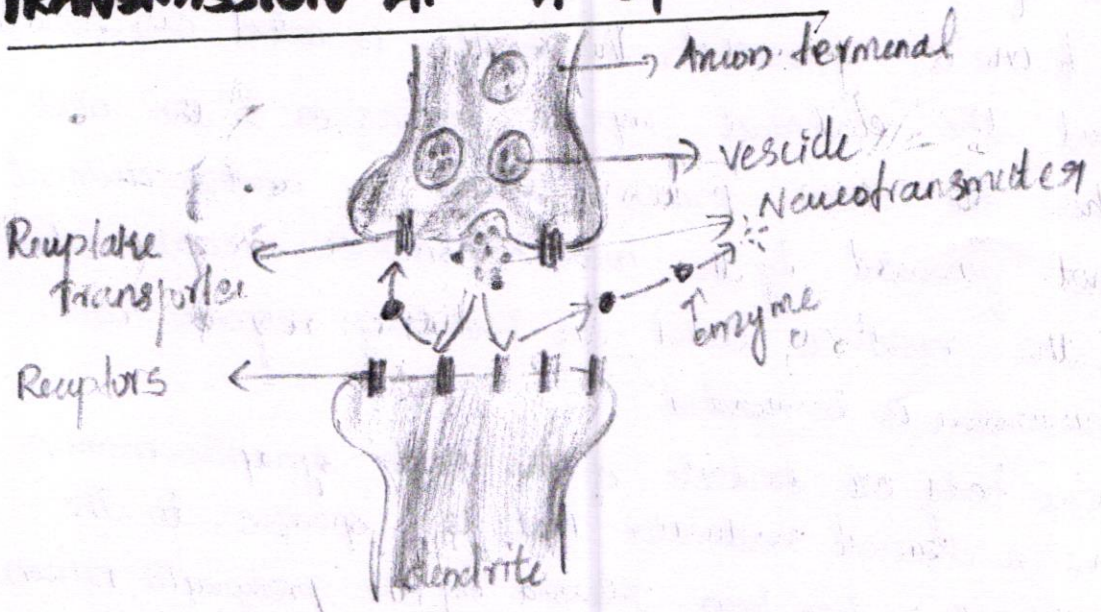
NORMAL IMPULSE TRANSMISSION

Process by which neuron communicate with each other through electrical impulses and chemical messages, called neurotransmitters. Neurotransmitters carries out the communication between neurons.

PROPERTIES OF NEUROTRANSMISSION

- Rapidly removed from synaptic cleft by uptake
- Synthesized in the presynaptic neuron.
- Localised to the vesicles in presynaptic neuron.
- Released from the presynaptic neurons under psychological conditions
- Presence of receptor of the post synaptic neuron
- Binding to the receptor elicits a biological response

TRANSMISSION AT A SYNAPSE



The transmission of a nerve impulse along a neuron from one end to other occurs as result of electrical changes across membrane of neuron. The membrane of an neuron is polarized that is a difference in electrical charge between the outside and inside, of negative with respect to the outside.

Polarization is established by maintaining an excess of Sodium ion (Na^+) on the outside and an excess of potassium

ion inside. A certain amount of Na^+ and K^+ is always leaking across the membrane through leakage channels, but Na^+/K^+ pump in the membrane actively restore the ions to appropriate side.

A chemical called a neurotransmitter is stored in the axon terminals of presynaptic neuron. An electrical impulse through the neuron cause the release of this neurotransmitter then diffuses across the synaptic cleft and combines with receptor sites that are situated on the cell membrane of the post synaptic neuron. The result of the combination of neurotransmitter receptor site is the determination of whether or not another electrical impulse is generated. If one is generated, the result is called can excitatory response and the electrical impulse moves on to the next synapse where the same process occurs. If another electrical impulse is not generated by the neurotransmitter - receptor site combination, the result is called an inhibitory response and synaptic transmission is terminated.

The cell body or dendrites of the post synaptic neuron also contains a chemical inactivator that is specific, to the neurotransmitter that has been released by the presynaptic neuron when the synaptic transmission has been completed. the chemical inactivator quickly inactivates the neurotransmitter, to prevent unwanted continuation impulses until a new impulses from the pre-synaptic neuron releases before neurotransmitter.

DEFENSE MECHANISMS

Defence mechanism is the path of adjustment through which an Individual relieves anxiety caused by an uncomfortable situation that threats self esteem

Classification :-

1) Positive defense mechanism
2) Negative defense mechanism

1) Positive defense mechanism

- Compensation

It is a pattern by which tension or anxiety relieved by an individual make up for personal weakness

eg: A student who fails in studies may compensate by becoming college champion in athletics

2) Substitution

It is a mechanism by which tension or anxiety reduced by replacing the unachieved goal with achievable goal

eg: A student who has been unable to get admission to MBBS may be substitude a course of physiotherapy or nursing

3 Sublimation

It is a mechanism that causes channalization, strictly unacceptable desire to acceptable form

eg: A young man who has lost his love may turn to write poetry about love

4) Rationalization.

It is a defense mechanism in which an individual justifies his failure and socially acceptable failure and behaviours by making excuses or formulate logical / reasonal socially approved reasons

Eg: A person without a vehicle says that he don't want to risk his life by driving.

5 Repression

It is a process of unconscious forgetfulness of our unpleasant experiences

eg. A man is jealous of his good friend success, but in unaware of his feelings and jealousy.

6) Undoing.

It is the act symbolically cancelling and reversing a previous act which is unacceptable

eg. A son shout at his father, as there is no petrol in car getting ready for office, brings a favourite film for his father to watch

7) Identification

In this individual false personal satisfaction in the certain aspect of the emotional disturbances or development do not advance

eg: Thumb sucking continues till adult age

8) Fantasy.

used to gratify frustated desire by imaginary achievement and wishful thinking

- A young boy, who could not help his father due to shortage of money day dreamering that he got lot of money from lottery ticket

a) Conversion

In this strong emotional conflicts which are not experienced or expressed are converted into physical symptoms

A student who is anxious about his exams, may develop head ache.

Negative defense Mechanism.

1) Supression

It is the voluntary block of unpleasant false and experien ces from one's awareness to avoid discomfort and anxiety

eg: A patient refer to conceide his difficulties by saying that he does not want to talk about it

2) Displacement.

An individual who is using this defense mechanism, involves transfering negative feelings from one person or thing to another

eg: A person who is angry with his boss but cannot show it may fight with his wife on return from his office.

3. Projection

Placing blame for own difficulties upon other

eg: A business man who values punctuality in his late, for a meaning and status, 'sorry Sam late, my assistant forgot to remind me of the time.

4) Regression.

It is means an immature way of responding to a stress or go back.

A nurse who makes an error in giving medications starts crying.

5) Fixation.

Refers to the point in the individual development in the success and achievement of others. or person

eg. An illiterate father often take his sons higher education as his own

6) Transference

The transference the image of one person is unconsciously identified with that of another

Eg. A patient who is close to girl of same age of his daughter and tell as his daughter

7) Intellectualization

It is an attempt to avoid express actual emotions associated with a stressful situations by using the intellectual process of logic, reasoning and analysis

eg. A young professor relieves a gift from his friends breaks of their engagement, He shows no emotion when discuss with his friend.

8) Introjection

It is the value and characteristics of significant person are incorporated in ones personality.

eg. A women who likes to live in a single cozy introjects in her sophisticated way of living like her husband

DISEASE CONDITION

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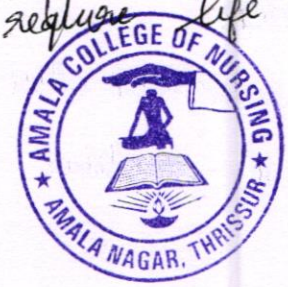
INTRODUCTION

Schizophrenia is the most common of all psychiatric disorders and is prevalant in all cultures across the coorld. Pethaps no psychological disorder is more crippling than schizophrenia. Characteristically disturbances in thought process perception and affect invariably result in a severe deterioration of social and occupational functioning. About 15% of new admissions in mental health hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50% of all mental hospital beds. Schizophrenia is equally prevalant in men and coomen. 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. The disease is most common in lower socio economic groups. The word schizophrenia was coined by the Swiss psychiatrist Eugen Bleuler. It is derived from Greek words Skizo (split) and phren (mind). Schizophrenia may result in some combination of hallucinations delusions and extremely disordered thinking and behaviour that impairs daily functioning and can be disabling. People with schizophrenia may require life long treatment.



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DEFINITION

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in the presence of clear consciousness, which usually leads to social withdrawal.

CLASSIFICATION - ICD-10 CRITERIA

F20 - F29 Schizophrenia, schizotypal and delusional disorders

F20 - Schizophrenia.
F20.0 - Paranoid schizophrenia
F20.1 - Hebephrenic schizophrenia
F20.2 - Catatonic schizophrenia
F20.3 - Undifferentiated schizophrenia.
F20.4 - Post schizophrenic depression
F20.5 - Residual schizophrenia
F20.6 - Simple schizophrenia.
F21 - schizotypal disease.
F22 - Delusional disorder
F23 - Brief psychotic disorder
F24 - Shared psychotic disorder
F25 - Schizoaffective disorder
F28 - Other psychotic disorder not due to a substance or known physiological condition
F29 - Unspecified psychosis.

CLINICAL TYPES

- PARANOID SCHIZOPHRENIA
  - commonest type, ~~earlier~~ later onset. Onset of symptoms is occur usually later (20-30yrs) than hebephrenic and catatonic schizophrenia
  - The clinical picture is dominated by relatively stable often paranoid delusions, usually accompanied by hallucinatory particularly the auditory variety. Paranoid delusions include, delusion of persecution, delusion of control, delusion of reference, and delusion of infidelity.
  - Disturbances of affect, volition and speech and catatonic symptoms are not prominant.
  - Affect is usually less blunted than in other varieties of schizophrenia.
  - Mood disturbances such as irritability, anger, suspeciousness, fearfulness.
  - less neurological and cognitive impairement.
  - Better prognosis
  - some evidences that prognosis particularly with regard to occupational functioning and capacity for independant living.
- HEBEPHRENIC SCHIZOPHRENIA
  - Early insidious onset

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usually between 15 - 25 years of age

- Affective changes are seen.
- Mood is swallow and inappropriate (silly and childish.)
- And ut is often accompanied by giggling or self satisfied., self absorbed smiling or by lofty manner, mirror gazing, grimanices, mannerisms pranks, hypochondriacal complaints.
- Hallucinations and delusions may present But it is not prominent
- Thought is disoragnized
- Speech rambling and incoherent
- Remain solitary
- Behaviour seems empty of purpose of feeling
- Drive and determinations are lost
- goals abandones
- Severe disintegration of personality
- cognitive psychomotor impairment
- Poor personal grooming and unable to complete activities without help

→ CATATONIC SCHIZOPHRENIA

- sudden onset.
- Prominent characteristic psychomotor disturbances

& types – Retarded catatonia and excited catatonia

Clinical features – Retarded catatonia

. mutism, rigidity, negativism, posturing, echopraxia, Echolalia, Ambivalence, automatic obedience.

- Excited catatonia.

Increased psychomotor activity – restlessness, agitation aggressiveness, violence

increased speech production.

loosening of association to incoherence.

Patient is not taking food → dehydration, hyperthermia & death

In this type excitement become very severe accompanied by rigidity, hyperthermia and dehydration can result in death. It is known as acute lethal catatonia / pernicious catatonia

- Undifferentiated Schizophrenia

Not met the criteria of any other sub types.

- RESIDUAL SCHIZOPHRENIA

Include emotional blunting, eccentric behaviour, illogical thinking, social withdrawal, loosening of association

At least one episode of schizophrenia in past without prominent psychotic symptoms

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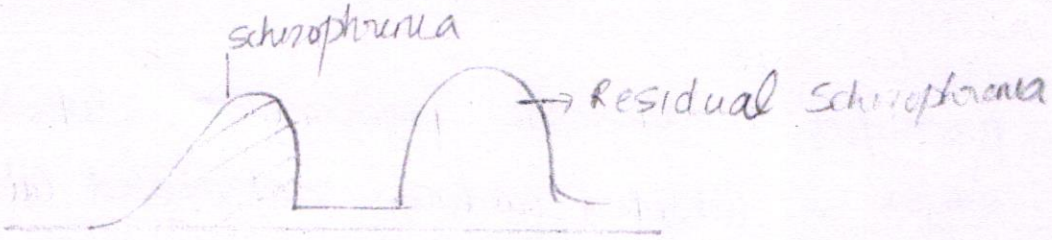
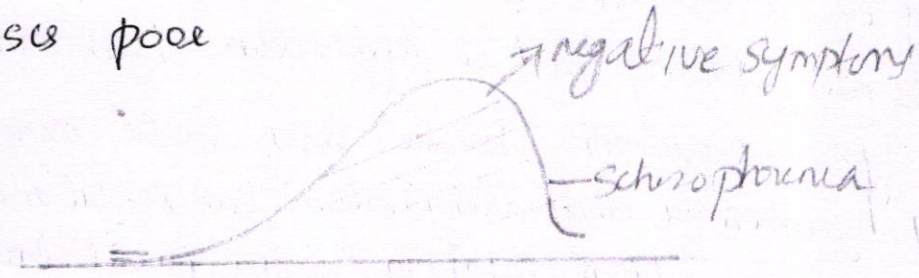
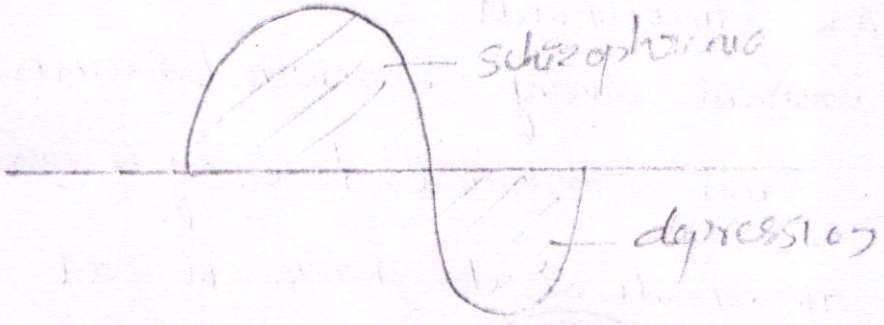


⇒ Simple SCHIZOPHRENIA

Characterized by early and insidious onset
Presence of negative symptoms, hypochondriacal symptoms
complains wandering, aimless activity.
Absence of psychiatric features
prognosis poor





Post schizophrenic depression

Post Schizophrenia depression

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

Schizotypal disorders

It is often described as odd or eccentric and usually have few if any those relationships. Intense discomfort and decreased ability to function in social relationships, Distortions in thought, perception, behavioural eccentricities, odd beliefs magical thinking, odd perceptual experience, suspiciousness etc may present

ETIOLOGY AND RISK FACTORS

PREDISPOSING FACTORS

These factors determine an individuals susceptibility to mental illness, they interact with precipitating factor resulting in mental illness

Eg: Genetic factors

PRECIPITATING FACTOR

These are the events that occurs shortly before the onset of the disorder appears to have induced it

PERPECTUATING FACTOR

These factors are responsible for aggravating or prolonging the disease already existing in the individual.

ETIOLOGY OF SCHIZOPHRENIA

1. BIOLOGICAL THEORIES

→ Genetic theory: Strong hereditary component is present. Individual with first degree related who has schizophrenia has a 10% chance of developing the disorder as opposed to the one percentage chance

→ Twin studies: The rate of schizophrenia among monozygotic twins is four times that of fraternal twins and approximately 50 times that of general population.

→ Biochemical Theories

- Dopamine Hypothesis

Increased production of dopamine within mesolimbic system causes positive symptoms

- Glutamate hypothesis

Hypoactivity of glutamate may lead to schizophrenia

- Serotonin Hypothesis

Hyperactivity of ~~glutamate~~ serotonin causes schizophrenia

- NEURO DEVELOPMENTAL MODEL

Silent lesions present in brain leads to schizophrenia.

CT and MRI OF brain shows, decreased brain

Volume, dilated lateral and third ventricles. Atrophy of frontal lobe, cerebellum and limbic structures. Increased size of sulci on the surface of brain.

ENVIRONMENTAL FACTORS

- prenatal exposure to viral infection
- Rh incompatibility
- Low O_2 levels during birth
- exposure to virus during infancy.
- lead poisoning and various environmental factors

PSYCHODYNAMIC THEORIES

- Stress diathesis model.
  - early parental loss or seperation
  - physical / sexual abuse in child hood

  etc may increase chances for occurance of disease

→ Family theories

- Family system theory - Family conflict, communication problem.
- Refrigerator mother theory: - cold over protective, domineering mothers, lack of maternal warmth.
- Marital schism: when two partners within a relation ship are opened dissatisfied with other.
- marital skew: A situation, which arises in family, where one parent assumes behaviour of other dominant partner.
- Double blind communication: In this condition one person is given mutually contradicted indicated signals by other person. This places them an impossible situation, causing internal conflict. Schizo

- phrenic symptoms represent an attempts to escape from the double bind!

→ Social factors

studies have shown that schizophrenia is more prevalent in areas of high social mobility and disorganization, especially among members of very low social classes stressful life events also can precipitate disease in predisposed individuals.

Book picture	Patient picture
- Predisposing factor	Mental illness in family (brother)
• Precipitating factor	Financial crisis.
• Perpetuating factor	-Being alone in family at day time
• Biological theories.	Family history of mental illness
• Psychological theories.	Absent.
• Stress diathesis model.	Financial crisis

PATHOPHYSIOLOGY

Precipitating event
Event that occur prior to onset of disease

Predisposing factors
- Genetic influences: Family history of schizophrenia, possible biochemical alteration
- Past experiences: prenatal exposure to viral infection
- Existing condition: Abnormal brain structure epilepsy, brain, tumor.

Cognitive appraisal

Primary → Perceived threat to self concept or integrity

Secondary → Ineffective coping mechanism related to diminished ego strength
- Defense mechanism utilized; Denial, Regression, projection identification.

Quality of response

adaptive ⟷ mal adaptive

Initial psychotic episodes or exacerbation of schizophrenia and symptoms

Hallucination
Delusions
Isolation
Social isolation
Inappropriate affect
Bizzare behaviour
Apathy
Autism

CLINICAL MANIFESTATION

Symptoms of Schizophrenia may appear suddenly or develop gradually overtime. Tension the inability to concentrate insomnia withdrawal or cognitive deficits may precede the first psychotic episode.

BLEULERS FOUR 'A'

Eugene Bleuler cited symptoms of schizo

→ Affective disturbances:
Blunted affect: severe reduction in the intensity of affect.

→ Autistic Thinking
Preoccupation with innerthought, fantacies, private logic egocentric, subjective thinking, lacking objectivity and connection with external reality. (Logical structures supporting a totally private view of reality)

→ Ambivalance: Inability to decide for/against due to coexistance of two opposing impulses or feelings for the same thing at the same time in same person.

→ Loosening of Association: The sequential connection between one idea and ~~anoth~~ the next is lost so that the talk seems muddled up and incoherent.

KURT SCHNEIDER, Proposed first rank symptoms of Schizophrenia

→ Auditory Hallucinations:
- 3rd person hallucination: Hallucinatory voice talking about the person as he or she.
- Thought echo: Type of additory hallucination in which individual is hearing one's own thought spoken aloud

- Command hallucination

The voices sometimes gives instructions to patient. Challunatory voices giving instructions

- Commentary hallucination

Hallucinatory voices describing person's behaviour as it occurs

→ Passivity experiences.

- made volition - one's own acts are experienced as imposed on body by some external force
- made feeling: Subject experience feelings as being imposed by external force
- made impulses: Subject experience impulses are being imposed by some external force.

→ Possession disorder.

- Thought withdrawal: Thought cease and subjective experience them as removed by external force.
- Thought insertion: Subject experiences that thoughts are imposed by some external force on his passive mind.
- Thought broad casting: Patient thinks that thoughts escape from his mind and become accessible to others.

→ Delusional perception → normal perception (impulse as delusional meaning)

Second rank symptoms.

→ Other disorders of perception.

→ Other thought disorder

→ Disturbances of mood and affect.

POSITIVE AND NEGATIVE SYMPTOMS

→ Positive symptoms: Phenomena which are addition to normal experience

- Hallucinations:
- Delusions
- disorganized thinking.
- disorganized speech
- disorganized catatonic behaviour

→ Negative symptoms - loss of personality features and abilities

- anhedonia - lack of pleasure in acts which are normally pleasurable
- Alogia
- Affective flattening - Absence or near absense of any sign of affective expression
- social isolation

More prognosis for positive symptoms.

OTHER SYMPTOMS

- Disorders of motor functions
- Disorders of thought
- Disorders of mood and affect
- Problems in judgement and insight
- Abstract thinking - problems
- cognitive disorders

⇒ DISORDERS OF MOTOR BEHAVIOUR

- Increase or decrease in psychomotor activity, mannerisms, grimacing, stereotypes, decreased self care, poor grooming

⇒ THOUGHT

→ Thought blocking - sudden interruptions in thought blocking.
→ neologism - A word newly coined or an every day word used in a special way.
→ poverty of content - Thought process which is inadequate in amount but contains less ideas.
→ verbigeration: senseless repetition of some words or phrases over and over again.
→ perseveration: Persistent repetition of words of frames beyond the point of relevance, also persistent repetition of same words ideas in response to different question.
- over inclusion: widening of the boundaries of concepts such as that things are grouped together that not often closely connected

⇒ DISORDERS OF MOOD AND AFFECT

Apathy
Emotional blunting
emotional shallowness
anhedonia
Inappropriate emotional response

PHASES

Three distinct phases are,

→ Prodromal phase

→ Active phase / acute episode

→ Residual phase.

Prodromal phase.

Refers to a period of time, from the first changes in person occurs until she or he develop full-blown psychosis

symptoms are: eccenteric idea.
irratic behaviour (anger out bursts)
loss of interest or volition
persecutory thoughts
poor hygiene
strange emotional affect

Acute episode / Active phase.

Acute episodes of psychosis typically features one or many positive symptoms and negative symptoms

The aim of treatment in acute phases is to abolish psychotic phase

Residual phase

Person is returned to normal and regain functions
- experiences some forms of negative symptoms
- Absence of psychotic features, - (lack of emotional experience and low energy.

- The aim of the treatment : prevention of reoccurance of active phase

Book Picture	Patient Picture
→ Affective disturbances - Autistic thinking	- Blunted affect present absent
- Hallucination.	Auditory hallucination present
- Delusions	- Persecutory and reference, control.
- Disorders of Thought	Delusions, thought withdrawal broadcasting present
- Disorders of speech.	reduced tone.
- Disorders of affect	blunted affect
- Disorders of motor behaviour	Absent
- Decreased functing at work	present
- loss of insight	grade I - Complete denial of illness
- suicidal attempts.	Absent
- Suspensiveness.	present
- Somatic passivity.	Absent
- made volitions;	Absent
- made impulse	Absent
- made feelings	Absent

DIAGNOSIS

→ HISTORY COLLECTION AND MENTAL STATUS EXAMINATION

Collect informations regarding present psychiatric illness past psychiatric history, family history, and personal history

- Through mental status examination obtains current

mental status of the person.

⇒ ROUTINE INVESTIGATIONS

* Complete hemogram and urine analysis are basic routine tests. leukopenia and agranulocytosis are associated with certain medications
* Serum electrolytes : Dehydration, and electrolyte imbalances may occur with treatments with antipsychotics lithium, Carbamazepine
* Blood glucose: Routine screening above 35 years old.
* ECG : Above 35 years of age. treatment with ECT, antipsychotics, antidepressants .. etc
* Drug level estimation : Drug levels are indicated to test for therapeutic blood levels, toxic blood level and for testing drug compliance.

⇒ ELECTROPHYSIOLOGICAL TESTS

* EEG - Measures brain electrical activity - identifies abnormal waves, used in diagnosis of seizure, dementia, neoplasm stroke, metabolic or degenative disease.
* Sleep studies - used in the diagnosis of sleep disorders and seizures.

⇒ BRAIN IMAGING TESTS

* Computed Tomography scan, measures accuracy of brain structures to detect possible lesions, abscess, areas of infarction or aneurysm. CT. Scan also identifies various anatomical differences.
* MRI Scan: Measures anatomical and biochemical status of various segments of the brain, detects

brain edema, ischemia, infection, trauma, neoplasm and other changes.

* PET, SPECT etc are also used.

⇒ NEURO-ENDOCRINE STUDIES

* Dexamethasone suppression test
* TRH stimulation test
* Serum prolactin level
* serum 17-hydroxy corticosteroid level
* serum melatonin level.

⇒ PSYCHOLOGICAL TESTS

Psychological testing of people is conducted by clinical psychologists who has been trained in the administration scoring and interpretation of these procedures

⇒ ICD-10 CLASSIFICATION

Book Picture	Patient picture
* History collection and mental status examination	Done
* Routine investigation	CBC done
* electrophysiological tests	Not done
* Brain imaging tests	Not done
* Psychological test	Not done
* ICD-10 classification	~~Not~~ done. On ICD 10-criteria, she has schizophrenia - paranoid subtype.

MANAGEMENT

⇒ PHARMACOTHERAPY

* Antipsychotics.

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.

commonly used conventional antipsychotics are,

- Chlorpromazine, Fluphenazine decanoate, Haloperidol Trifluoperezine.

Atypical antipsychotics control wider range of signs and symptoms and cause few or no adverse motor effects

- commonly used atypical antipsychotics are,

Clozapine, Risperidone, Olanzapine, Quetiapine, Ziprasidone, Aripaprazole, Paliperidone, Amisulpride etc.

* Antidepressants

→ Tricyclic antidepressants.

It blocks the serotonin transport and nor-epinephrine transport respectively. Results in elevation of synaptic concentration of these neurotransmitters and therefore an enhancement of neurotransmission.

eg: Imipramine, amitryptyllin.

→ Selective Serotonin Reuptake Inhibitors.

Increase the extracellular level of the neurotransmitter serotonin by limiting its reuptake into presynaptic cell, increasing

the level of serotonine in synaptic cleft
ex: Fluoxetine.

→ Serotonin norepinephrine reuptake inhibitor
Potent inhebition of reuptake of serotonen and norepinephrine
Ex - Duloxetine, milnacipran.

→ Monoamine oxidase inhibitor.
They are chemicals which inhibit the activity of the monoamine oxidase enzyme, which is responsible for the degradation of catecholamine after reuptake
Ex - Trazadone, Isocarboxazid.

→ Atypical antidepressant - Fluimo Amineptine

* Mood Stabilizers

→ Antimanic: Accelerate presynaptic reuptake and destruction of catecholamine like nor-epinephrine.
- Inhibit the release of catachelamines at the synapse
- Decrease post synaptic serotonene receptor sensitivity.
eg: Lithium carbonate.

→ Anticonvulsants
Drugs that decrease frequency and severity of seizures increase inhibitory neurotransmitter GABA and decreene excitatory neurotransmitter glutamate.
eg: Sodium valproate.

* Antiparkinsonian agent

Mainly to treat medication induced movement disorders.
ie, neuroleptic induced parkinsonism
+ anticholinergics - Trihexyphenidyl.
Dopaminergic agents

Monoamine type B Inhibitors – selegiline.

These increases release of presynaptic vescule, Block reuptake of dopamine in postsynaptic nerve terminal.

* Anxiolytics – Benzodiazepines.

These are medications that reduces anxiety.

* Vitamines.

Vitamine C. Protects the body from damage

Vitamine B.

Book Picture	Patient Picture
- Antipsychotics	- Clozapine, Haloperidol.
- Anticleppressants	Not given.
- mood stabilizers	- Not given
- Antiparkinsonian drugs	Paciterne
- Anxiolytics	Lorazepam
- Vitamines	Not given

PSYCHOLOGICAL MANAGEMENT

→ Group therapy

Social interaction, sense of cohesiveness, identification and reality testing achieved within the group setting have been proven to be highly therapeutic for these individual

→ Family therapy

Typically consists of brief programme of family education about schizophrenia. It has been found that relapse rates of schizophrenia are higher in families with high expressed emotions, where significant others make critical comments, express hostility or show emotional over involvement

→ Psychological rehabilitation

Include activity therapy to develop work habits, training in new vocation of retraining a previous skill, vocational guidance and independant job placement

→ Social skill training

Training of maintaining eye to eye contact, individual space transportation, money management and communication skills.

Book picture	Patient picture
Group therapy	Not done
cognitive therapy	Not done
Family therapy	Not done
Social skill training	Not done
- psychological rehabi- litation	Not done

SOMATIC MANAGEMENT

Electro convulsive therapy

ECT is the induction of grandmal seizure through the application of electrical current to the brain. Indications of ECT in schizophrenia are

→ catatonic stupor
→ uncontrolled catatonic excitement
→ severe side effects with drug
→ schizophrenia refractory to all other forms of treatment

NURSING MANAGEMENT

ASSESSMENT

- schizophrenic patients in a acute episode of illness are seldom able to make a significant contributions to their history. Data may be obtained from family members / others familiar with patient and also from old records. A nursing assessment includes, assessment risk behaviours, suicidal tendancies, previous incidences of mental illness or psychotic episodes.

→ Observe behavioural pattern posturing, psychomotor disturbance appearance, hygiene.
→ Identify 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 thought or present situation
→ Assess for theme and content of delusional thinking. If the delusion of persecution oriented, assess the nature of threat for the risk for violence.
→ Assess speech patterns associated with delusion
→ Assess the ability to perform self care activity, ie sleep, pattern and interaction with other patients
→ Determine any suicidal intent or recent attempts that may have been made.

INTERVENTIONS

Delusional behaviour

→ Assess the content of delusion without appearing to probe
→ Assess Intensity, frequency and duration of delusion.
→ 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.
→ Discourage long discussions about the irrational thinking. Instead talk about real events and real people.
→ use the same staff as far as possible.
→ Avoid physical contact in the form of touching the patient

→ Avoid competent activities.
→ Patients participation is encouraged but not forced.
→ use assertive, matter-of fact, yet friendly approach.

Improve health

→ Assess malnutrition and dehydration.
→ creative approaches may need to taken with patients who is not eating such as allowing to take foods, fruits, eggs etc.
→ Provide less stimulating environment to suspicious people whose sleep may be disturbed by nightmares or severe anxiety
→ Administer sedatives as needed.
→ Prevent day time naps by involving in physical exercise or day treatment

Improve self care activities.

- Provide assistance with self care needs as required.
- Develop structured schedule for patients routine for hygiene toileting and meals.
- Pease the patient for complete activities of daily living and for initiating self care activities.
- Encourage wearing appropriate clothes for the setting.
- Allow enough time to complete any tasks.

Violent behaviour

→ maintain low level of stimulation in patient environment
→ Remove all dangerous objects from the environment
- Do not use any physical restrains without sufficient reason
- Talk with patient in low calm voice.
- Help the patient identify and practice ways to relieve anxiety.
- Redirect violent behaviour with physical outlets

LIST OF PROBLEMS

1) Risk for injury.
   - easy irritability.
   - aggressiveness

2 Disturbed thought process
   - presence of delusions
   - presence of possession (Thought withdrawal)

3. Disturbed Sensory perception.
   - Hallucinations

4) Impaired social interaction.
   - Reduced talking.
   - Difficulty to form relationships

5) Disturbed sleep pattern.
   - Reduced sleep, anxiety.

6. Imbalanced nutrition.
   Delusion of persecution, decreased food intake, decreased appetite., suspiciousness

7 Deficient knowledge

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NURSING DIAGNOSIS

1) Risk for injury related to irritable behaviour
2) Disturbed thought process related to biochemical alterations as evidenced by presence of delusions
3) Disturbed sensory perception related to anxiety as evidenced by presence of hallucinations.
4) Impaired social interaction related to inability to form new relationships as evidenced by social with drawal.
5) Disturbed sleep pattern related to anxiety as evidenced by early morning waking.
6. Imbalanced nutrition related to delusion of suspicious persecution as evidenced by generalized weakness.

Assessment	Diagnosis	objectives	Interventions	Rationale	Implementation	Evaluation
Objective data - Irritability - aggressiveness.	Risk for injury related to irritable behaviour.	Client maintains free from injury as evidenced by reducing irritable behaviour.	→ Assess the risk behaviour	To gather information and to provide safety precaution	- Assessed the risk behaviour and found patient has irritable and aggressive behaviour	Client remained free from injury as evidenced by reduced irritable behaviour as actively participating in activities ie, games, exercises, colouring etc.
			→ Observe the patient closely and provide low stimulating environment	- To avoid the chance for irritability	- observed patient closely and provided calm environment	
			→ provide diversional activities.	To reduce irritability and aggressiveness	Provided time for games, such as carams, picture colouring, exercises	
			→ Provide adequate safety precaution	Preventing from injury to self and to others	→ Removed all sharp objects from patient environment	
			→ provide relaxation Therapies to patient	- To provide relaxation to patient	→ Provided relaxation exercises such as deep breathing exercises	

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Assessment	Diagnosis	Objectives	Intervention	Rationale	Implementation	Evaluation
Subjective data Patient says when I am praying, some ~~Force~~ enemies comes and disturbing me. objective data → Fear. → delution of persecution → delusion of reference → suspeciousness	Disturbed thought process related to biochemical alteration as evidenced by delusion of persecution	Client maintains normal thought process as evidenced by distracts from delusions.	- Assess the thought process of the patient → Encourage patient to explore her thoughts → Encourage patient to participate in diversional activities → Encourage patient to engage in activities → Encourage the patient to do relaxation techniques	- To plan proper interventions. - To understand more about abnormal thought process To distract patient from disturbing thoughts To distract patient from disturbing thoughts. To provide relaxation to patient	Assessed and found patient is suspicious towards others and has fear of persecution → Encouraged to explore thoughts & found delusion of persecution and delusion of reference is present. - Provided diversional activities such as crafts, colouring games etc. Encouraged patient to play in group and to introduce self in a group. explained and encouraged to do deep breathing exercises	Client maintained normal thought process as evidenced by participating in activities like making cards, participating in group games and activities

Assessment	Diagnosis	Objectives	Interventions	Rationale	Implementation	Evaluation
Subjective data Patient says I hear some body speaking to me. Objective data → Patient verbalizations	Disturbed sensory perception related to anxiety as evidenced by presence of hallucinations.	Patient maintains normal sensory perception as evidenced by reduced hallucinations	- Assess the level of sensory perception of the patient → Encourage the patient to explore the perception experiences. → Encourage patient to engage in diversional activities. → Show acceptance and use active listening skills → Educate the patient family members about medication → Advised to take medication as per doctors order	- To plan proper interventions → To know more about the hallucinations of the patient To distract patient from disturbing sensory perceptions To establish trust interpersonal relationships To increase the level of knowledge To reduce hallucinatory episodes	Assessed the sensory perception level of patient and found presence of auditory hallucination. → Encouraged patient to explore his sensory perceptions and hallucinations. - Encouraged patient to participate in activities such as- games, colouring, craft works etc showed acceptance and used active listening skill to hear what she is saying. Educated the patient and family about disease. Advised patient to take medications	Patient maintained normal sensory perceptual as evidenced by distracted from auditory hallucinations actively participating in activities such as coloring picture, games and interactive sessions

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Assessment	Diagnosis	Objectives	Interventions	Rationale	Implementation	Evaluation
Subjective data Patient says I have difficulty in maintaining relationship others Objective data - Social withdrawal - Not participating in group activities	Impaired social interaction related to inability to form relationships as evidenced by social withdrawal.	Patient maintaining normal social interaction as evidenced by actively interacting with others	→ Assess patient ability to interact with others → Encourage patient to express the feelings → Actively listen to the patient. → Provide activities and encourage patient to participate in it → Provide opportunities for interact with others	Assessment helps to plan proper interventions → To resolve problems in interaction To promote interaction To promote the social interaction of patient To increase the social interaction ability of the patient	Assessed and found social withdrawal is present - Encouraged patient to express her feeling and found shyness is present. Actively listened and promoted patient to talk Provided opportunities for participating in group games and interactive sessions Provided opportunities such as interactive sessions and group games such as carroms, pazeles etc	Patient maintained normal social interaction as evidenced by actively interacting with others participating in interactive sessions and group games.

PSYCHOEDUCATION

SYMPTOM MANAGEMENT

⇒ Managing the Symptoms

- Instructed patient to accept the realities.
- Instructed patient to participate various activities
- Instructed patient to participate in group activities
- Instructed patient to participate actively in games
- Instructed patient to try to speak with others
- Instructed patient to be calm and think about the positive aspects of others and they are not trying to harm you or harrase you or cheat you.
- Maintain a good relationship with the family members.
- Maintain speaking with family members.
- Clarify the doubts with family members or staffs.

TREATMENT

→ Maintaining Medication Compliance

- Take all the medication as prescribed by the doctor
- Take the medication same time everyday.
- Do not take any over the counter medication with out doctors permission while taking medications
- Include family members also in the taking of the medications

- Keep daily alarms for reminding to take medications.
- keep medication boxes for keeping seperate medication for morning, noon and night.
- Place the medication box in the easy noticing area.

DAILY LIVING ACTIVITIES

→ Maintaining adequate sleep

- Go to bed at same time every day
- Avoid exercises before going to bed.
- Avoid heavy meals before going to bed.
- Sleep in a calm and quiet atmosphere.
- Switch off light and other stimulations before going to bed.
- Have the dinner early in the night.
- Avoid day time naps.
- Read books before going to bed.
- Try to sleep 6 hours daily

ACTIVITY PLAN-1

Name of the activity - card making

objectives - To distract patient from disturbing thoughts and sensory perception
- To increase relaxation

Duration - 45 minutes

Description of environment	Description of activity	Evaluation of patient
Provided a comfortable environment to the patient Articles needed. - chart paper - A4 paper - colour paper - gum - Heart shapes.	- Set all the necessary articles at patient side. → provide a paper to the patient and ask him to fold it in to a card. → Provided small heart shapes and asked to stick on card after placing gum on one side → Asked to stick birth day wishes on the lower part of the card → Asked to stick heart shapes inside the card	- Patient was ready to do the activities. - He followed the instructions correctly she took the paper and folded it in the shape of the card. She put gum on the back side of heart shape and sticked on card and sticked birthday wishes on the card. She opened the card and sticked shapes inside also

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ACTIVITY PLAN II

Name : Group activity.

Objectives : To improve social interaction
To help the patient to destract from distubing thoughts

Description of environment	Description of activity	Evaluation of patient
Provided suitable environment to the patient	→ Grouped the patient to 2 groups. → Instructed patient to sit in the arranged chairs. → Selected one person from a group at a time → Told him about the name of a film → Instructed him to present the name by acting or making gestures → Instructed other members to identify the name of film.	- Patient actively participated. - But she was unwilling to come-forward to act even after compelling. - She showed interest to observe the activities.

ACT

ACTIVITY PLAN-III

Name : Flower making.
Objective :- To distract the patient from disturbing thoughts.
Duration : 10 minutes.

Description of the environment	Description of the activity	Evaluation of the patient
Provided appropriate environment to the patient. Articles needed → colour papers, which is good in square shapes and done many different cuttings - gum	→Instructed to take the colour paper cut in square, → unfold the colour paper → fold in opposite direction and. → stick the open ends. - Roll a piece of of paper into the shape of a stick - attach the folded paper on the stick in a factory fashion - paste leaves to the stick	Patient was ready to do the activity - She took the paper and unfolded and pasted the opposite ends - she tried to make the sticks, but it was incomplete -and pasted the paper on the sticks - Attached leaves - patient showed interest in doing activity

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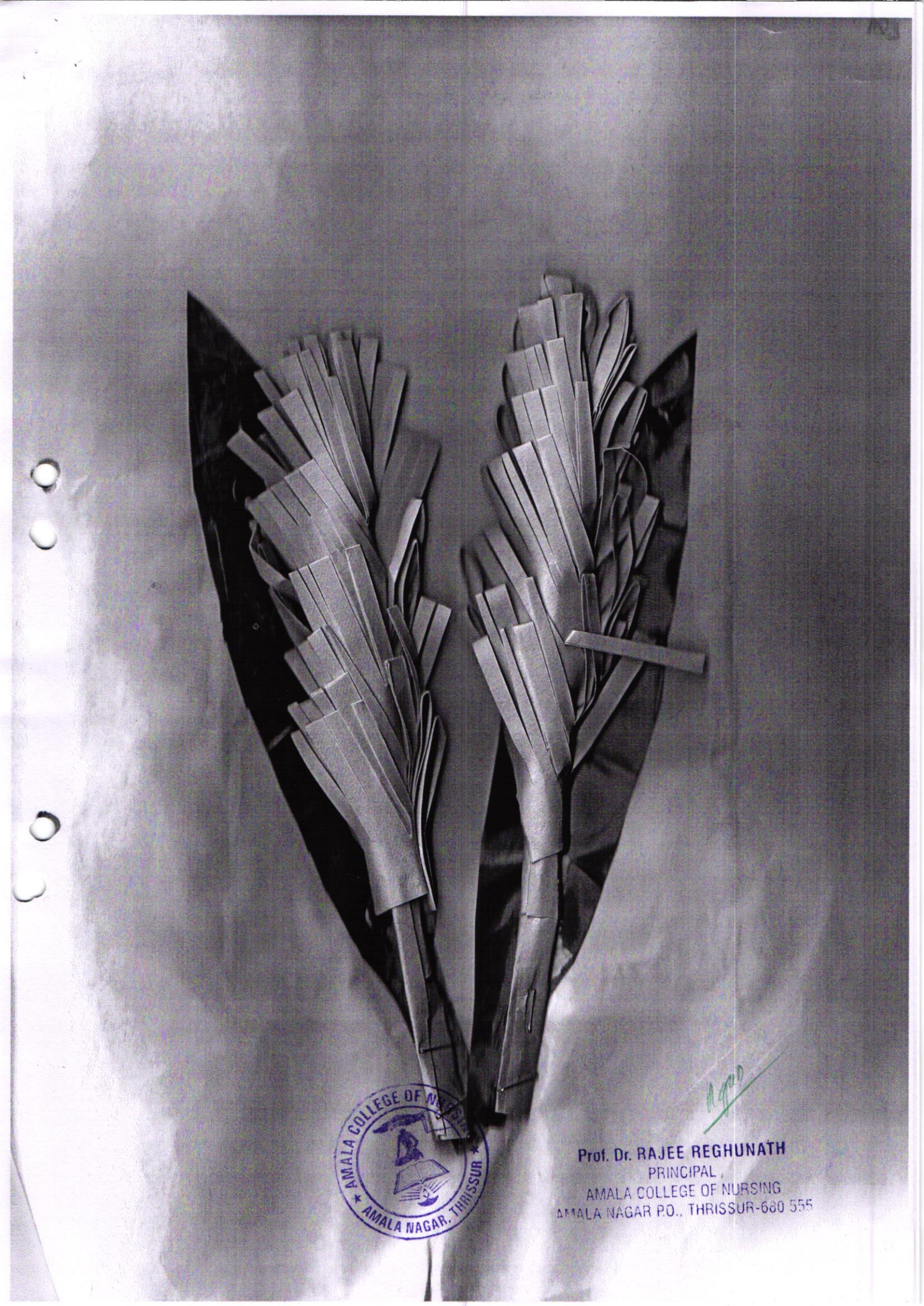

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HAPPY BIRTHDAY

PROGRESS NOTE

Day -1

Mrs. Seenath, 47 years old female got admitted in Ansar hospital on 20/10/22 with complaints of aggressiveness, not following instructions, decreased sleeping patterns, over religiosity and suspeciousness and irritability towards certain colours and persons etc.

On mental status examination, it was found that general appearance is anxious and sad, difficulty in maintaining rapport with others. thought problems such as delusions, thought withdrawal and thought broadcasting (ie possession problems) in assessment of perception hallucinations, auditory type are present. Patient has blunted affect. Normal attention is present. concentration and remote memory is impaired. Patient has normal intelligence, abstract thinking and judgement and has insight of grade 1, On physical examination no abnormalities are noted.

Patient is having medications such as T. Lorazepam, T. pantane, T-Halidole and T. Sizopin. Provided diversional activities such as craft making, colouring pictures, group and individual games to patient

Day II

Patient Condition is improving. Patient has improved Sleeping patterns. Patient is less aggressive and less irritable. She initiated to participate in individual games

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On MSE, patient thought process, possession and sensory perception are impaired. Patient has normal concentration, judgement and abstract thinking the Remote memory is impaired and insight is grade I.

No new medications are added. To treatment regimen. provided individual and group games. interactive sessions card craft making explained patient regarding the importance and ways to maintain compliance to medication

Day-3

Patent condition is improving. Patient is trying to maintain rapport with others. Has less aggressive behaviour. and improved Sleeping patterns.

On MSE the general appearance is sad and anxious impaired thought, possession and perception are still existing. Patient has blunted affect and has impaired concentration. other mental functions are intact. patient has the insight level of grade I.

Provided diversional activities such as group games individual games and interactive sessions, craft works etc. Provided psychoeducation regarding symptom management of delusion and ways to maintaining adequate sleeping pattern.

CONCLUSION

As a part of my third year Bsc Nursing psychiatric posting I got a chance to provide care to Mrs. Seenath 47 years old female who was admitted in hospital with symptoms of schizophrenia. Care was provided to the patient. Provided activities such as card making, flower making and group interacting activities to provide distraction from the disturbing thoughts. Patient was very cooperative. This experience helped to understand the signs and provide care to people with same disease condition.

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