**Smt.Nagarathnamma college of nursing**

Soladevanahalli, Bangalore -90

**Subject – Mental Health and Psychiatric Nursing**

**Unit – Mental disorders and Nursing Interventions**

**Phobic Anxiety disorders**

**Anxiety:**

* Is a subjective, individual experience characterized by a feeling of apprehension, uneasiness, uncertainty, or dread?
* It occurs as a result of threats that may be actual or imagined, misperceived or misinterpreted, or from a threat to identity or self-esteem.
* It often precedes new experiences.

**Phobia:**

A phobia is an unreasonable fear of a specific object, activity or situation. This irrational fear is characterized by various features that cannot be dealt with by reasoning / controlled through will powder.

Phobic anxiety disorders, the individual experiences intermittent anxiety which arises in particular circumstances, that is in response to the phobic object / situation.

**Classification**

1. Agoraphobia
2. Social phobia
3. Specific phobia
4. Other phobic anxiety disorders
5. Phobic anxiety disorder, unspecified

**Types of Phobia**

1. **Simple phobia** – It is an irrational fear of a specific object / stimulus. Simple phobias are common in childhood. For ex –
2. Acrophobia – fear of height
3. Hematophobia – fear of blood
4. Claustrophobia – fear of closed spaces
5. Gamophobia – fear of marriage
6. Insectophobia – fear of insects
7. Zoophobia – fear of animals
8. Microphobia – fear of germs
9. Brontophobia – fear of thunder
10. Algophobia – fear of pain

**Signs and symptoms of specific phobias –**

* Irrational and persistent fear of object / situation
* Immediate anxiety on contact with feared object / situation
* Loss of control, fainting, or panic response
* Avoidance of activities involving feared stimulus
* Anxiety when thinking about stimulus
* Worry with anticipatory anxiety
* Possible impaired social or work functioning
1. **Social phobia** – it is an irrational fear of performing activities in the presence of other people or interacting with others. The patient is afraid of his own action being viewed by others critically, resulting in embarrassment or humiliation.

**Signs and symptoms of social phobia –**

* Hyperventilation
* Sweating, cold, clammy hands
* Blushing
* Palpitations
* Confusion
* Gastro – intestinal symptoms
* Trembling hands and voice
* Urinary urgency
* Muscle tension
* Anticipatory anxiety
* Fear / embarrassment / ridicule
1. **Agoraphobia** – it is characterized by an irrational fear of being in places away from the familiar setting of home, in crowd, or in situations that the patient cannot leave easily.

**Signs and symptoms of Agoraphobia –**

* Overriding fear of open / public spaces

**Etiology –**

1. **Psychodynamic theory –**

According to this theory anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanism (displacement) of ego come into action.

1. **Learning theory –**

According to classical conditioning a stressful stimulus produces an unconditioned response – fear. When the stressful stimulus is repeatedly paired with a harmless object, eventually the harmless object alone produces the fear, which i

1. **Cognitive theory –**

It believes that some individuals engage in negative and irrational thinking that produce anxiety reactions. The individual begins to seek out avoidance behavior to prevent the anxiety reactions, and phobia results.

**Treatment –**

1. **Pharmacotherapy –**
* Benzodiazepines – ex : Alprazolam, Clonazepam, Lorazepam
* Anti depressant – Impramine, Sertraline
1. **Behavioral therapy**
* Flooding
* Systematic desensitization
* Exposure and response prevention
* Relaxation techniques
1. **Cognitive therapy**
2. **Supportive therapy**

**Nursing diagnosis –**

1. Fear related to a specific stimulus evidenced by behavior directed towards avoidance of the feared object / situation
2. Social isolation related to fear of being in a place from which one is unable to escape, evidence by staying alone, refusing to leave the room / home.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Generalized anxiety disorder**

**Generalized anxiety disorder** (**GAD**) is an [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) that is characterized by excessive, uncontrollable and often irrational worry about everyday things that is disproportionate to the actual source of worry.

**Symptoms of GAD**

 (present most days for at least 6mths)

 DSM-IV At least 3 (or 1 in children) out of: restlessness or feeling keyed up or on edge; easy fatiguability; concentration difficulties or mind going blank irritability; muscle tension; sleep disturbance.

ICD-10 At least 4 (with at least 1 from autonomic arousal out of:

* Symptoms of autonomic arousal: palpitations/tachycardia; sweating; trembling/shaking; dry mouth.
* Physical symptoms: breathing difficulties; choking sensation; chest pain/discomfort; nausea/abdominal distress.
* Mental state symptoms: feeling dizzy, unsteady, faint or lightheaded; derealisation/depersonalisation; fear of losing control, going crazy, passing out, dying.
* General symptoms: hot flushes/cold chills; numbness or tingling sensations.
* Symptoms of tension: muscle tension/aches and pains; restlessness/ inability to relax; feeling keyed up, on edge, or mentally tense; a sensation of a lump in the throat or difficulty swallowing.
* Other: exaggerated responses to minor surprises/being startled; concentration difficultiesmind going blank due to worry or anxiety; persistent irritability; difficulty getting to sleep due to worrying.

 Course Chronic and disabling, prognosis generally poor, remission rates low (-30% after 3yrs, with treatment), 6yr outcomeâ€”68% mild residual symptoms, 9% severe persistent impairment. Often comorbidity becomes more significant (esp. alcohol misuse) and this worsens the prognosis

 **Treatment**

 A meta-analysis of 35 studies shows [cognitive behavioral therapy](http://en.wikipedia.org/wiki/Cognitive_behavioral_therapy) to be more effective in the long term than pharmacologic treatment (drugs such as [SSRIs](http://en.wikipedia.org/wiki/SSRIs)), and while both treatments reduce anxiety, CBT is more effective in reducing depression.

 **Cognitive behavioral therapy**

 **SSRIs (** [Selective serotonin reuptake inhibitor](http://en.wikipedia.org/wiki/Selective_serotonin_reuptake_inhibitor))

* [paroxetine](http://en.wikipedia.org/wiki/Paroxetine) (Paxil, Aropax)
* [escitalopram](http://en.wikipedia.org/wiki/Escitalopram) (Lexapro, Cipralex)
* [sertraline](http://en.wikipedia.org/wiki/Sertraline) (Zoloft)

**Other Drugs**

* [Buspirone](http://en.wikipedia.org/wiki/Buspirone) (BuSpar). Buspirone (BuSpar) is a [serotonin](http://en.wikipedia.org/wiki/Serotonin) [receptor](http://en.wikipedia.org/wiki/Receptor_%28biochemistry%29) [agonist](http://en.wikipedia.org/wiki/Agonist) belonging to the [azaspirodecanedione](http://en.wikipedia.org/wiki/Azaspirodecanedione) class of compounds.
* [Duloxetine](http://en.wikipedia.org/wiki/Duloxetine) (Cymbalta)
* [Imipramine](http://en.wikipedia.org/wiki/Imipramine) (Tofranil). Imipramine (Tofranil) is a [tricyclic antidepressant](http://en.wikipedia.org/wiki/Tricyclic_antidepressant) (TCA). TCAs are thought to act on serotonin, norepinephrine, and [dopamine](http://en.wikipedia.org/wiki/Dopamine) in the brain.
* [Venlafaxine](http://en.wikipedia.org/wiki/Venlafaxine) (Effexor, Effexor XR). Venlafaxine (Effexor) is a [serotonin-norepinephrine reuptake inhibitor](http://en.wikipedia.org/wiki/Serotonin-norepinephrine_reuptake_inhibitor) (SNRI). SNRIs, a class of drugs related to the SSRIs, alter the chemistries of both [norepinephrine](http://en.wikipedia.org/wiki/Norepinephrine) and serotonin in the brain.
* [Propranolol](http://en.wikipedia.org/wiki/Propranolol) (Inderal)

**Benzodiazepines**

* [alprazolam](http://en.wikipedia.org/wiki/Alprazolam) (Xanax, Xanax XR, Niravam)
* [chlordiazepoxide](http://en.wikipedia.org/wiki/Chlordiazepoxide) (Librium)
* [clonazepam](http://en.wikipedia.org/wiki/Clonazepam) (Klonopin)
* [clorazepate](http://en.wikipedia.org/wiki/Clorazepate) (Tranxene)
* [diazepam](http://en.wikipedia.org/wiki/Diazepam) (Valium)
* [lorazepam](http://en.wikipedia.org/wiki/Lorazepam) (Ativan)

**NURSING MANGMENT OF GAD**

 **CLIENT ASSESSMENT DATA BASE**

**Activity/Rest**

* Restlessness, pacing anxiously, or, if seated, restlessly moving extremities
* Feeling “keyed up”/“on edge,” unable to relax
* Easily fatigued
* Difficulty falling or staying asleep; restlessness, unsatisfying sleep

**Circulation**

* Heart pounding or racing/palpitations; cold and clammy hands; hot or cold spells, sweating; flushing, pallor
* High resting pulse, increased blood pressure

**Ego Integrity**

* Excessive worry about a number of events/activities, occurring more days than not for at least 6 months
* Complains vociferously about inner turmoil, has difficulty controlling worry
* May demand help
* Facial expression in keeping with level of anxiety felt (e.g., furrowed brow, strained face, eyelid twitch)
* May report history of threat to either physical integrity (illness, inadequate food and housing, etc.) or self-concept (loss of significant other; assumption of new role)

**Elimination**

* Frequent urination; diarrhea

**Food/Fluid**

* Lack of interest in food, dysfunctional eating pattern (e.g., responding to internal cues other than hunger)
* Dry mouth, upset stomach, discomfort in the pit of the stomach, lump in the throat

**Neurosensory**

* Absence of other mental disorder, such as depressive disorder or schizophrenia
* Motor tension: shakiness, jitteriness, jumpiness, trembling, muscle tension, easily startled
* Dizziness, lightheadedness, tingling hands or feet
* Apprehensive expectation: anxiety, worry, fear, rumination, anticipation of misfortune to self or others, inability to act differently (feeling stuck)
* Excessive vigilance/hyperattentiveness resulting in distractibility, difficulty in concentrating or mind going blank, irritability, impatience
* Free-floating anxiety usually chronic or persisting over weeks/months

**Pain/Discomfort;**Muscle aches, headaches

**Respiratory**

* Increased respiratory rate, shortness of breath, smothering sensation

**Sexuality**

* Women twice as likely to be affected as men

**Social Interactions**

* Significant impairment in social/occupational functioning

**Teaching/Learning**

* Age of onset usually 20s and 30s

**DIAGNOSTIC STUDIES**

**Drug Screen:** Rules out drugs as contribution to cause of symptoms.

Other diagnostic studies may be conducted to rule out physical disease as basis for individual symptoms (e.g., ECG for severe chest pain, echocardiogram for mitral valve prolapse; EEG to identify seizure activity; thyroid studies).

**NURSING PRIORITIES**

1. Assist client to recognize own anxiety.

2. Promote insight into anxiety and related factors.

3. Provide opportunity for learning new, adaptive coping responses.

4. Involve client and family in educational/support activities.

**DISCHARGE GOALS**

1. Feelings of anxiety recognized and handled appropriately.

2. Coping skills developed to manage anxiety-provoking situations.

3. Resources identified and used effectively.

4. Client/family participating in ongoing therapy program.

5. Plan in place to meet needs after discharge

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Panic disorder**

 **Panic disorder** is an [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) characterized by recurring severe [panic attacks](http://en.wikipedia.org/wiki/Panic_attack). It may also include significant behavioral change lasting at least a month and of ongoing worry about the implications or concern about having other attacks. The latter are called *anticipatory attacks* (DSM-IVR). Panic disorder is *not* the same as [agoraphobia](http://en.wikipedia.org/wiki/Agoraphobia), although many with panic disorder also suffer from agoraphobia.

|  |
| --- |
|  |

**Causes**

 There is no single cause for panic disorder, however, panic disorder has been found to run in families, and suggests that [inheritance](http://en.wikipedia.org/wiki/Heredity) plays a strong role in determining who will get it. It has also been found to exist as a co-morbid condition with many hereditary disorders, such as [bipolar disorder](http://en.wikipedia.org/wiki/Bipolar_disorder), and a genetic predisposition to [alcoholism](http://en.wikipedia.org/wiki/Alcoholism).

 Psychological factors, stressful life events, life transitions, environment, and thinking in a way that exaggerates relatively normal bodily reactions are also believed to play a role in the onset of panic disorder. Often the first attacks are triggered by physical illnesses, major stress, or certain [medications](http://en.wikipedia.org/wiki/Medication). People who tend to take on excessive responsibilities may develop a tendency to suffer panic attacks. Post-traumatic stress disorder ([PTSD](http://en.wikipedia.org/wiki/PTSD)) patients also show a much higher rate of panic disorder than the general population.

 There is some evidence to suggest [hypoglycemia](http://en.wikipedia.org/wiki/Hypoglycemia), [hyperthyroidism](http://en.wikipedia.org/wiki/Hyperthyroidism), [mitral valve prolapse](http://en.wikipedia.org/wiki/Mitral_valve_prolapse), [labyrinthitis](http://en.wikipedia.org/wiki/Labyrinthitis) and [pheochromocytoma](http://en.wikipedia.org/wiki/Pheochromocytoma) can cause or aggravate panic disorder.

[Prepulse inhibition](http://en.wikipedia.org/wiki/Prepulse_inhibition) has been found to be reduced in patients with Panic Disorder.

 [Stimulants](http://en.wikipedia.org/wiki/Stimulants) are a rather common cause for panic attacks. An excess of common stimulants such as [caffeine](http://en.wikipedia.org/wiki/Caffeine). Many [SSRIs](http://en.wikipedia.org/wiki/Selective_serotonin_reuptake_inhibitor) also have stimulant side-effects during the beginning of treatment which may exacerbate the condition and have actually caused first-time panic attacks in otherwise healthy individuals being treated for depression.

 There are other researchers looking at some individuals with panic disorder as having a chemical imbalance within the [limbic system](http://en.wikipedia.org/wiki/Limbic_system) and one of its regulatory chemicals [GABA](http://en.wikipedia.org/wiki/GABA)-A. The reduced production of GABA-A sends false information to the [amygdala](http://en.wikipedia.org/wiki/Amygdala) which regulates the body's "fight or flight response" mechanism and in return, produces the physiological symptoms that lead to the disorder. Clonazepam, an anticonvulsant benzodiazepine with a long half-life, has been successful in keeping the condition in check

**Mediators and Moderators of Panic Disorder**

 Recently, researchers have begun to identify mediators and moderators of aspects of panic disorder. One such mediator is the partial pressure of carbon dioxide, which mediates the relationship between panic disorder patients receiving breathing training and anxiety sensitivity; thus, breathing training affects the partial pressure of carbon dioxide in a patient’s arterial blood, which in turn lowers anxiety sensitivity. Another mediator is hypochondriacal concerns, which mediate the relationship between anxiety sensitivity and panic symptomatology; thus, anxiety sensitivity affects hypochondriacal concerns which, in turn, affect panic symptomatology

**Substance abuse and panic disorder**

 A growing body of evidence exists that shows a link between [substance abuse](http://en.wikipedia.org/wiki/Substance_abuse) and panic disorder.

 **Smoking**

Several studies have found that [cigarette smoking](http://en.wikipedia.org/wiki/Cigarette_smoking) increases the risk of [panic attacks](http://en.wikipedia.org/wiki/Panic_attack) and panic disorder in young people. c attacks.

**Alcohol and sedatives**

About 30% of people with panic disorder use [alcohol](http://en.wikipedia.org/wiki/Alcoholic_beverage) and 17% use other psychoactive drugs.[[14]](http://en.wikipedia.org/wiki/Panic_disorder#cite_note-13) This is in comparison with 61% (alcohol)[[3]](http://www.cdc.gov/nchs/fastats/alcohol.htm) and 7.9% (other psychoactive drugs) [[4]](http://www.cdc.gov/nchs/fastats/druguse.htm) of the general population who use alcohol and psychoactive drugs, respectively..

**Signs and symptoms**

 Physical symptoms/signs are related to autonomic arousal (e.g. tremor, tachycardia, tachypnoea, hypertension, sweating, GI upset) which are often compounded by HVS .

* Concerns of death from cardiac or respiratory problems may be a major focus, leading to patients presenting (often repeatedly) to emergency medical services.
* Panic disorder may be undiagnosed in patients with unexplained medical symptoms3 (chest pain, back pain, GI symptoms including IBS, fatigue, headache, dizziness, or multiple symptoms4).
* Thoughts of suicide (or homicide) should be elicited as acute anxiety (particularly when recurrent) can lead to impulsive acts (usually directed towards self). N.B. Risk of attempted suicide is substantially raised where there is co morbid depression, alcohol misuse, or substance misuse.

Symptoms associated with panic attacks (in order of frequency of occurrence)

* Palpitations, pounding heart, or accelerated heart rate.
* Sweating.
* Trembling or shaking.
* Sense of shortness of breath or smothering.
* Feeling of choking or difficulties swallowing (globus hystericus).
* Chest pain or discomfort.
* Nausea or abdominal distress.
* Feeling dizzy, unsteady, light-headed, or faint.
* Derealisation or depersonalisation (feeling detached from oneself or one's surroundings).
* Fear of losing control or going crazy.
* Fear of dying (angor animus).
* Numbness or tingling sensations (paraesthesia).
* Chills or hot flashes.

Panic disorder sufferers usually have a series of intense episodes of extreme [anxiety](http://en.wikipedia.org/wiki/Anxiety) during [panic attacks](http://en.wikipedia.org/wiki/Panic_attacks).

**DIAGNOSTIC STUDIES**

The [DSM-IV-TR](http://en.wikipedia.org/wiki/DSM-IV-TR) diagnostic criteria for panic disorder require unexpected, recurrent panic attacks, followed in at least once instance by at least a month of a significant and related behavior change, a persistent concern of more attacks, or a worry about the attack's consequences. There are two types, one with and one without agoraphobia. Diagnosis is excluded by attacks due to a drug or medical condition, or by panic attacks that are better accounted for by other mental disorders.[[30]](http://en.wikipedia.org/wiki/Panic_disorder#cite_note-29)
 Drug Screen: Identifies drugs that may be used by client to reduce anxiety, rules out drugs that may produce symptoms.
 Other diagnostic studies may be conducted to rule out physical disease as a basis for individual symptoms, e.g.:
 EEG: To rule out epilepsy, other neurological disorders.
 EKG: In the presence of severe chest pain to rule out cardiac conditions.
 Thyroid Studies: To rule out hyperthyroidism.

**MANGEMENT**

Identification of treatments that engender as full a response as possible, and can minimize relapse, is imperative.[[31]](http://en.wikipedia.org/wiki/Panic_disorder#cite_note-30) [Cognitive behavioural therapy](http://en.wikipedia.org/wiki/Cognitive_behavioural_therapy) is the treatment of choice for panic disorder. When cognitive behavioural therapy is not an option pharmacotherapy can be used. [SSRIs](http://en.wikipedia.org/wiki/SSRIs) are considered a first line pharmacotherapeutic option.

In addition, people with panic disorder may need treatment for other emotional problems. [Comorbid](http://en.wikipedia.org/wiki/Comorbid) [clinical depression](http://en.wikipedia.org/wiki/Clinical_depression), [personality disorders](http://en.wikipedia.org/wiki/Personality_disorders) and [alcohol abuse](http://en.wikipedia.org/wiki/Alcohol_abuse) are known risk factors for treatment failure.

As with many disorders, having a support structure of family and friends who understand the condition can help increase the rate of recovery. During an attack, it is not uncommon for the sufferer to develop irrational, immediate fear, which can often be dispelled by a supporter who is familiar with the condition. For more serious or active treatment, there are support groups for anxiety sufferers which can help people understand and deal with the disorder.

**Psychotherapy**

**Pharmacological mangement**

* SSRIs (e.g. paroxetine [at least 40 mg], fluoxetine, fluvoxamine, citalopram, sertraline) are recommended as the drug of choice (unless contraindicated). In view of the possibility of initially increasing panic symptoms, start with low dose and gradually increase. Beneficial effect may take 38 weeks.
* Alternative antidepressant TCAs (e.g. imipramine or clomipramine) although not specifically licensed in the UK have been shown to be 70â€“80% effective (possible alternatives include: desipramine, doxepin, nortryptiline, or amitriptyline.) MAOIs (e.g. phenelzine) again not licensed, but may be superior to TCAs (for severe, chronic symptoms). There is also some favourable evidence for RIMAs (e.g. moclobemide).
* BDZs (e.g. alprazolam or clonazepam) should be used with caution (due to potential for abuse/dependence/cognitive impairment) but may be effective for severe, frequent, incapacitating symptoms. Use for 1â€“2 weeks in combination with an antidepressant may â€˜coversymptomatic relief until the antidepressant becomes effective. N.B. â€˜Anti-panicâ€™ effects do not show tolerance, although sedative effects do.
* If initial management is ineffective Consider change to a different class agent (i.e. TCA, SSRI, MAOI) or combination (e.g. TCA+Lithium, SSRI+TCA). If treatment-resistantconsider alternative agent (e.g. carbamazepine, valproate, gabapentin, low-potency BDZ [diazepamâ€”may need high dose], venlafaxine, inositol, verapamil).
* If successful Continue treatment for -1yr before trial discontinuation (gradual tapering of dose). Do not confuse â€˜withdrawalâ€™ effects (10â€“20% of patients) with re-emergence of symptoms (50â€“70% of patients). If symptoms recur, continue for -1yr before considering second trial discontinuation. (N.B. Patient may wish to continue treatment, rather than risk return of symptoms).

**Psychological**

* Behavioural methods: to treat phobic avoidance by exposure, use of relaxation, and control of hyperventilation.
* Cognitive methods: teaching about bodily responses associated with anxiety/education about panic attacks, modification of thinking errors2.
* Psychodynamic methods: there is some evidence for brief dynamic psychotherapy, particularly emotion-focused treatment (e.g. panic-focused psychodynamic psychotherapy where typical fears of being abandoned or trapped are explored.

 Despite increasing focus on the use of antidepressants and other agents for the treatment of anxiety as recommended best practice, benzodiazepines have remained a commonly used medication for panic disorder.

 **Emergency treatment of an acute panic attack**

* Maintain a reassuring and calm attitude (most panic attacks spontaneously resolve within 30 mins).
* If symptoms are severe and distressing consider prompt use of BDZs (immediate relief of anxiety may help reassure the patient, provide confidence that treatment is possible, and reduce subsequent emergency presentations).
* If â€˜first presentation exclude medical causes (may require admission to hospital for specific tests).
* If panic attacks are recurrent, consider differential diagnosis for panic disorder and address underlying disorder (may require psychiatric referral).

**NURSING PRIORITIES**
1. Provide for physical safety.
2. Assist client to recognize onset of anxiety.
3. Help client learn alternative responses.
4. Assist with desensitization to phobic object/situation, if present.
5. Promote involvement of client/family in group or community support activities.
 **DISCHARGE GOALS**
1. Stays in feared situation even when discomfort is experienced.
2. Identifies techniques to lower/keep fear at manageable level.
3. Confronts the phobia and is desensitized to the stimulus.
4. Demonstrates greater independence and an increasingly freer lifestyle.

1. Plan in place to meet needs after discharge.

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Obsessive–compulsive disorder**

 **Obsessive–compulsive disorder** (**OCD**) is an [anxiety disorder](http://en.wikipedia.org/wiki/Anxiety_disorder) characterized by [intrusive thoughts](http://en.wikipedia.org/wiki/Intrusive_thoughts) that produce [anxiety](http://en.wikipedia.org/wiki/Anxiety), by repetitive behaviors aimed at reducing anxiety, or by a combination of such thoughts (obsessions) and behaviors ([compulsions](http://en.wikipedia.org/wiki/Compulsive_behavior)). Symptoms may include repetitive hand-washing; extensive [hoarding](http://en.wikipedia.org/wiki/Compulsive_hoarding); preoccupation with [sexual](http://en.wikipedia.org/wiki/Sexual_obsessions) or aggressive impulses, or with particular religious beliefs; aversion to odd numbers; and nervous habits, such as opening a door and closing it a certain number of times before one enters or leaves a room. These symptoms can be [alienating](http://en.wikipedia.org/wiki/Social_alienation) and time-consuming, and often cause severe emotional and economic loss. The acts of those who have OCD may appear [paranoid](http://en.wikipedia.org/wiki/Paranoid) and come across to others as [psychotic](http://en.wikipedia.org/wiki/Psychotic). However, OCD sufferers generally recognize their thoughts and subsequent actions as irrational, and they may become further distressed by this realization.

**ETIOLOGICAL THEORIES**

**Psychodynamics**

 Freud placed origin for obsessive-compulsive characteristics in the anal stage of development. The child is mastering bowel and bladder control at this developmental stage and derives pleasure from controlling his or her own body and indirectly the actions of others.

 Erikson’s comparable stage for this disorder is autonomy versus shame and doubt. The child learns that to be neat and tidy and to handle bodily wastes properly gains parental approval and to be messy brings criticism and rejection.

 The obsessional character develops the art of the need to obtain approval by being excessively tidy and controlled. Frequently the parents’ standards are too high for the child to meet, and the child continually is frustrated in attempts to please parents.

 The defensive mechanisms used in obsessive-compulsive behaviors are unconscious attempts by the client to protect the self from internal anxiety. The greater the anxiety, the more time and energy will be tied up in the completion of the client’s rituals. First, the client uses regression, a return to earlier methods of handling anxiety. Second, the obsessive thoughts are either devoid of feeling or are attached to anxiety. Thus, isolation is used. Third, the client’s overt attitude toward others is usually the opposite of the unconscious feelings. Thus, reaction formation is being used. Last, compulsive rituals are a symbolic way of undoing or resolving the underlying conflict.

**Biological**

 Although biological and neurophysiological influences in the etiology of anxiety disorders have been investigated, no relationship has yet been established. The mind-body connection is well accepted, but it is difficult to establish whether the biological changes cause anxiety or the emotional state causes physiological manifestations. However, recent findings suggest that neurobiological disturbances may play a role in obsessive-compulsive disorder, with physiological and biochemical factors also playing significant roles.

**Family Dynamics**

 The individual exhibiting dysfunctional behavior is seen as the representation of family system problems. The “identified patient” (IP) is carrying the problems of the other members of the family, which are seen as the result of the interrelationships (disequilibrium) between family members rather than as isolated individual problems.

Multiple factors contribute to anxiety disorders.

**Neurotransmitters role**

 Researchers have yet to pinpoint the exact cause of obsessive-compulsive disorder (OCD), but brain differences, genetic influences, and environmental factors are being studied. Brain scans of people with OCD have shown that they have different patterns of brain activity than people without OCD and that different functioning of circuitry within a certain part of the brain, the [striatum](http://en.wikipedia.org/wiki/Striatum), may cause the disorder. Differences in other parts of the brain and an imbalance of brain chemicals, especially [serotonin](http://en.wikipedia.org/wiki/Serotonin) and [dopamine](http://en.wikipedia.org/wiki/Dopamine), may also contribute to OCD.[[28]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-27) Independent studies have consistently found unusual [dopamine](http://en.wikipedia.org/wiki/Dopamine) and [serotonin](http://en.wikipedia.org/wiki/Serotonin) activity in various regions of the brain in individuals with OCD. These can be defined as [dopaminergic](http://en.wikipedia.org/wiki/Dopaminergic) [hyperfunction](http://en.wiktionary.org/wiki/hyperfunction) in the [prefrontal cortex](http://en.wikipedia.org/wiki/Prefrontal_cortex) and [serotonergic](http://en.wikipedia.org/wiki/Serotonergic) [hypofunction](http://en.wiktionary.org/wiki/hypofunction) in the [basal ganglia](http://en.wikipedia.org/wiki/Basal_ganglia).

|  |
| --- |
|  |

**Signs and symptoms**

**Obsessions**

[Intrusive thoughts](http://en.wikipedia.org/wiki/Intrusive_thoughts)

 A typical person with OCD performs tasks, or [compulsions](http://en.wikipedia.org/wiki/Compulsive_behavior), to seek relief from obsession-related anxiety. Within and among individuals, the initial obsessions, or intrusive thoughts, can vary in their clarity and vividness. A relatively vague obsession could involve a general sense of disarray or tension, accompanied by a belief that life cannot proceed as normal while the imbalance remains. A more articulable obsession could be a preoccupation with the thought or image of someone close to them dying. Other obsessions concern the possibility that someone or something other than oneself—such as [God](http://en.wikipedia.org/wiki/God), the [Devil](http://en.wikipedia.org/wiki/Devil), or [disease](http://en.wikipedia.org/wiki/Disease)—will harm either the person with OCD or the people or things that the person cares about. Others may sense that the physical world is qualified by certain immaterial conditions. These people might intuit invisible protrusions from their bodies, or could feel that inanimate objects are [ensouled](http://en.wikipedia.org/wiki/Soul)

 Some people with OCD experience [sexual obsessions](http://en.wikipedia.org/wiki/Sexual_obsessions) that may involve intrusive thoughts or images of "kissing, touching, fondling, [oral sex](http://en.wikipedia.org/wiki/Oral_sex), [anal sex](http://en.wikipedia.org/wiki/Anal_sex), [intercourse](http://en.wikipedia.org/wiki/Sexual_intercourse), [incest](http://en.wikipedia.org/wiki/Incest) and [rape](http://en.wikipedia.org/wiki/Rape)" with "strangers, acquaintances, parents, children, family members, friends, coworkers, animals and religious figures", and can include "[heterosexual](http://en.wikipedia.org/wiki/Heterosexual) or [homosexual](http://en.wikipedia.org/wiki/Homosexual) content" with persons of any age. As with other intrusive, unpleasant thoughts or images, most people have some disquieting sexual thoughts at times, but people with OCD may attach extraordinary significance to the thoughts. For example, obsessive fears about [sexual orientation](http://en.wikipedia.org/wiki/Sexual_orientation) can appear to the person with OCD, and even to those around them, as a crisis of [sexual identity](http://en.wikipedia.org/wiki/Sexual_identity). Furthermore, the doubt that accompanies OCD leads to uncertainty regarding whether one might act on the troubling thoughts, resulting in self-criticism or self-loathing

 The person with OCD understands that their notions do not [correspond](http://en.wikipedia.org/wiki/Correspondence_theory_of_truth) with the external world; however, they feel that they must act as though their notions were correct. For example, an individual who engages in [compulsive hoarding](http://en.wikipedia.org/wiki/Compulsive_hoarding) might be inclined to treat [inorganic matter](http://en.wikipedia.org/wiki/Inorganic_compound) as if it had the [sentience](http://en.wikipedia.org/wiki/Sentience) or [rights](http://en.wikipedia.org/wiki/Rights) of living organisms, but such an individual might find their consequent behavior irrational on a more intellectual level. In severe OCD, obsessions can shift into delusions when resistance to the obsession is abandoned and insight into its senselessness is lost

**Compulsions**

 [Compulsive behavior](http://en.wikipedia.org/wiki/Compulsive_behavior)

 While some with OCD perform compulsive rituals because they inexplicably feel they must, others act compulsively so as to mitigate the anxiety that stems from particular obsessive thoughts. The person with OCD might feel that these actions somehow either will prevent a dreaded event from occurring, or will [push the event from their thoughts](http://en.wikipedia.org/wiki/Metacognition). In any case, the individual's reasoning is so idiosyncratic or distorted that it results in significant distress for the individual with OCD or for those around them. Excessive skin picking (i.e., dermatillomania) or hair plucking (i.e., trichotillomatia) and nail biting (i.e., onychophagia) are all on the Obsessive-Compulsive Spectrum. Individuals with OCD are aware that their thoughts and behavior are not rational, but they feel bound to comply with them to fend off feelings of panic or dread.

 Some common compulsions include counting specific things (such as footsteps) or in specific ways (for instance, by intervals of two) and doing other repetitive actions, often with atypical sensitivity to numbers or patterns. People might repeatedly wash their hands[[11]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-10) or clear their throats, making sure certain items are in a straight line, repeatedly check that their parked cars have been locked before leaving them, constantly organizing in a certain way, turn lights on and off, keep doors closed at all times, touch objects a certain number of times before exiting a room, walk in a certain routine way like only stepping on a certain color of tile, or have a routine for using stairs, such as always finishing a flight on the same foot.

 People rely on compulsions as an escape from their obsessive thoughts; however, they are aware that the relief is only temporary, that the intrusive thoughts will soon come back. Some people use compulsions to avoid situations that may trigger their obsessions. Although some people do certain things over and over again, they don't necessarily perform these actions compulsively. For example, bedtime routines, learning a new skill, and religious practices are not compulsions. Whether or not behaviors are compulsions or mere habit depends on the context in which the behaviors are performed. For example, arranging and ordering DVDs or videos for eight hours a day would be expected of one who works in a video store, but would seem abnormal in other situations. Put another way, if the activity helps bring efficiency to one's life, it is probably a habit, if it interferes with one's normal enjoyment of life, it is probably a compulsion.

 In addition to the anxiety and fear that typically accompanies OCD, some people may spend hours performing such tasks (i.e., compulsions) every day. In such situations it can be hard for the person to fulfill their work, family, or social roles. In some cases, these behaviors can also cause adverse physical symptoms. For example, people who obsessively wash their hands with [antibacterial soap](http://en.wikipedia.org/wiki/Antibacterial_soap) and hot water to remove what they consider to be contamination can make their skin red and raw with [dermatitis](http://en.wikipedia.org/wiki/Dermatitis).[[](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-12)

 People with OCD can use rationalizations to explain their behavior; however these rationalizations do not apply to the overall behavior but to each instance individually; for example, a person compulsively checking the front door may argue that the time taken and stress caused by one more check of the front door is much less than the time and stress associated with being robbed, and thus the check is the better option. In practice, after that check, the person is *still* not sure and deems it is *still* better in terms of time and stress to do one more check, and this reasoning can continue as long as necessary.

**OCD without overt compulsions**

[Purely Obsessional OCD](http://en.wikipedia.org/wiki/Purely_Obsessional_OCD)

 OCD sometimes manifests without overt compulsions.[[14]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-13) Nicknamed "Pure-O",[[15]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-Hyman-14) OCD without overt compulsions could, by one estimate, characterize as many as 50 percent to 60 percent of OCD cases.[[16]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-15) Rather than engaging in observable compulsions, the person with this subtype might perform more covert, mental rituals, or might feel driven to avoid the situations in which particular thoughts seem likely to intrude.[[15]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-Hyman-14) As a result of this avoidance, people can struggle to fulfill both public and private roles, even if they place great value on these roles and even if they had fulfilled the roles successfully in the past.[[15]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-Hyman-14) Moreover, the individual's avoidance can confuse others who do not know its origin or intended purpose, as it did in the [case](http://en.wikipedia.org/wiki/Case_study) of a man whose wife began to wonder why he would not hold their infant child.[[15]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-Hyman-14)

 **Diagnostic Guidelines**

 For a definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics:

(a) they must be recognized as the individual's own thoughts or impulses:
(b) there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists;
(c) the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense);
(d) the thoughts, images, or impulses must be unpleasantly repetitive.

Includes:
\* anankastic neurosis
\* obsessional neurosis
\* obsessive-compulsive neurosis

**Differential Diagnosis**
 Differentiating between obsessive-compulsive disorder and a depressive disorder may be difficult because these two types of symptoms so frequently occur together. In an acute episode of disorder, precedence should be given to the symptoms that developed first; when both types are present but neither predominates, it is usually best to regard the depression as primary.

In chronic disorders the symptoms that most frequently persist in the absence of the other should be given priority.

Occasional panic attacks or mild phobic symptoms are no bar to the diagnosis. However, obsessional symptoms developing in the presence of schizophrenia, Tourette's syndrome, or organic mental disorder should be regarded as part of these conditions.

Although obsessional thoughts and compulsive acts commonly coexist, it is useful to be able to specify one set of symptoms as predominant in some individuals, since they may respond to different treatments

 **Management**

 According to a team of [Duke University](http://en.wikipedia.org/wiki/Duke_University_Hospital)-led psychiatrists, [behavioral therapy](http://en.wikipedia.org/wiki/Behavioral_therapy) (BT), [cognitive behavioral therapy](http://en.wikipedia.org/wiki/Cognitive_behavioral_therapy) (CBT), and [medications](http://en.wikipedia.org/wiki/Psychiatric_medication) should be regarded as first-line treatments for OCD.[[](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-Doctor-37) [Psychodynamic psychotherapy](http://en.wikipedia.org/wiki/Psychodynamic_psychotherapy) may help in managing some aspects of the disorder. The [American Psychiatric Association](http://en.wikipedia.org/wiki/American_Psychiatric_Association) notes a lack of [controlled](http://en.wikipedia.org/wiki/Scientific_control) demonstrations that [psychoanalysis](http://en.wikipedia.org/wiki/Psychoanalysis) or [dynamic psychotherapy](http://en.wikipedia.org/w/index.php?title=Dynamic_psychotherapy&action=edit&redlink=1) is effective "in dealing with the core symptoms of OCD.

**Behavioral therapy**

 The specific technique used in BT/CBT is called [exposure and ritual prevention](http://en.wikipedia.org/wiki/Exposure_and_response) (also known as "[exposure and response prevention](http://en.wikipedia.org/wiki/Exposure_and_response_prevention)") or ERP; this involves gradually learning to tolerate the anxiety associated with not performing the ritual behavior. At first, for example, someone might touch something only very mildly "contaminated" (such as a tissue that has been touched by another tissue that has been touched by the end of a toothpick that has touched a book that came from a "contaminated" location, such as a school.) That is the "exposure". The "ritual prevention" is not washing. Another example might be leaving the house and checking the lock only once (exposure) without going back and checking again (ritual prevention). The person fairly quickly [habituates](http://en.wikipedia.org/wiki/Habituation) to the anxiety-producing situation and discovers that their anxiety level has dropped considerably; they can then progress to touching something more "contaminated" or not checking the lock at all—again, without performing the ritual behavior of washing or checking.]

Exposure ritual/response prevention (ERP) has a strong evidence base. It is generally considered the most effective treatment for OCD.]Using ERP alone, one can become completely symptom free. However, the individual must be highly motivated and consistent.

It has generally been accepted that [psychotherapy](http://en.wikipedia.org/wiki/Psychotherapy), in combination with [psychotropic medication](http://en.wikipedia.org/wiki/Psychotropic_medication), is more effective than either option alone. However, more recent studies have shown no difference in outcomes for those treated with the combination of medicine and CBT versus CBT alone.

 More recent behavioral work has focused on *associative splitting*. It is a new technique aimed at reducing obsessive thoughts. The method draws upon the “fan effect” of associative priming:[[42]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-41) The sprouting of new associations diminishes the strength of existing ones. As OCD patients show marked biases or restrictions in OCD-related semantic networks (e.g., cancer is only associated with “illness” or “death”, fire is only associated with “danger” or “destruction”),[[43]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-42) they are encouraged to imagine neutral or positive associations to OCD-related cognitions (cancer = zodiac sign, animal, crab; fire = fireflies, fireworks, candlelight-dinner). First studies tentatively confirm the feasibility and effectiveness of the approach for a subgroup of patients.[[44]](http://en.wikipedia.org/wiki/Obsessive%E2%80%93compulsive_disorder#cite_note-43)

**Medication**

* [selective serotonin reuptake inhibitors](http://en.wikipedia.org/wiki/Selective_serotonin_reuptake_inhibitor) (SSRIs) such as [paroxetine](http://en.wikipedia.org/wiki/Paroxetine), [sertraline](http://en.wikipedia.org/wiki/Sertraline), [fluoxetine](http://en.wikipedia.org/wiki/Fluoxetine), [escitalopram](http://en.wikipedia.org/wiki/Escitalopram), and [fluvoxamine](http://en.wikipedia.org/wiki/Fluvoxamine) and the [tricyclic antidepressants](http://en.wikipedia.org/wiki/Tricyclic_antidepressant)
* The neurotransmitter [glutamate](http://en.wikipedia.org/wiki/Glutamate) or the binding to its receptors. These include [riluzole](http://en.wikipedia.org/wiki/Riluzole), [memantine](http://en.wikipedia.org/wiki/Memantine), [gabapentin](http://en.wikipedia.org/wiki/Gabapentin), [N-Acetylcysteine](http://en.wikipedia.org/wiki/N-Acetylcysteine), and [lamotrigine](http://en.wikipedia.org/wiki/Lamotrigine). [MDMA](http://en.wikipedia.org/wiki/MDMA), which is a powerful and illicit serotonergic drug, has also been anecdotally reported to temporarily alleviate the symptoms of OCD.
* newer [atypical antipsychotics](http://en.wikipedia.org/wiki/Atypical_antipsychotic) [olanzapine](http://en.wikipedia.org/wiki/Olanzapine), [quetiapine](http://en.wikipedia.org/wiki/Quetiapine), [ziprasidone](http://en.wikipedia.org/wiki/Ziprasidone), and [risperidone](http://en.wikipedia.org/wiki/Risperidone)
* **Experimental drug treatments**

The naturally occurring sugar [inositol](http://en.wikipedia.org/wiki/Inositol) has been suggested as a treatment for OCD as it appears to modulate the actions of serotonin and reverse [desensitisation](http://en.wikipedia.org/wiki/Desensitisation) of [neurotransmitter](http://en.wikipedia.org/wiki/Neurotransmitter) receptors.

[Nutrition deficiencies](http://en.wikipedia.org/wiki/Nutrition_disorder) may also contribute to OCD and other [mental disorders](http://en.wikipedia.org/wiki/Mental_disorder). [Vitamin](http://en.wikipedia.org/wiki/Vitamin) and mineral supplements may aid in such disorders and provide [nutrients](http://en.wikipedia.org/wiki/Nutrient) necessary for proper mental functioning.

* **Electroconvulsive therapy (ECT)**
* **Psychosurgery**

**NURSING MANGEMENT**

**Diagnoses Nursing Care Plans For Obsessive Compulsive Disorder**

* Anxiety
* Chronic low self-esteem
* Fear
* Ineffective coping
* Ineffective role performance
* Impaired social interaction
* Risk for injury
* Social isolation

**Key outcomes Nursing Care Plans For Obsessive–Compulsive Disorder**

* The patient will express feelings of anxiety as they occur.
* The patient will develop self-esteem.
* The patient will express fears and concerns.
* The patient will demonstrate effective social interaction skills.
* The patient will cope with stress without excessive obsessive-compulsive behavior.
* The patient will reduce the amount of time spent each day on obsessing and ritualizing.
* Ritualistic behavior won't produce harmful effects.
* The patient will maintain family and peer relationships
* Client is able to maintain anxiety at level in which problemsolving can be accomplished.
* Client is able to verbalize signs and symptoms of escalating anxiety.
* Client is able to demonstrate techniques for interrupting the progression of anxiety to the panic level.

**Interventions Nursing Care Plans For Obsessive–Compulsive Disorder**

* Approach the patient unhurriedly.
* Provide an accepting atmosphere; don't show shock, amusement, or criticism of the ritualistic behavior.
* Allow the patient time to carry out the ritualistic behavior (unless it's dangerous) until he can be distracted into some other activity. Blocking this behavior raises anxiety to an intolerable level.
* Keep the patient's physical health in mind. For example, compulsive hand washing may cause skin breakdown, and rituals or preoccupations may cause inadequate food and fluid intake and exhaustion. Provide for basic needs, such as rest, nutrition, and grooming, if the patient becomes involved in ritualistic thoughts and behaviors to the point of self-neglect.
* Let the patient know you're aware of his behavior. For example, you might say, I noticed you've made your bed three times today; that must be very tiring for you. Help the patient explore feelings associated with the behavior. For example, ask him, What do you think about while you are performing your chores?
* Make reasonable demands, and set reasonable limits; make their purpose clear. Avoid creating situations that increase frustration and provoke anger, which may interfere with treatment.
* Explore patterns leading to the behavior or recurring problems.
* Listen attentively, offering feedback.
* Encourage the use of appropriate defense mechanisms to relieve loneliness and isolation.
* Engage the patient in activities to create positive accomplishments and raise his self-esteem and confidence.
* Encourage active diversional resources, such as whistling or humming a tune, to divert attention from the unwanted thoughts and to promote a pleasurable experience.
* Assist the patient with new ways to solve problems and to develop more effective coping skills by setting limits on unacceptable behavior (for example, by limiting the number of times per day he may indulge in obsessive behavior). Gradually shorten the time allowed. Help him focus on other feelings or problems for the remainder of the time.
* Identify insight and improved behavior (reduced compulsive behavior and fewer obsessive thoughts). Evaluate behavioral changes by your own and the patient's reports.
* Identify disturbing topics of conversation that reflect underlying anxiety or terror.
* Observe when interventions don't work; reevaluate and recommend alternative strategies.
* Monitor effects of pharmacologic therapy.

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Somatoform Disorders**

**Definition**

* Somatoform disorders are characterized by physical symptoms, which suggest medical diseases, but without organic pathology to support the illness.
* It refers to all mechanisms by which anxiety is translated into physical illness.
* Somatoform disorders include somatization disorder.

**Types of Disorder**

1. **Somatization disorder**
* This chronic syndrome is characterized by multiple somatic symptoms that cannot be explained medically.
* The physical symptoms are associated with psychological stress.
1. **Conversion disorder**
* A loss or change in bodily function is the result of psychological conflict, allowing the client to resolve the conflict through loss of a physical function.
* The client often exhibits a lack of concern about the severity of the disease (la belle indifferences).
1. **Sleep disorder**
* This is characterized by difficulty initiating or maintaining sleep.
* Sleep disorders include hypersomnia or excessive sleepiness, narcolepsy, parasomnias, undesirable behaviors that occur during sleep.
* In sleep disorders, the sleep-wake schedule and circadian rhythm are disturbed.
1. **Hypochondriasis**
* This is a person’s unwanted fear or belief that he or she has a serious disease without significant pathology.
* Hypochondrias interferes with client’s work and social relationships.
1. **Body dysmorphic disorders**
* The client is preoccupied with an image defect in appearance when there is no abnormality.
* Client obsesses about imaged bodily defects (facial flaws, heavy buttocks or thighs) and becomes embarrassed about them.
1. **Pain disorder**
* The pain is unrelated to a medical disease.
* The individual experiences severe pain that is in disproportion to the originating source.

**Risk Factors**

 1. Gender: Female

 2. Age: Children and older adults

**Signs and Symptoms**

 1. Pain in the absence of organic pathology.

 2. Preoccupation with physical symptoms, disease, physical flaws, and oneself.

 3. Dependence on addictive substances for relief of pain that is unsubstantiated by physical findings.

 4. Frequent visits to health care providers.

 5. Symptoms of anxiety and/or depression.

 6. Hydrochondriasis is not a conscious decision on the part of the client; they believe that they are ill.

**Nursing Diagnoses**

* + Impaired adjustment
	+ Chronic pain
	+ Sleep pattern disturbance

**Nursing Interventions**

* Alternative therapeutic interventions may be used, such as therapeutic touch, imaging, and acupuncture.
* Assist the client in identifying and describing in stress he/she experiences.
* Assist the client in monitoring stress and knowing when to intervene.
* Teach the client about medications and to avoid alcohol and other such drugs used to alleviate stress approximately.
* Recognize medical problem.

**Complications**

* Risk to self and others.
* Dependency on addictive medications.
* Withdrawal symptoms related to discontinuation of sedatives, hypnotics, and narcotics

\*\*\*\*\*\*\*\*\*\*\*

**DISSOCIATIVE AND CONVERSIVE DISORDERS**

 It is charecterised by the presence of one / more symptoms suggesting the presence of neurological disorders that cannot be explained by any known neurological / medical disorder (Dissociative disorders of movement & sensation)

**CLINICAL FEATURES:-**

* Disturbance in the normally integrated functions of consciousness, identity / memory
* Sudden onset & disturbances is usually temporary
* Primary gain & secondary gain - Symptoms are produced because they reduced the anxiety of patient by keeping the psychologic conflict out of conscious awareness, a process called as **primary gain** & these symptoms of conversion are often advantageous to patient. Such advantage is called **secondary gain.**
* Physical examination & investigations do not any abnormality that can explain symptoms adequately.

**CLINICAL TYPES:-**

* Dissociative amnesia
* Dissociative fugue
* Dissociative identity disorder
* Trance & possession disorder
* Other Dissociative disorders

**DISSOCIATIVE AMNESIA**

 It is commonest type of Dissociative disorder occurring mostly in adolescent & young adults.

It is charecterised by a sudden inability to recall important personal information particularly concerning stressful / traumatic life events. During the amnesia period there may be slight clouding of consciousness. In the post amnesic period the awareness of disturbances of memory is present.

**TYPES:-**

* Circumscribed amnesia:- inability to recall present events during circumscribed period of time usually concentration with stress
* Selected amnesia:- inability / selective person’s events
* Continuous amnesia:-following the stressful events till present
* Generalized amnesia:- whole life in the face of stressful life events

**DISSOCIATIVE FUGUE**

 It is charecterised by episodes of wandering away. During the episodes the person usually adopts a new identity with complete amnesia for the earlier life.

**ONSET:** - it is sudden in severe stress. Termination is abrupt & is followed by amnesia for the episode. Sudden, unexpected travel away from home / work place.

**COURSE** is typically a few hours to days & sometimes months.

**Multiple personality disorders**

**(DISSOCIATIVE IDENTITY DISORDER)**

 In this disorder the person is dominated by 2/ more personalities of which only one is manifested at a time. Usually one personality is not aware of existence of other personalities. Each personality has a full range of higher mental functions & performs complex behavior patterns. Transmission from one personality to another is sudden & the behavior usually contrasts strikingly with the patient normal state. Both onset & termination of control of each personality is sudden.

**TRANCE & POSSESSION DISORDERS**

 It is charecterised by the control of personality by a spirit during the episodes. Usually the person is aware of existence of other. This is very commonly seen in India & certain African countries.

**OTHER DISSOCIATIVE DISORDERS**

**GANSER’S SYNDROME:-**

 Condition charecterised by giving approximate answers psychogenic physical symptoms hallucinations & apparent clouding of consciousness.

**CONVERSION DISORDER (DISSOCIATIVE DISORDERS OF MOVEMENT & SENSATION)**

* Dissociative motor disorder
* Dissociative anesthesia & sensory loss
* Dissociative convulsions (hystencal fits)

**CLINICAL FEATURES:-**

* Presence of symptoms / deficits affecting motor / sensory functions, suggesting a medical / neurological disorders
* Sudden onset
* Clear relationship between stress & exacerbation of symptoms
* Patient does not produce symptoms intentionally
* Secondary gain
* **DISSOCIATIVE MOTOR DISORDER:-**

 It is charecterised by motor disturbances like paralysis / abnormal movements. The paralysis may be a monoplegia, paraplegia / quadriplegia. Examination shows normal / voluntarily increased tone normal reflexes abnormal movement ranges from tremors, gait disturbances to convulsive movement. Movements either occur / increase when attention is directed towards them & may disappear when patient is watched unobserved.

* **DISSOCIATIVE ANESTHESIA & SENSORY LOSS:-**

 It is charecterised by sensory disturbances like hemianesthesia, blindness, deafness & glove & stocking anesthesia. Detailed examination shows absence of objective signs of particular illness & disturbances is usually based on patient’s knowledge of that illness.

* **DISSOCIATIVE CONVULSIONS (HYSTENCAL FITS):-**

It is charecterised by convulsive movements & partial loss of consciousness.

|  |  |  |
| --- | --- | --- |
| **CLINICAL POINTS** | **EPILEPTIC SEIZURES** | **HYSTERICAL FITS** |
| Aura (warning) | Usual | Unusual |
| Attack pattern | Stereotyped known clinical pattern | Purposive body movement absence of patient pattern |
| Tongue bite | Present | Absent |
| Incontinence of urine & feces | Can occur | Very rare |
| Injury | Can occur | Very rare |
| Place of occurrence | Any where | Safe places |
| Time of day | Anytime | Nervousness during sleep |
| Duration | 30-70 sec | 20-80 sec |
| Amnesia | Complete | Partial |
| Post-ictal confusion | Present | Absent |
| Neurological signs | Present | absent |

**CAUSES:-**

 Etiological theories of DCD:

* **Psychodynamic theory:-**

 Ego defense mechanisms involved are repression & conversion. Conversion / dissociation symptoms allow a forbidden wish / urge to be partially expressed but sufficiently disguised so that the individual does not have to face the unacceptable wish.

Fixation in early development at phallic stage

Sexual drive during adulthood / an event with sexual contact

Conflict over sexual drive with reactivation of anxiety at fixation point

Repression

Dissociation & conversion

Dissociation

Dissociative disorders

Relief from anxiety / primary gain

Conversion disorder

Primary defense mechanism

Not fully successful

In both

Either

Or

Conflict is converted into somatic symptom

A part of personality is dissociated from rest

* **Behavioral theory:-**

 According to this theory Dissociative symptoms are learned responses in the face of stress. First time symptoms may be learned from the surrounding environment. The development of symptoms brings about psychological relief by avoidance of stress & is thus secondary reinforced.

* **Biological theory:-**

 Conversion releases symptoms are seen in some cerebral cortex lesion, however these are only conversion symptoms & are not Dissociative disorders.

**TREATMENT:-**

* Positive clinical features
* Premorbid histrionic personality traits
* Physical examination to exclude organic causes.
* Behavior therapy (aversion therapy, operant conditioning)
* Psychotherapy with abreaction
* Supportive psychotherapy
* Psychoanalysis
* Drug therapy: short term benzodiazepam

**NURSING INTERVENTIONS:-**

* Monitor physician’s ongoing assessment & lab reports
* Identify primary & secondary gain
* Do not allow patient to use disability as manipulative tool if patient continues to focus on physical limitations
* Encourage patient to verbalize fears & anxieties
* Positive reinforcement for identification / demonstration of accurative adaptive coping strategies
* Identify specific conflicts that remain unresolved & assist patient to identify possible solution
* Assist patient to set realistic goals for future
* Help patient to identify areas of life situations that are not with in his ability to control
* Encourage verbalization of feelings related to inability