BIPOLAR AND RELATED DISORDERS

- Was under mood disorders

1) Bipolar I disorder- more than one manic episode (and may be) accompanied/alternate by major depressive episode. MDP
2) Bipolar II disorder- more than one major depressive episode accompanied by hypomanic episodes.
3) Cyclothymic disorder- more than 2 years (or 1 yr in children) of many episodes of hypomania and Mild/moderate depressive symptoms
4) Bipolar disorder not otherwise specified
5) Bipolar disorder due to substance/medication,
6) Bipolar disorder due to Another Medical Condition

- Bipolar disorder is a recurrent mood problem featuring one or more episodes of mania/hypomania or mixed episodes of mania and depression.
- Bipolar disorder is distinct from major depressive disorder by virtue of a history of manic or hypomanic (milder and not psychotic ie no delusions, no hallucinations,) episodes.
- Other differences concern the nature of depression in bipolar disorder. Its depressive episodes are typically associated with an earlier age at onset, a greater likelihood of reversed vegetative symptoms, more frequent episodes or recurrences, and a higher familial prevalence (mean onset age for bp1d is approximately 18yrs vs mid 20"s in bp11d).
- Another noteworthy difference between bipolar and non bipolar groups is the differential therapeutic effect of lithium salts and other mood stabilizers, which are more helpful for bipolar disorder.
- Between **25-50%** of patients in developed countries with bipolar disorders are estimated to attempt suicide with almost 15% of them succeeding/complete act.
- *A bridge between depressive disorders and scz spectrum + other psychotic disorders?

a) **Mania** is derived from a French word that literally means crazed or frenzied. The mood disturbance can range from pure euphoria or elation to irritability to a labile admixture that also includes dysphoria.

- Thought content is usually grandiose but also can be paranoid. Grandiosity usually takes the form both of overvalued ideas (e.g.,) and of frank delusions.
- Auditory and visual hallucinations complicate more severe episodes.
- Speed of thought increases, and ideas typically race through the manic person's consciousness. Nevertheless, distractibility and poor concentration commonly impair implementation.
- Judgment also can be severely compromised; spending sprees, offensive or disinhibited behavior, and promiscuity (so social to even strangers) or other objectively reckless behaviors are commonplace.
- Subjective energy, libido, and activity typically increase but a perceived reduced need for sleep can sap physical reserves. Sleep deprivation also can exacerbate cognitive difficulties and contribute to development of catatonia or a florid, confusional state known as delirious mania.
- **About 0.6 percent** of the adult population suffers from the type I form, and **0.3 percent** from the type II form. Episodes of mania occur, on average, every 2 to 4 years, although accelerated mood cycles can occur annually or even more frequently.
- The type I form of bipolar disorder is about equally common in men and women, unlike major depressive disorder, which is more common in women.
- >90% of people with a single manic episode go on to have recurrent mood episodes

b) **Hypomania-** By definition, an episode of hypomania is never psychotic nor are hypomanic episodes associated with marked impairments in judgment or performance. In fact, some people with bipolar disorder long for the productive energy and heightened creativity of the hypomanic phase.

- Hypomania can be a transitional state (i.e., early in an episode of mania), although at least 50 percent of those who have hypomanic episodes never become manic.
- Whereas a majority have a history of major depressive episodes (bipolar type II disorder), others become hypomanic only during antidepressant treatment.
- Despite the relatively mild nature of hypomania, the prognosis for patients with bipolar type II disorder is poorer than that for recurrent (unipolar) major depression.

- Women with bipolar disorder are also at increased risk for an episode during pregnancy and the months following childbirth.
- NB: Pts have decreased need to sleep but not insomnia, have appetite but no time to eat

***Etiology- BPS: For manic and hypomanic phases only, depressive phase same as depression*

***NT- ↓gaba (marked) while ↑glutamate, da, na, 5ht, dopamine (marked) & aspartate,*

*** Genetics very strong bp11d>bp1d>mdd*

*** Class B personalities (esp borderline have high risk), attachment/psychosocial*

*** Prev high y > low y countries?, singles>married*

*** Stress both negative and positive*

1) DSM-IV TR/V criteria for manic episode

A. A distinct period of ***abnormally and persistently*** elevated, expansive, or irritable mood and persistent increase in goal directed activity or energy ***lasting at least 1 week*** (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, ***three (or more)*** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree, represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (ie purposeless non goal directed activity)
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

- The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy or light therapy) should not count toward a diagnosis of bipolar I disorder unless they persist at a fully syndromal level beyond the physiological effects of that treatment.

- The bipolar features cannot be explained by a schizophrenia spectrum disorder or other psychotic disorder

2) DSM-IV TR/V criteria for Hypomanic episode

A. A distinct period of ***abnormally and persistently*** elevated, expansive, or irritable mood and increase in goal directed activity ***lasting at least 4 days***.

B. During the period of mood disturbance, ***three (or more)*** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree, represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

3. More talkative than usual or pressure to keep talking

4. Flight of ideas or subjective experience that thoughts are racing

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

- The mood disturbance is NOT severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, there are NO psychotic features.

- The episode is associated with an equivocal change in functioning uncharacteristic of the individual when not symptomatic. The disturbance in mood and change in functioning is observable by others

- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition (e.g., hyperthyroidism).

NB: In hypomania symptoms do not need admission or impair functioning & no psychotic features

3) DSM-IVTR/V Criteria for Major Depressive Episode

A. **Five (or more)** of the following symptoms have been present during the same **2-week** period and represent a change from previous functioning; **at least one** of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure (cardinal).

1. Depressed mood most of the day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, (as indicated by either subjective account or observation made by others) i.e. anhedonia

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

4. Insomnia or hypersomnia

5. Psychomotor agitation or retardation (observable by others, not merely subjective feelings or restlessness or being slowed down).

6. Fatigue or loss of energy

7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional, not merely self-reproach or guilt about being sick); reduced self esteem.

8. Diminished ability to think or concentrate, or indecisiveness (either subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

- The symptoms are not better accounted for by bereavement ie after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. In other losses if it persists for too long eg after financial loss, loss of natural disaster, serious medical illness/disability

4) Cyclothymia

- Cyclothymia is marked by hypomanic and depressive states, yet neither is of sufficient intensity nor duration to merit a diagnosis of bipolar disorder or major depressive disorder. The diagnosis of cyclothymia is appropriate if there is a history of hypomania, but no prior episodes of mania or major depression.
- Longitudinal follow up studies indicate that the risk of bipolar disorder developing in patients with cyclothymia is about 33 percent; although 33 times greater than that for the general population, this rate of risk still is too low to justify viewing cyclothymia as merely an early manifestation of bipolar type I disorder.

Diagnostic criteria for Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode. **Note:** In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No major depressive episode, manic episode, or mixed episode has been present during the first 2 years of the disturbance.

Note: After the initial 2 years (1 year in children and adolescents) of cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar II disorder and cyclothymic disorder may be diagnosed).

D. The symptoms in Criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

- Lifetime prevalence of 0.4-1%, male to female ratio of 1:1

INVESTIGATIONS/ DIFFERENTIALS in mania/hypomania phase

- Usually done with aim of ruling out other possible causes of manic/hypomanic episodes especially general medical conditions and drug/substance abuse.
- Together, bipolar disorders due to known physiological or medical causes may account for as many as ***5 to 15 %*** of all treated cases. They often go unrecognized until after standard therapies have failed.

a). Lab tests

- Thyroid function test- hyperthyroidism
- Adrenal function test- hyperadrenalism, phaeochromocytoma
- HIV/AIDS and other viral eg rabies,
- Malaria - Bs for mps etc
- Syphilis-neuro (GPI)
- Full haemogram
- Urine/blood drug of abuse screen- alcohol, stimulants, marijuana, anabolic steroids, etc
- Neurological diseases- epilepsy,TLE
- Other mental illnesses
- Medication/ drugs – **sympathomimetics** () -**antidepressants** eg tricyclics and non tricyclics
- Metabolites of neurotransmitters (dopamine) in urine, serum, CSF

NB; investigation for depressive phase is as for MDD investigations

b). Psychological tests, social (corroborative Hx)

TREATMENT in mania

- Approach to treatment is a Biopsychosocial one.
- Outpatient (hypomaniac) vs inpatient (maniac)- eg suicidal/homicidal, violent, destructive, not eating, catatonic, stupor, no insight, no social support, intercurrent severe medical illnesses

A) PHARMACOLOGICAL

I) Mood stabilizers;

- Carbamazepine, valproic acid/valproate, lamotrigine, gabapentine, lithium carbonate

II) Antipsychotics/neuroleptics;

- TYPICAL- eg chlorpromazine (largactil), haloperidol, stelazine
- ATYPICAL- eg risperidone, olanzapine, quetiapine
- *NB ; in depressive phase give antidepressants*

III) Others- used briefly in addition if necessary eg in agitation, anxious, aggressive, insomnia- benzodiazepines. Infection (antibiotics), hypoglycemia (dextrose)

NB: Reduce neuroleptics with improvements

B) PHYSICAL

- ECT - manic

C) PSYCHOLOGICAL

- Insight oriented psychotherapy
- Cognitive behavioral therapy
- Behavioral therapy
- Counseling
- Patient education
- Caretakers education on- the illness nature, treatment modalities, course and prognosis,
- Social support & follow up e.g. Clinics

NB; in treatment of bipolar disorders, mood stabilizers are the mainstay. They are used in combination with neuroleptics/antipsychotics or with antidepressants depending on clinical picture. The period of maintenance therapy is usually 1-2 years. The use of

antidepressants alone during depressive phases of bipolar disorder is not recommended due to risk of precipitating a manic episode.

When ok, continue with mood stabilizers (+/- antidepressants/antipsychotic) for 1-2 yrs

5) SIBPD, AMC induced BPD, Unspecified/Others

POST PARTUM DISORDERS- puerperal psychosis (peripartum disorders)

1) Post partum blues- normal phenomenon, up to 50% of women are affected. Self limiting lasts a few days. Feelings of tearful, fatigue, anxiety, irritability, low moods

2) Post partum depression- 10-20% of mothers, up to 6 months after delivery. Low moods, feels inadequate as a parent, sleep disturbed, obsessive thoughts of harming herself/baby.

Rx- antidepressants + psychotherapy

3) PP psychosis- Occurs in 2/1000 childbirths, 50% of the ladies have family history of "mood disorders".

Delusions, thoughts of harming baby/self, depressed, hallucinations, talking alot, aggressive

Most end up with mood disorders in future especially bipolar disorders.

- Onset is within days of delivery up to 8 weeks.

Etiology:

- Hormonal changes as main event (estrogen, progesterone)
- Genetics (relatives)
- Perinatal events eg infections; drug intoxication eg scoline; toxaemia; blood loss/anemia
- Recent life stressful events
- Primigravidas more at risk

Patient is a danger to self and baby, 5% commit suicide vs 4% commit infanticide.

There is an increased risk of recurrence in subsequent pregnancies

Rx -a psychiatry emergency thus admit

- Antidepressants ()
- Antipsychotics (chlorpromazine 100mg BD, Max 900mg in 3 divided doses; Haloperidol 5mg BD; Risperidone 1mg BD or 2mg BD; Olanzapine 10-20 mg)
- Mood Stabilizers (Carbamazepine/Tegretol 200mg BD, Max 1600mg in divided doses; S. valproate 500mg OD; Lithium)

- ECT (6-10 sessions)
- Psychotherapy to spouse and family
- (Group; Family; Social –precipitators and how they can be removed, occupation i.e. rehabilitation and habilitation)

NB. Rare cases of it reported in husbands/fathers

Bipolar myths

DEPRESSIVE DISORDERS

Defn- a group of psychiatric disorders whose main feature is an odd/peculiar, characteristic state of altered mood/ feelings. The common feature is presence of sad, empty or irritable mood accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. There mood is abnormal, distressing, persisting and is experienced by the individual or other people (affect). The sense of control is lost

TYPES/GROUPS

**1) Major depression (MDD)- severe, lasts at least 2 weeks

*2) Dysthymia/Persistent depressive disorder- low moods with other features for at least 2 years in adult or 1 year in children. The features don't meet criteria for major depression.

*3) Disruptive mood dysregulation disorder, mainly in childhood

4) Premenstrual dysphoric disorder

5) Substance/medication induced depressive disorder ie physiological effect not psychological

6) Depressive disorder due to another medical condition, e.g. endocrine disorders

7) Other depressive disorders (not specified vs specified - eg mild and moderate depression/ie depressive episode with insufficient symptoms; recurrent brief depression; short duration depressive episode)

* Must know

DEPRESSION (MDD)

Most African patients don't volunteer feelings of sadness, loneliness, guilt but instead they have/present with physical complaints eg headaches, muscle pains, joint pains, general malaise etc leading to numerous laboratory investigations, consultations and treatments. Many patients eventually believe that they are suffering from a serious incurable physical illness. Psychotic features (delusions, hallucinations) when present are usually congruent with depressed mood, self deprecation and negative anticipation of the future. EG-------- ----------

Clinical Depression versus Normal Sadness

At some time or another, virtually all adults will experience a tragic or unexpected loss, romantic heartbreak, or a serious setback and times of profound sadness, grief, or distress. Indeed, something is awry if the usual expressions of sadness do not accompany such situations so

common to the human condition— eg death of a loved one, severe illness, prolonged disability, loss of employment or decline in social status, or a child's difficulties,

What is called major depressive disorder (MDD), however, differs both quantitatively and qualitatively from normal sadness or grief. Normal states of dysphoria (a negative or aversive mood state) are typically less pervasive and generally run a more time-limited course. Moreover, some of the symptoms of severe depression, such as anhedonia (the inability to experience pleasure), hopelessness, and loss of mood reactivity (the ability to feel a mood uplift in response to something positive) only rarely accompany "normal" sadness. Suicidal thoughts and psychotic symptoms such as delusions or hallucinations virtually always signify a pathological state.

Nevertheless, many other symptoms commonly associated with depression are experienced during times of stress or bereavement. Among them are sleep disturbances, changes in appetite, poor concentration, and ruminations on sad thoughts and feelings. When a person suffering such distress seeks help, the diagnostician's task is to differentiate the normal from the pathologic and, when appropriate, to recommend treatment.

1) EPIDEMIOLOGY

-Depression affects 3% of men and 6% of women.

-The lifetime prevalence in men is 8-12% vs 20-26% in women. About 15-20% of people who experience an acute episode of depression will eventually develop a chronic depressive syndrome= mainly due to wrong diagnosis and wrong drug treatment.

--15% of patients with major/severe depression eventually commit suicide.

-In Kenya, ***10%*** of primary care out patients suffers from depressive illnesses vs ***15-20%*** in the inpatients (sometimes unnoticed).

-30% of Alcoholics drink because of depression. Alcohol only masks the illness while it worsens or leads to develop other multiple complications. At times depression occurs as a co- morbid illness in patients with chronic diseases eg HIV/AIDS, TB, Diabetes, cancer, hypertension, chronic dermatological diseases, arthritis etc.

- Anxiety is commonly co-morbid with major depression. About one-half of those with a primary diagnosis of major depression also have an anxiety disorder. The co-morbidity of anxiety and depression is so pronounced that it has led to theories of similar etiologies. Other common co-

morbidities include personality disorders. The depression also may alter or "scar" personality development.

Depression also has a deleterious impact on the economy, both in diminished productivity and in use of health care resources. In the workplace, depression is a leading cause of absenteeism and diminished productivity. Although only a minority seek professional help to relieve a mood disorder, depressed people are significantly more likely than others to visit a physician for some other reason. Depression-related visits to physicians thus account for a large portion of health care expenditures. Seeking another or a less stigmatized explanation for their difficulties, some depressed patients undergo extensive and expensive diagnostic procedures and then get treated for various other complaints while the mood disorder goes undiagnosed and untreated.

2) AETIOLOGY OF DEPRESSION (CAUSES?)

a) Biological

i) Genetic- increased risk of **2-10** times if a first degree relative has depression ie parents, siblings. – risk markedly increased if one twin has depression ie identical twins is 50% vs 20% in non identical twins.

ii) Biochemical- decrease of neurotransmitters in brain eg serotonin (5HT), noradrenalin, and dopamine. – neuroendocrine axis regulation dysfunction eg hypothalamus, pituitary, adrenal, thyroid (not to the level of hyperthyroidism), growth hormone, gonadal/testestorone, pineal gland/melatonin.

b) Psychosocial

i) Personality- anxious, fearful, insecure people or rigid, strict, orderly, uncompromising. (Avoidant, dependent, obsessive compulsive, histrionic)

ii) Losses- bereavement of spouse/parent, job, failed exams, quarrels with someone very close, failed relationship, business. Children not up to date as expected, serious physical illness,

iii) Other risk factors- age (mean of 40, women early 20-30), sex (2:1 female vs men), and marital status- married, divorced, widowed, separated, living alone. Religion- Christians more at risk, less in Catholics; unemployment; substance abusers; chronic general medical condition;. Socio-economic status?, Race/ethnicity?

3) CLINICAL FEATURES/ DIAGNOSIS- MDD

***Assessment: Diagnosis and Syndrome Severity

Major depressive disorder features one or more major depressive episodes, each of which lasts at least 2 weeks (DSM-IV TR/V). Since these episodes are also characteristic of bipolar disorder, the term "major[6] depression" refers to both major depressive disorder/unipolar and the depression of bipolar disorder.

The cardinal symptoms of major depressive disorder are depressed/low mood and loss of interest or pleasure.

Other symptoms vary enormously. For example, insomnia and weight loss are considered to be ***classic signs***, even though some depressed patients gain weight and sleep excessively.

Such heterogeneity is partly dealt with by the use of diagnostic subtypes (or course modifiers) with differing presentations and prevalence. For example, a more severe depressive syndrome characterized by a constellation of classical signs and symptoms, called melancholia (deep sadness or gloom), is more common among older than among younger people, as are depressions characterized by psychotic features (i.e., delusions and hallucinations) (DSM-IV). In fact, the presentation of psychotic features without concomitant melancholia should always raise suspicion about the accuracy of the diagnosis (vis-à-vis schizophrenia or a related psychotic disorder). The so-called reversed vegetative symptoms (oversleeping, overeating, and weight gain) may be more prevalent in women than men. Anxiety symptoms such as panic attacks, phobias, and obsessions also are not uncommon (as comorbidity).

Other auxiliary symptoms include-

a) Somatic- frequent headaches, other pains/aches, feeling of pressure/fullness in head, coldness feeling, heavy limbs etc

b) Undifferentiated symptoms of visceral origin- GI fullness/gas, noise, nausea, constipation,; CVS complaints/palpitations; sweating, burning sensation..RS amenorrhea, low libido

NB- commonest association of chronic pain is depression. Pain is the most common reason for a person to consult a doctor/ health professional.

The symptoms can also be grouped into 4 categories- mood/affect; thought/cognition; psychomotor activity; somatic.

** Psychotic features if present eg delusions (sin, poverty, imminent disaster/nihilistic); hallucinations (auditory-defamatory, accusatory; olfactory-rotting filth/decomposing flesh); are usually mood congruent.

DSM-IVTR/V Criteria for Major Depressive Episode

A. **Five (or more)** of the following symptoms have been present during the same **2-week** period and represent a change from previous functioning; **at least one** of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure(cardinal).

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day,(as indicated by either subjective account or observation made by others) i.e. anhedonia

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

4. Insomnia or hypersomnia

5. Psychomotor agitation or retardation (observable by others, not merely subjective feelings or restlessness or being slowed down).

6. Fatigue or loss of energy

7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional, not merely self-reproach or guilt about being sick). Reduced self esteem.

8. Diminished ability to think or concentrate, or indecisiveness (either subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- Never been in a manic/hypomanic episode; no schizophrenia spectrum
- The symptoms are not better accounted for by bereavement ie after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. In other losses if it persists for too long eg after financial loss, loss of natural disaster, serious medical illness/disability
- Severe/Major: $\geq$ 5 symptoms, Moderate: 3 – 4 symptoms, Mild: $\leq$ 2 symptoms

4) INVESTIGATIONS/ DIFFERENTIALS

Usually done with aim of ruling out other possible causes of depressive feelings; especially general medical conditions and drug/substance abuse.

a). Thyroid function test- hypothyroidism/myxoedema (has low mood, loss of appetite, fatigue)

. Adrenal function test- hypoadrenalism(Cushings disease/syndrome, Addison's),

. HIV ** and other viral infections eg infectious mononucleosis, influenza, viral pneumonia

. Malaria - Bs for mps etc

. Typhoid- widal?etc

. Full haemogram - chronic anemia

. Urine/blood drug of abuse screen- alcohol, amphetamines etc

. Neurological diseases- parkinsons, alzheimers, epilepsy- TLE rt, brain tumuors, cvs disease 2 years later.

. Other mental illnesses

. Medication/ drugs – ****anti hypertensives** (beta blockers eg inderal (propranolol); centrally acting eg aldomet, hydralazine, clonidine) -**sedative/hypnotics**eg long acting benzodiapines,

barbiturates, ethanol - ****steroids/hormones**eg prednisone, oral contraceptives, -**psychotropics/ antipsychotics** eg phenothiazines, butyrophenones -**stimulants/appetit**e suppressants eg amphetamines -**anti neoplastics**

. Metabolites of neurotransmitters in urine, serum, csf

b). Psychological tests- personality, intelligence, adhd, etc

. social tests-

Take a Comprehensive history, physical exam, neurological exam, routine lab tests, mental state examination.

5) TREATMENT

Approach to treatment is a Biopsychosocial one.

Outpatient vs inpatient- suicidal/homicidal, not eating, catatonic, stupor, no insight, no social support

A) PHARMACOLOGICAL

I) Antidepressants;

. TRICYCLICS- amitryptiline, imipramine,nortriptyline

. SSRI- fluoxetine, paroxetine, setraline, citalopram

. OTHERS- venlafaxine, mirtazapine, bupropion, valdoxan

II) Mood stabilizers can be added;

. Carbamazepine, valproic acid/valproate, lamotrigine, gabapentine, lithium carbonate

III) Others- used in addition if necessary eg in agitation, anxious, insomnia- benzodiazepines. Arcalion, rehydration- IVF, IV dextrose etc.

***1st sympyoms to clear are- poor sleep, appetite pattern

B) PHYSICAL

. ECT (Electoconvulsive therapy) .TMS (Transcranial magnetic stimulation)

. Others like phototherapy, vagus nerve stimulation, psychosurgery,

C) PSYCHOLOGICAL

. Insight oriented psychotherapy. Cognitive behavioral therapy. Behavioral therapy.

. Counseling .Patient psycho education and Caretakers education on- the illness nature, treatment modalities, course and prognosis, signs of suicidal tendencies,
- Social support and follow up eg clinics.

NB. Role of traditional healers/spiritual healers- due to belief that mental illness is caused by witchcraft or wicked people??, herbal therapy, ?

NB; It is recommended that depressed patients should continue with medication for 6-8 months after clearing of most of the symptoms/remission. Should relapse occur, treatment may need to be continued for at least 2 years

Dysthymia (persistent depressive disorder- PDD)

Dysthymia is a chronic form of depression. Its early onset and unrelenting, "smoldering" course are among the features that distinguish it from major depressive disorder.
Dysthymia becomes so intertwined with a person's self-concept or personality that the individual may be misidentified as "neurotic" (resulting from unresolved early conflicts expressed through unconscious personality defenses or characterologic disorders). Indeed, the onset of dysthymia in childhood or adolescence undoubtedly affects personality development and coping styles, particularly prompting passive, avoidant, and dependent "traits." To avoid the pejorative connotations associated with the terms "neurotic" and "characterologic," the term "dysthymia" is used in DSM-IVTR/V as a descriptive, or a theoretical, diagnosis for a chronic form of depression.
Affecting about 2 percent of the adult population in 1 year, dysthymia is defined by its subsyndromal nature (i.e., fewer than the five persistent symptoms required to diagnose a major depressive episode) and a protracted duration of at least 2 years for adults and 1 year for children. Like other early-onset disorders, dysthymic disorder is associated with higher rates of comorbid substance abuse.
People with dysthymia also are susceptible to major depression. When this occurs, their illness is sometimes referred to as ***"double depression,"*** that is, the combination of dysthymia and major depression. Unlike the superimposed major depressive episode, however, the underlying

dysthymia seldom remits spontaneously. Women are twice as likely to be diagnosed with dysthymia as men.

DSM-IVTR/V Diagnostic Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating

2. Insomnia or hypersomnia

3. Low energy or fatigue

4. Low self-esteem

5. Poor concentration or difficulty making decisions

6. Feelings of hopelessness

**During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

**Major depressive episode has been/not present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance may be accounted for by chronic major depressive disorder, or major depressive disorder, in partial remission.

**There has never been a manic episode, a mixed episode, or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

**The disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia spectrum and related disorder.

**The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

**The symptoms cause clinically

DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)

-A childhood/adolescent disorder

-Child with persistent irritability and frequent episodes of extreme behavioral dyscontrol (put under depressive disorders to avoid potential of over diagnosing BPD in children).

-They seem to develop unipolar depressive disorders or anxiety disorders rather than BPD as they mature into adolescence and adulthood

-Males>females unlike in BPD, MDD.

-Prevalence of 2-5% in pediatric mental clinics. Age 6yrs-18yrs

-Interferes with a child family and peer relationships, school performance. Suicidal ideas, attempts and aggression can occur

- Some may initially have had features of oppositional defiance disorder (ODD) and even dx, ADHD, Anxiety disorder (AD) but all present from a relatively early age (<6 years). Comorbidity rates with ODD very high. After 6 yrs OOD, ADHD or AD becomes DMDD.

a) Severe chronic/recurrent (irritability-anger or outbursts) temper outbursts manifested verbally and /or behaviorally eg aggression towards people/property that are grossly out of proportion in intensity or duration to the situation or provocation

b) The temper outbursts are inconsistent with development level

c) The temper outbursts occur on average at least 3 times/week

d) The mood outburst is persistently irritable or angry most of the day and is observable by parents, teachers, peers etc

e,f) Criteria A-D is present for at least 12 months, and no period of >3 months without the symptoms, Criteria A-D are present in at least 2 settings (home, school, with peers) and is severe in at least 1 of these

g,h) age of onset is before 10 years old. The dx should NOT be made for the first time before age 6 yrs or after age 18yrs

i) No distinct period of mania/hypomania

j) Not due to physiological effects of a substance/drug/medication/another medical condition

k) Not occurring exclusively during MDD, not better explained by another mental disorder eg autistic spectrum, ptsd, dysthymia BUT can be comorbid with mdd, conduct disorder, sud

***Recurrent brief depression-** depressed mood and at least 4 symptoms for 2-13 days at least once/month for last 12 months (not associated with menstrual cycle)

***Short duration depressive episode-** 4-13 days

***Depressive episode with insufficient symptoms-** mild, moderate

ALCOHOL-ethanol

Introduction:

- Mankind has lived with the use and abuse of Alcoholic beverages for a long, long time.
- It plays an important role in the social and religious life of many communities. Were done many centuries before Christ..
  ADVERSE EFFECTS DOCUMENTATION
- Knowledge prompted the Buddhists to prohibit its use in 6th Century B.C.
- And followers of Islam in the

Cont'd

- * Global status report on alcohol and health 2011 by WHO.--- 300,200 people btw ages 15-29 yrs die yearly from alcohol related causes (200,000 ten years ago).
- Approximately 20% of patients admissions in acute psychiatric admissions are due to alcohol. - 50% of RTA fatalities, worse in late evenings - 3rd largest health problem in USA after cardiac, cancer.
- **HIV prev of 19% in female drinkers vs 9% in non drinkers. 15% in alcohol users vs 8% national..-(2008)

Metabolism

- Alcohol is rapidly absorbed and distributed throughout all the tissues.
- 20% of alcohol is absorbed in the stomach.
- 80% of alcohol is absorbed in the small intestine enter into the bloodstream
- Solubility in water is 30 times greater than it is in fat. Men> women
- 90% is metabolized in liver
- Two to five per cent is eliminated unchanged through lungs and in urine.

Cont;d

- Amount of alcohol breathed out is directly proportional to the concentration in the blood.
- Food can retard absorption of alcohol and allows alcohol in the bloodstream to clear
- Breakdown of alcohol occurs at a set rate. Alcohol----ADH----acetaldehyde----- acetic acid-------AADH------ water + co2
- ADH- Alcohol Dhase, AADH- Acetylaldehyde Dhase. AADH rxn is the step limiting stage

cont’d

- Women absorb about 30% more alcohol than men
- They produce less alcohol dehydrogenase, in the stomach. Less enzyme in the stomach means more alcohol absorption into the blood. Men produce more
- Women have more body fat than men, alcohol is not stored easily in fat
- Women have proportionately less total body water than do men of equal weight, hence alcohol in women bodies is more concentrated
- Menstrual cycle: Alcohol is quickly absorbed during premenstrual phase. Hormones increase absorption
- Contraceptives: birth control pills quicken absorption.

Cont'd

- Genetic factors may protect some races from developing alcoholism
- Half of all Far East Asians produce low levels of alcohol dehydrogenase, an enzyme that help metabolize alcohol, they cannot tolerate even small amounts while Russians produce more
- Genetic factors may also predispose some people to alcoholism by influencing rates of absorption
- Carbonated drinks like sodas speed up absorption
- Water slows absorption rate
- Food also slows absorption

Acute or short term effects of alcohol

- Alcohol reaches most organs within minutes.
- Subjective effects are felt within 15 to 30 minutes.
- Effects are basically governed by the level of alcohol in the body and the strength of the drink. Concentrated drinks have faster effects than diluted ones.
- .Quick drinking rather than sipping drinks slowly . Drinking on an empty stomach lead to stronger and speedier effects.

Alcohol

- Progressively depresses many parts of the brain.
- Conspicuous effects are reflected in changes in
  - Mood
  - Judgement; and
  - Behaviour.

***Alcohol is not a stimulant

- General effects include: lowering of temperature, Impaired concentration, co-ordination, memory and judgment. These may result in accidents and risk taking behavior

Cont'd

- Dehydration
- Irritation of stomach and increased secretion of acid in the stomach
- Fall in blood sugar increased, leading to fainting (Inhibit gluconeogenesis).
- It may also cause rise in blood sugar (Inhibit insulin)
- Potentiating effects of tranquillizers
- Sexual desires are increased but performance is decreased
- Increased sleep but reduced quality (↓REM)

Effects of long term use/chronic use

Terminology used:

- Alcoholism
- Alcohol addiction
- Alcohol dependence
- Problem drinking.
- Alcohol use disorder- more than 2 symptoms in the last 12 month period (DSM V)

Cont'd

- They all suggest that the condition is chronic.
- The term alcoholic is over inclusive and vague but is preferred by Alcoholics Anonymous (A.A).
- Alcoholic addiction is claimed to imply moral and social judgments.
- Dependence is said to be too narrow and clinical.
- Furthermore all these four terms (Alcoholism, Alcoholic addiction, Alcohol dependence, alcohol use disorder) accepts that alcohol long term use is a disease.

Cont'd

- A relatively new term " Problem drinking" is being used to overcome the difficulties of (Alcoholism, Alcoholic addiction, Alcohol dependence)
- A problem drinker is any one who suffers from harm or causes harm to others due to the use of alcohol.

Cont'd

- The following are some of the more commonly observed indicators of dependence:
  - Fear of losing control
  - *Inability to feel "normal" without a certain amount of alcohol in the blood.
  - *Increasing preoccupation with and craving for the effects of alcohol and ensuring adequate supplies (compulsion)

Cont’d

- Realization of loss of control
- *Repeated minor withdrawal symptoms put right by use of alcohol, such as irritability, feeling shaky or anxious, etc.
- Increased episodes of not remembering events during drinking (lapses of memory)-blackout
- *Tolerance
- *Narrowing of repertoire (time between drinking sessions)

Alcohol related disorders

- Alcohol use disorder
- Alcohol intoxication
- Alcohol withdrawal
- Other alcohol induced disorders
- Unspecified alcohol related disorders

CAGE

- Cut-down, Annoyed, Guilty, Eye opener in the morning
- ≥2 is positive and require further assessment & classfication of severity & Mx
- 4 needs deeper assessment of the severity

Substance Use Disorders (*DSM-V Criteria*)

a) **Impaired Control over substance use:**

1) Drug taken in large amounts or over a longer period than was intended.
2) Persistent desire or unsuccessful effort to cut down or control substance use.
3) A great deal of time is spent in activities necessary to obtain the drug, use the drug or recover from its effects.
4) **Craving- intense desire or urge for the drug at any time or in env't where drug was previously used/obtained.

CONT

b) Social impairment:

5) Recurrent drug use resulting in a failure to fulfill major role obligations at work, school, home.

6) Recurrent drug use despite having persistent or recurrent social /interpersonal problems caused or exacerbated by effects of the drug e.g. arguments, fights with spouse, etc.

c) Risky use of substance:

7) Vital social, occupational or recreational activities are given up or reduced because of the substance. May withdraw from family activities/hobbies

8) Recurrent drug use in situations where its physically hazardous eg driving, machine operation.

CON'T

d) Pharmacological criteria

9) Drug use is continued despite knowledge of having a persistent or recurrent physical/ psychological problem that is likely to have been caused or worsened by the drug, e.g. alcohol & PUD.

10) Tolerance- need more or decreased effects of same quantity with continued use.

11) Withdrawal- signs and symptoms or by same/related drug taken to relieve or avoid withdrawal s & s.

- *Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: ≥6 symptoms (impaired control, social impairment, risky use, pharmacological criteria*)

Complications of alcohol use disorder:

a) Medical
b) Psychiatric
c) Social

a) Medical Aspects of Drug and Alcohol Use

- Disorders of every body system have been associated with alcohol use
- These include:

➢ GIT:

- Gastritis, gastric ulcers, gastric ca
- Liver disorders eg hepatitis, cirrhosis, ca
- Pancreatitis → DM, Steatorhea
- Carcinoma: Oropharnyx, larynx, oesophagus and liver

Cont”d

- CVS: Dilated Cardiomyopathy, arrhythmias, hypertension
- CNS: Peripheral neuropathy, Cerebral ataxia (reversible and benign)
- Hematology: Anemia
- Resp: aspiration pneumonia, infections
- Renal: RF, anemia, Ca
- Immunological: ISS
- Skin: worsens some skin conditions

Cont…

- **Reproductive**:
- Loss of libido, erectile dysfunction, infertility
- In Pregnancy:
- Fetal alcohol syndrome characterised by

(a) Mental retardation (intellectual disability)

(b) Growth retardation

(c) Microcephaly

(d) Craniofacial malformation

(e) Limbs and heart defects

b) SOCIAL COMPLICATIONS

- Individual, family, community, national
- Marital problems/domestic (family)
- Work problems/school (personal/individual)
- Legal problems- fights, sexual, steal, disorderly vagrancy - wandering about (community)
- Poor relations with others, personality deterioration
- **Suicide = 3-4 % (80 times that of general pop)

b) SOCIAL COMPLICATIONS…

- At individual level there is:
  - Personality deterioration
  - Some people lack sense of responsibility
  - In economic terms there is general reduction in income
- At family level:
  - Domestic violence is common and this may lead to separation and divorce
  - Children from such families develop serious emotional disorder usually leading to poor academic perfomance

b) SOCIAL COMPLICATIONS…

- At community level:
- High crime rates
- Indiscipline in school /colleges
- Road traffic accidents
- At national level:
  - There is a big burden of caring for substances dependent individuals
  - Such persons contribute to loss of many man hours through absentecism and repeated treatment for associated morbidity like depression and physical ailments
  - Road traffic accidents loss of lives , damage to properties

C) Psychiatric

1) Alcohol intoxication

- Recent ingestion
- Slurred speech, motor incordination, unsteady gait, nystagmus, impairment in attention and memory/blakcout (anterograde amnesia), inappropriate sexual or aggressive behavior, mood labiality, vomiting, impaired judgment, stupor/coma/death

Alcohol intoxication… (stupor, coma): Mx

- Admit
- ABC
- IVF, NGT, Catheterise
- Thiamine + Glucose, NO Diazepam
- NB: Dz can potentiate CNS depression leading to stupor, coma & death
- If aggressive & agitated, sedate with low dose:
  - Largactril IM not IV or
  - Haloperidol injection
  - PLUS a low dose anticonvulsant e.g. carbamazepine
- Anesthetic review
- No dextrose ? 40ml of 50D = 20g of dextrose

2) Withdrawal or Abstinence Syndrome

- The severity of the syndrome will vary with the degree of the dependence and from person to person.
- In its severe form it can be life threatening and 10% or more may die if untreated.
- Intercurrent medical illness
- Its main feature is marked excitation of the brain, and these symptoms begin to be evident from the third or fourth day of sudden abstinence.
- They are all more severe if the person is debilitated or has an acute infection.

Cont'd

- S & S starts 6 hrs after sudden cessation & peak at 2-3 days
- The Main features are:
  - Increasing in restlessness and agitation
  - Visible tremor of hands, especially when trying to use them
  - Marked apprehension ie worried, fearful, frightened

Cont’d

- Feeling of being persecuted and chased
- Seeing frightening creatures esp in the dark
- Confusion interspersed with short periods of lucidity
- Unpredictable mood – may be violent or suicidal.
- Raised temperature
- Profuse sweating
- Feels sick and unable to eat/no appetite
- Fits/ convulsions

Cont'd: Mx

- Benzodiazepines (Dz 10mg -reduce gradually for 3 weeks, i.e. 10mg → 8mg → 6mg)
- Carbamazepine (200mg BD or 400mg BD), not tapered.
- Thiamine (iv/im),
- Multivitamins (folate, pyridoxine, ascorbic acid)
- Fluids+ cho,
- In quiet well lit place (darkness increase hallucinations),
- Antipsychotics? Added in severe hallucinations, Largactil with an anticonvulsant
- Treat infections

Abstinence Syndrome

- Features of Delirium /Tremens:
  - Tremor * chlordiazepoxide/ diazepam
  - Autonomic overarousal
  - Clouding of Consciousness
  - Disorientation
  - Altered motor activity
  - Disorientation
  - Mood Instability
  - Illusions/ hallucinations * lorazepam
  - Delusions
  - Convulsions * diazepam

3) Alcoholic Hallucinosis

- Condition is characterized by a prolonged state of: auditory hallucinations and delusions:
  - Preservation or slight clouding of consciousness
  - Absence of distinct schizophrenic features such as formal thought disorder

Cont’d

- Hallucinations are in third person, derogatory
- Delusions are secondary
- The syndrome does not have a clear link with alcohol withdrawal
- ** benzo, nutrition + fluids, antipsychotics.
- Usually resolve within a week

4) Alcoholic Paranoia

- Distinctive feature is the combination of paranoid delusions with high alcohol consumption.
- Auditory hallucinations may be present
- Personality is well preserved
- Impotence is common in male alcoholics both as an immediate effect of alcohol intake and as a long-term result of hypogonadism, hence morbid jealousy/ delusions of infidelity. Heavy use of alcohol affects production and metabolism of testosterone – testicular atrophy, oligospermia and erectile impotence.
- Gynaecomastia from excess estrogens.

Cerebral Damage in Alcoholism

- Brain shrinkage – due to alteration with ventricular dilation of white matter.
- Neuronal damage in the cerebral cortex
- Subcortial dementia due to damage of nucleus basalis of Meysner hence cognitive impairment of alcoholism.
- Psychometric anomalies e.g impaired abstracting and problem-solving functions.

5) Wernicke-Korsakoff Syndrome

- Lesions are located in the medial areas of the base of the brain around the third ventricle, sylvian aqueduct and brain stem nuclei.
- Mamillary bodies are always affected. Medial dorsal of nucleus of the thalamus is also involved when memory loss occurs
- Hypothalamus, medulla, pons, fornix, cerebellum,

Cont’d

- Features include:
  - Mental changes/memory/confusion
  - Ataxia (8^{th} , vermis of c)
  - Ophthalmoplegia (3^{rd} ,6^{th} c nerves- horizontal nystagmus, lat ocular palsies, dev gaze)

6) Korsakoff's

- Features: ***memory loss***
  - Condition follows as a long-standing sequel of Wernicke's disorder
  - Amnesia of events occurring before and after the onset of illness

Cont'd

- Patients tend to conceal forgetfulness by confabulations
- Thiamine supplements are proposed as a preventive means for the Wernicke's Korsakoff's syndrome , oral/iv
- W- responds rapidly to large doses of thiamine 100mg tds *2/52..
- K- few fully recover, thiamine * 6/12 + stop alcohol use

7) Cerebellar Atrophy

- Presents as gait ataxia and nystagmus is rarely seen.
- The gait is wide-based and the patient may look drunk as he walks.
- CT Scan shows atrophy, which can be present before clinical signs.
- Treatment is abstinence from alcohol and vitamin supplements.
- Once established the syndrome is largely irreversible.

8) Subdural Haematoma

- Alcoholics are liable to develop subdural haematoma from head injury when intoxicated
  - Headache
  - Memory Impairment
  - Drowsiness and impairment of consciousness develop often in fluctuating manner
  - Papilloedema can be absent

Investigative Developments

- New techniques for investigations of cerebral structure and functions hold promise to deepen understanding of brain damage in alcoholism – e.g. magnetic resonance imaging (MRI) and CT scan reveals atrophy of the mammilary bodies in Wernicke's disease.
- Positron Emission Tomography (PET) and Single Photon Emission Tomography (SPECT) allow evaluation of ***cerebral metabolism, cerebral blood flow*** *and* ***neuroceptor system***

9) Pellagra

- Niacin- tryptophan deficiency (vit b3) 6 D? of- diarrhea, dermatitis, dementia, delirium, delirium t, death
- Also in malnutrition esp in prisoners
- ** Rx; B3 replacement

11) Disorders of Mood

- Substance misusers are prone to mood disturbances of depression and anxiety.
- Co morbidity of depression and alcoholism is commoner in women than in men.

Reasons for Coexistence of Alcoholic Dependence and Depression

- Loss of social supports, unemployment due to drink secondary alcoholism
- Pharmacological effects of alcohol
- Primary depressive disorder (but secondary alcoholism may then have its own course)
- *Alcohol misusers more likely to attend clinics if depressed

12) Fetal alcohol syndrome

- Leading cause of MR in the USA
- Alcohol inhibits intra uterine growth and post natal devt
- It impairs blood flow & tissue metabolism
- Women with abuse/ dependence have risk of 35% to get child with defects
- Microcephaly ; spinal cord defects; cranio facial malformations- palpebral fissure, philtrum, thin upper lip; limbs and heart defects; short adult stature and a range of maladaptive behaviors
- ** ethanol/metabolites, hormone imbalances

Other investigations

- A) BASIC
- Random blood sugar;
- Hemogram (Megaloblastic Anemia) + ESR;
- LFTs eg increase GGT, AST, ALT, CDT, albumin, bilirubin;
- CDT- used to help detect heavy ethanol consumption.
- Renal function test- uric acid;
- Urine/blood/breath toxicological/alcohol screen or concentration
- Lipid profile (↑LDL);
- VDRL, ELISA, BS for mps, PITC
- Radiological-abdominal ultrasound, barium meal, CXR, sxr, cat scan, MRI scan, pet scan, spect, testicular ultra sound.

B) PSYCHOLOGICAL TEST- Cont'd

- Intelligence test,
- Personality test:
- Projective tests (open –ended) e.g. Rorschach Inkblot, draw a person, sentence completion, animal metaphor,
- Objective tests (MCQ type), e.g. MMPI
- MMSE,
- Adult ADHD
- Done when there is an underlying disorder that predisposes to alcohol use

- C) SOCIAL-
- By social workers
- Home visit, corroborative history from school/ home/ relatives/ employer

TREATMENT

- A) PHYSICAL –
  diazepam/ lorazepam/ chlormethiazone or carbamazepine -
  multivitamins esp thiamine –
  rehydration and electrolyte imbalance -
  treat physical illness ie medical -
  treat psychiatric disorders **
  antabuse/ disulfiram (250-500mg) , flagyl (educate the caregiver on the effects- vomiting, severe headache, ↑BP- not the pt) **
  naltrexone -50mg od (reduces craving)
  **accamposate **topamax

Cont’d

- B) PSYCHOLOGICAL
  psychotherapy
  psychotherapy
  rehab)
  therapy (spouse- depression)
  counseling

-supportive
–insight oriented
– group therapy (daily on
–marital/family
*

CONT

- C)social
- Aa (run by recovered alcoholics in kenya)
- AL ANON (members of alcoholics families)
- AL TEEN (teenagers of alcoholic families)
- FAMILY SUPPORT

- D) PREVENTION-
- Primary- don’t start (more marks e.g. 13/20)
- Secondary- early rx
- Tertiary- Rx complications (habilitation vs rehabilitation)
- E) RELAPSE- is part of rx in alcoholics
- - 40-60% vs 30-50% in DM, 50-70% in HTN, 50-70% in asthma
- Relapse prevention= psycotherapy ,aa, medication

Blood Alcohol Concentration (BAC)

- The rate of alcohol metabolism in the blood is 0.25 to 0.30 ounce per hour (7-8.4g).
- Hour BAC Effects
- 1 drink 0.02 Relaxed, feels warmer
- 2-3 0.05 Decreased inhibition, impaired judgment
- 4 drinks 0.08 Legally drunk, impaired perception, slower resp
-
- 5 drinks 0.10 Slurred speech, slowed thinking, poor co-ord.

- NB: resp =response

Cont’d

- 7 drinks 0.15 vomiting, loss of balance
- less muscle control
-
- 9 drinks 0.20 double vision, memory
- loss, nausea, blackouts
- 14 drinks 0.30 Tremors,blackouts,
- lowered body temp.
- 18-22 0.40-0.50 difficulty breathing,
- And above possible coma, death

DRUG /SUBSTANCE USE DISORDERS

- Drug- substance when taken into a living body will alter ≥1 functions.
- Substance – a chemical when taken into a living body will alter ≥1 functions.
- Unsanctioned use- not approved by the society.
- Harmful use- use known to have caused tissue damage or mental illness.
- Psychoactive substance- chemical that produces emotional, cognitive or behavioral changes which may be desirable/pleasurable to user with adverse medical consequences and is socially unsanctioned.

Importance

- Alcohol/drug abuse is common
- Alcohol/drugs problems are often missed or undetected clinically or socially
- Overall impact on health
- Behaviors are changeable- learned & reversible
- Heavy socioeconomic burden

Primary barriers to detecting drug use disorders (DUDs)

- Assumption – well dressed, learned, eloquent pts are assumed no to be DUs
- Stigma of DUDs and addiction
- Afraid to discover a problem if u don't know how to Mx it
- Uncomfortable asking, the medic is also a DU
- Forgotten
- Think you don't have time
- CAGE Mx: Cut-down, Annoyed, Guilty, Eye opener in the morning
- ≥2 is positive and require further assessment of severity & Mx

CLASSES OF DRUGS OF ABUSE

- 1) Stimulants- amphetamines, meth amphetamines, dextroamphetamine/ khat/ephedrine + pseudo/ritalin/. *Cocaine- aka snow, pink, crack (most potent of cocaines)
- 2) Cannabis- 9THC, 3 forms- marijuana, hashish, oil cannabis.
- 3) Caffeine (grp of its own than in DSM IV- stimulants)
- 4) Alcohol…….
- 5) Opioids- heroine/opium, codeine, pethidine, fentanyl, morphine.
- 6) Hallucinogens- LSD/ectasy, PCP, mescaline, psilocybin
- 7) Inhalants- contain benzene derivatives, Hydrocarbons, Glue , Halothane,
- 8) Sedatives/ hypnotics/ anxiolytics- benzodiazepines, barbiturates, ketamine
- 9)Nicotine- tobacco, kuber, shisha ///anxiolytic, stimulant
  10) Others- steroids, laxatives/purgatives/diuretics,
- *Put here by DSM V

SUBSTANCE USE DISORDERS (*DSM-V*)

a) **Impaired Control over substance use:**

1) Drug taken in large amounts or over a longer period than was intended.
2) Persistent desire or unsuccessful effort to cut down or control substance use.
3) A great deal of time is spent in activities necessary to obtain the drug, use the drug or recover from its effects.
4) **Craving- intense desire or urge for the drug at any time or in env't where drug was previously used/obtained.

CONT

b) Social impairment:

5) Recurrent drug use resulting in a failure to fulfill major role obligations at work, school, home.

6) Recurrent drug use despite having persistent or recurrent social /interpersonal problems caused or exacerbated by effects of the drug e.g. arguments, fights with spouse, etc.

c) Risky use of substance:

7) Vital social, occupational or recreational activities are given up or reduced because of the substance. May withdraw from family activities/hobbies

8) Recurrent drug use in situations where its physically hazardous eg driving, machine operation.

CON'T

d) Pharmacological criteria

9) Drug use is continued despite knowledge of having a persistent or recurrent physical/ psychological problem that is likely to have been caused or worsened by the drug, e.g. alcohol & PUD.

10) Tolerance- need more or decreased effects of same quantity with continued use.

11) Withdrawal- signs and symptoms or by same/related drug taken to relieve or avoid withdrawal s & s.

- *Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: ≥6 symptoms (impaired control, social impairment, risky use, pharmacological criteria*)

Features associated with drug use disorders

- Route of administration- the quicker/faster the effects the better eg inj, drink on empty stomach, smoke, inhale, snout
- Duration of axn- most prefer short acting ones
- Age of onset- mostly in early 20's and 30's. alc dependence in 40's but earlier associated with conduct disorders, schooling problems, personality, other mental illnesses

Indicators of drug use disorder

1) Young people go to great lengths to conceal their abuse of drugs.
2) As adults employed, they continue to conceal the behavior to safeguard their jobs.
3) Need to be very close to them and alert to notice the signs and symptoms. **
4) Typical s & s is failure to fulfill major role obligation at work, school, college, home.

Cont”d

5) Injection sites on the body + scars, abscesses, thrombophlebitis,,, include hidden areas eg legs, ankles, groins, breasts, penis,
6) Disturbed behavior may suggest intoxication eg sleep disturbance, drowsiness, unsteady gait, slurred speech, aggressive behavior, hallucinations, pin point pupils in opioids, paranoid delusions,
7) Loss of property at home
8) Drugs that can be mind altering start disappearing from home

Cont”d

9) Asks for multiple repeated prescriptions for psychoactive drugs-feign illness
10) Withdrawal symptoms eg unexplained seizures, moodiness, sweating, agitation, restlessness, nausea/vomiting, runny nose for no medical reason,
11) Metabolites of substance in urine-
12) Unkempt appearance, indifference/ deterioration to hygiene and grooming
13) Unpleasant unknown smells but now frequent at home,

contd

14) Cover up scents eg air fresheners, incense, chewing mint gum, water bottles ?

15) Others- keeping to themselves, rapid change of friends/ first names/evasive, sudden unworthy laughter outbursts, early morning urgent leaving and return odd hours, hounding- requests to go out of work with reasons made to sound like it’s a matter of life and death

CAUSES OF DRUG USE DISORDER

- A) BIOLOGICAL FACTORS-
- -Role of genetics; Parents, relatives, twins identical/fraternal
  - Neurotransmitters eg dopamine, gaba, 5ht, ach, opioids like endorphins
- -Personality type eg antisocial, borderline, narcissistic, impulsive
-
- B) PSYCHOLOGICAL FACTORS–
- -Stress as a major cause ie imbalance between the demands of life and our ability to cope with them
- -Experimentation/Curiosity/Exploration,,
- - Role modeling by parents, celebs (social learning theory)

contd

- - Parenting style; authoritarian/dictatorial breeds rebellion vs laissez faire/carefree without direction – lack of love
  – instability/ inconsistency eg change of environments, marital conflicts
  – illness or death of a significant other/provider –other traumatic situations eg divorce/ dumped or jilted, disappointments/frustrations
  - cultural shock –freedom/ idleness
- - Chronic physical illness, handling too much money

contd

- C) SOCIAL FACTORS
- –search for peer approval or acceptance
  –culture eg muratina, mnazi, busaa. ‘Naming of children ceremonies’
- – lax law enforcement; police, courts, - advertisements and marketing which glamorize drugs, models, competitions - availability & accessibility e.g. working in bars, home
- -extreme poverty & lack of family support
- Role of “traditional African woman”

contd

- d) SPIRITUAL FACTORS – trying to connect with a higher power, fill a void inside, hunger for divinity? cults/elders, bhang smoking vs Rastafarians?

COMPLICATIONS OF DRUG USE DISORDERS

- 1) PHYSICAL- MEDICAL
- 2) PSYCHOLOGICAL / PSYCHIATRY
- 3) SOCIAL

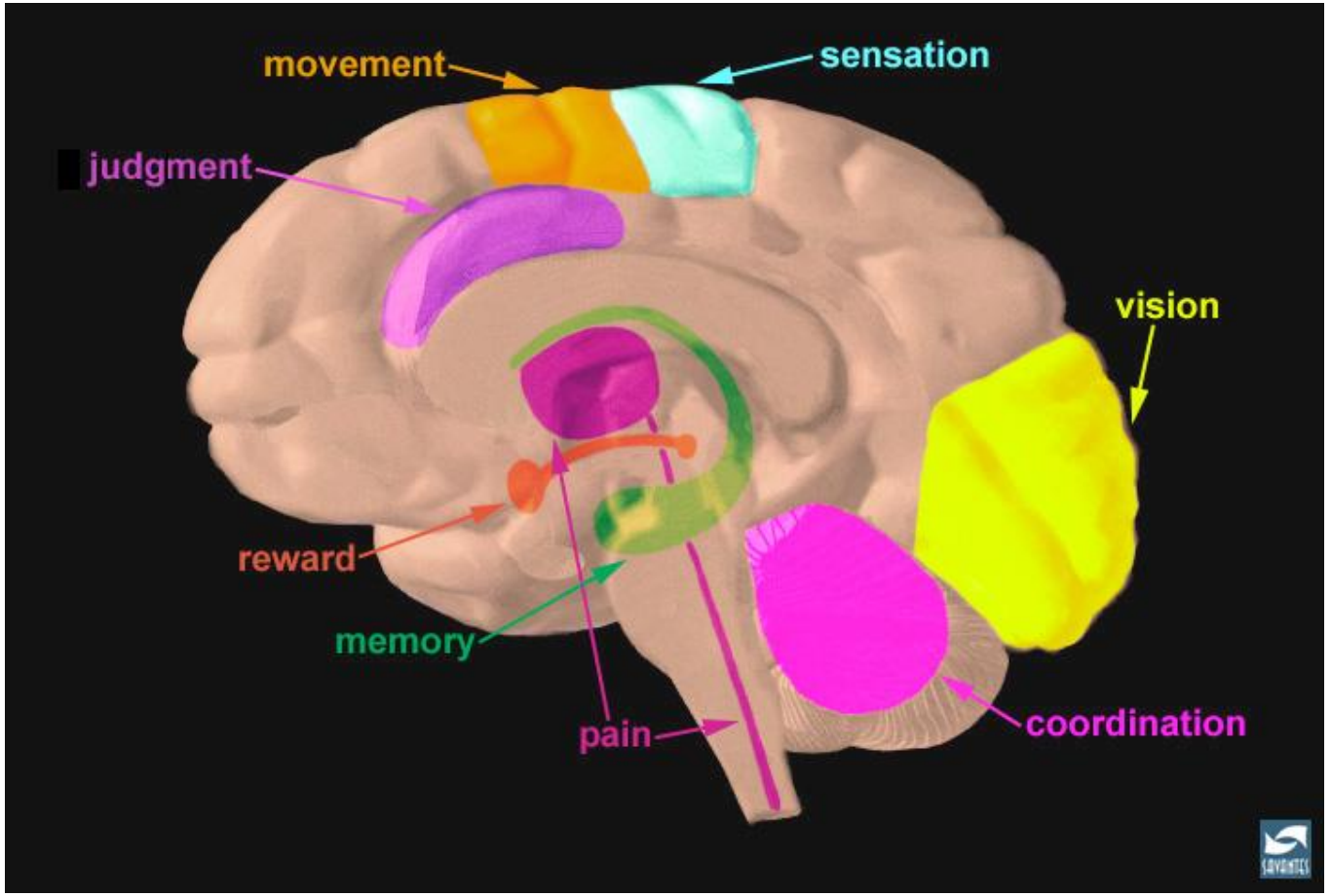
DRUG DEPENDENCE/ADDICTION

- - A chronic brain/ physical illness - Manifests as a compulsive behavior - Has social components
  - Can be prevented/treated

***BRAIN REWARD PATHWAYS, CENTRES, CIRCUITS

- MIDBRAIN; nucleus accumbens, ventral tegmental area, thalamus, locus ceruleus (prefrontal cortex influence for control vs amygdala, hippocampus for memory)
- **Gambling, Sex, …

brain


movement
sensation
judgment
vision
reward
memory
pain
coordination

Why importance?

- - Alcohol/drug abuse is common
- - A/drug problems often missed or undetected
- - A/drug abuse impacts overall on health
- - Behaviors are changeable
- - Heavy socioeconomic burden

Primary barriers to asking

- - Assumptions about patient
- - Stigma of A/drug abuse/addiction
- - Uncomfortable asking
- - Afraid to uncover a problem
- - Forgot
- - Think you don’t have time
- ** C.A.G.E

Catha edulis (Khat/Miraa) - Amphetamines

- -It has psycho stimulant effect (psychoactive + sympathomimetic)
- -Main chemical component is cathinone, tannins and norephedrine
- * When taken it produces- euphoria, suppress appetite and hunger, makes one alert. Thus used for relaxation, to facilitate communication at social events, suppress sleep and fatigue in work situations.
- -At times used combined with other substances eg alcohol, nicotine/tobacco,
- -Can cause physical/physiological dependence (addiction) hence tolerance, withdrawal
- 1) medical effects
- -Oral complications (mouth ulcers, mucosal discoloration)
- -Dental complications (discoloration, fluorosis, gingivitis)
- -GIT =gastritis, constipation, ischemic colitis

CONT

- CVS- myocardial infarction, severe hypertension, cerebrovascular disease
- Rep = erectile dysfunction, spermatorrhoea, pregnancy- low bwt, smaller head circumference, growth retardation *
- 2) Psychiatric effects/complications
- a)Amphetamine intoxication- rare with khat as it is absorbed sublingually, common in injectable ones
- *problematic change in behavior/psychological- euphoria or affect blunting; changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension or anger ;impaired judgment; impaired social or occupational functioning; hallucinations may occur-auditory, visual, tactile
- **tachycardia or bradycardia; pupillary dilatation; elevated or lowered blood pressure; perspiration or chills; nausea or vomiting; evidence of weight loss; psychomotor agitation or retardation; muscular weakness, respiratory depression, chest pain or cardiac arrhythmias; confusion, seizures, dystonia or coma (2 or more of above may develop).
-

CONT

- b) Amphetamine withdrawal (depressive like/ ‘crash”)
- Occurs after cessation of use or reduction after prolonged use/dependence, peak in 2-4 days after cessation of use and resolve after 1 week
- Lead to impaired functioning
- **Dysphoric mood + at least 2 of the following- Fatigue; vivid, unpleasant dreams; insomnia or hypersomnia; increased appetite; psychomotor agitation or retardation; others-headache, profuse sweating, muscle cramps, stomach cramps (bradycardia is prominent feature)

Con;t

- c) Psychotic induced disorder
- *Has a lot of clinical similarity to features in paranoid schizophrenia.
- -Paranoia as main hallmark
- -Visual hallucinations –appropriate affect –hyperactivity –hypersexuality –confusion and incoherence -delusions
- NB: Clinically amphetamine induced psychotic disorder can be indistinguishable from scz but the resolution of symptoms in a few days/urine findings of metabolites can differentiate

- 3). Social effects
- Stealing, etc

Cocaine-

- *Medical effects*
- IV- thrombophlebitis, hepatitis, abscesses, HIV/STDs,
- Intranasal- sinusitis, bleeding of nasal mucosa, septum perforation, respiratory problems eg coughing, bronchitis, pneumonitis…
- CVS: MI, palpitations, arrhythmias stroke, seizures,….
- In pregnancy- abruptio placenta, premature Labor, low bwt

CANNABIS SATIVA

- ***Aka,*** marijuana, bhang, hashish, hemp, ganja, dagga/, grass, weed, pot, tea, mary jane,
- Has many active ingredients eg 9THC, (psychoactive-tetrahydrocannabinol)
- Chewed leaves/seeds, smoked, leaves also boiled with water and taken as tea (the world's most commonly used illicit drug)
- ***Effects/intoxication*** - mild sedation, stimulation, euphoria, anxiety. – gives a feeling of relaxation and well being –energy – slowed sense of time – grandiosity, inappropriate laughter
- sharpened sensory awareness (eg colours seem brighter than in past, reveals new details) –delusions and illusions, hallucinations (not common unless with high potent doses but paranoid ideation is common)
- –increased heart rate/tachycardia -red eyes/conjuctiva – dry mouth – increased appetite

contd

- -may also lead to impaired motor coordination (can last 8-12 hours after use and can interfere with motor/machine operations), impaired judgment, derealization or depersonalization.. It is fat soluble, thus longer duration
- -3-4hrs duration in smoked but longer 12-24 hrs in ingested orally
- ***withdrawal***
- Onset 24-72hrs after stopping use in chronic, peak within 1 week and lasts max 2 weeks, occurs in 30-90%, symptoms not usually severe to warrant medical attention (unlike in alcohol, opiates,)
- -> of the following: -irritability, anger, aggression –nervousness/anxiety, restlessness – sleep disturbance eg insomnia, dreams –decrease appetite, wt loss –depressed mood
- ->1 of physical symptoms: - abdominal pains – tremors/shaking – sweating-fever-chills - headache

CONT

- Chronic and heavy use may also lead to lung diseases + cancers, amotivation syndrome, interference with male reproduction functions.
- Amotivation syndrome- unwillingness to persist in a task (school, work or any setting that requires prolonged attention). Person is apathetic and anergic, usually gains weight and appears slothful- *dysthymia like*
- ** cannabinoids are fat soluble- can persist in body fluids for extended periods of time and are excreted slowly
- * No withdrawal symptoms
- **Nausea due to chemotherapy, multiple sclerosis, chronic pain (eg migraine, fibromyalgia, cancer, arthritis), glaucoma, AIDS, Parkinsons disease, PTSD, (USA California and colorado states, Israel) --cbd (antiinflammatory cannabidiol) Uruguay
-

OPIOID RELATED DISORDERS

Heroin, methadone, morphine, pethidine, fentanyl, codeine

- -taken oral, injection (iv,sc), snorted intranasally,
- **C/F- euphoric high/rush, feeling warm, heaviness of extremities, dry mouth, itchy face esp the nose, facial flushing. Initial euphoria is followed by a period of sedation (nodding off). Can cause respiratory depression (brainstem)
- a) Opioid intoxication
- -initial euphoria followed by apathy, dysphoria; psychomotor agitation/retardation; impaired judgment
- -pupillary constriction (or dilatation due to anoxia from severe overdose)
- -drowsiness/coma –slurred speech –impairment in attention and memory
- - can have perceptual disturbance

cont

- b) Opioid withdrawal
- Substances with short duration of action tend to produce short, intense withdrawal syndromes while long action substances produce prolonged but mild withdrawal syndromes.
- **Heroine and morphine ws begins 6-8 hours after last dose usually after >1 week period of continuous use. Ws reach peak intensity during 2-3rd day and subside in next 7-10 days.
- -dysphoric mood/irritable/depressive/restlessness; nausea/vomiting ; muscle cramps, bone aches; lacrimation or rhinorrhoea; pupillary dilation, piloerection (goose flesh), sweating ; diarrhea; yawning; insomnia; increased BP, tachycardia, fever (temperature dysregulation with hyper/hypothermia).
- Residual symptoms eg insomnia, temp dysregulation, bradycardia and craving for opioids may persist for months after withdrawal…. Injection to clear ws??

cont

- c) Opioid induced- psychotic disorder, mood disorder, delirium, sleep disorder, sexual dysfunction
- -- Overdose treatment- ensure adequate airway; tracheopharyngeal should be aspirated and airway may be inserted/mechanical ventilation. Give naloxone iv (opioid antagonist), naltrexone
- -- Heroine withdrawal and detoxification; use of methadone oral 20-120mg od.+ clonidine 0.1-0.3mg tds. Methadone also for maintenance (frees from opioid dependence and hiv risk, has minimal euphoria and rarely causes drowsiness/depression, help patient re engage in useful activities).. Psychotherapy- individual, behavioural, cogn beh, family therapy, support groups (NA), social skills training
-

NON-SUBSTANCE RELATED DISORDERS

- ***Gambling Disorder 312.31 (F63.0)***
  - **Gambling behavior leading to significant impairment or distress as indicated by four or more criteria within a 12 month period**
    - Need to gamble with increasing amounts of money
    - Restless and irritable when try to cut down or stop
    - Repeated unsuccessful efforts
    - Preoccupation
    - Gambles when feeling distressed
    - "Chases" one's losses
    - Lies
    - Jeopardizes relationships
    - Relies on others for money to relieve desperate financial situations
  - **Not explained by manic episode**

ANXIETY DISORDERS

Anxiety- a state of tension and apprehension with hyper activity of the autonomic nervous system as a natural response to perceived threat.Fear- emotional response to real or perceived imminent threat

In AD, intensity and frequency of anxiety responses is out of proportion when compared to situations that trigger them.

AD have 3 components; cognitive, physiological, behavioral

1. Behavioral responses- characterized by avoidance of certain situations and impaired task performance

2, Cognitive component-there is subjective feeling of apprehension, a sense of impending danger and a feeling of inability to cope

3. Physiological responses- eg increased heart rate, blood pressure, excessive sweating, rapid breathing, dry mouth, muscle tension, frequent urination, diarrhea etc

*Classification/groups of AD

1. Separation anxiety

2. Selective mutism

3. Phobic disorders-agoraphobia, specific phobias, social phobia

4. Generalized anxiety disorder

5. Panic disorder

6. Anxiety disorders secondary to another medical condition

7. Anxiety disorders due to substances/medications eg alcohol, cannabis, amphetamines, caffeine, opioids,

- arranged developmentally with disorders sequenced according to the typical age at onset

**Aetiology-- BPS

1. SEPARATION ANXIETY DISORDER

There is developmentally inappropriate and excessive fear or anxiety concerning separation from those whom the individual is attached, evidenced by at least three of the following

- Recurrent excessive distress when anticipating/experiencing separation from home or from major attachment figures

- Persistent and excessive worry about losing major attachment figures or about possible harm to them eg illness, injury, disasters, death

- Persistent and excessive worry about experiencing an untoward event (eg being kidnapped, having an accident, getting lost, becoming ill) that causes separation from major attachment figure

- persistent reluctance or refusal to go out, away from home, to school/work/elsewhere due to fear of separation

-persistent and excessive fear of or reluctance about being alone or without major attachment figures at home/in other settings

-persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure

- repeated nightmares involving the theme of separation

- repeated complaints of physical symptom e.g. headaches, nausea, stomachaches, vomiting etc when separation from major attachment figures occurs or is anticipated.

NB; the fear/anxiety/avoidance is persistent lasting at least 4 weeks in children/adolescents and at least 6 months in adults. The disturbance causes clinically significant distress/impairment in social, academic, occupational or other areas of functioning. The disturbance is not better explained by another mental disorder eg autistic spectrum (with resistance to change), psychotic disorder

Prevalence decreases from childhood thro adolescence and adulthood. Its most prevalent anxiety disorder in children <12 yrs old

High co morbidity with gad and specific phobias in children vs specific phobias, ptsd, panic disorder, gad, ocd, personality disorder, mood disorders in adults

Rx- biological, psychological, social therapies

2. SELECTIVE MUTISM

A relatively rare disorder. When encountering other individuals in social interactions, children with sm don't initiate speech or reciprocally respond when spoken to by others. Sometimes they may use nonspoken/non verbal means eg pointing, grunting or writing to communicate. The child may also have excessive shyness, fear of social embarrassment, social isolation, clinging, temper tantrums.

Onset is usually before age 5yrs but may not be diagnosed easily until entry to school ie increased social interaction. Most outgrow the problem

-consistent failure to speak in specific social situations in which there is an expectation for speaking eg school despite speaking in other situations

-the disturbance interferes with educational/occupational achievement or with social communication

-duration of at least one month

-failure to speak is not due to lack of knowledge, or comfort with the spoken language required in social situation

-not better explained by a communication disorder, autism, scz and other psychotic disorders

* may eventually face social isolation, deteriorating academics standards, personal needs not met, teasing by peers

*high co morbidity with social anxiety disorder, separation anxiety disorder, specific phobia

3. SPECIFIC PHOBIA

Phobia-A pathological persistent irrational fear/exaggerated occurring in particular situations and leading to avoidance of the feared situation or object. In children the fear may be expressed as crying, clinging. The fear/anxiety or avoidance is persistent typically lasting at least 6 months (flexible) and causes clinically significant distress/impairment in social, occupational or other areas of functioning. Usually the fear cannot be explained by symptoms of another mental disorder eg ptsd, ocd, separation anxiety disorder

Claustraphobia- closed places, Ailurophobia- cats, Acrophobia- high places

Xenophobia- strangers, Needle phobia- persistent intense pathological fear of receiving an injection

Others- fear of blood, invasive medical procedures, natural envt (heights, storms, water), situational (airplanes, elevators, enclosed places), animals (cats, spiders, dogs etc)

NB; its common for an individual to have multiple specific phobias

Females>males 2:1, USA, Europe prevalence of 6-9% but lower in Africa, Asia, Latin America 2-4%, rates lower in older individuals than in children/adolescents, most develop in early childhood esp before age 10yrs

Co morbidity with depression in adults, other anxiety disorders, substance related disorders, personality disorder esp dependent. Suicide risk up to 60% more than general pop

4. SOCIAL ANXIETY DISORDER (social phobia)

- marked fear/anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Includes social interactions (eg meeting unfamiliar people, having a conversation), being observed (eg drinking, eating), performing in front of others (eg giving a speech)

- The person fears that may act in a way or show anxiety symptoms that will be negatively evaluated (humiliating, embarrassing, lead to rejection or offend others)

-the social situations almost always provoke fear/anxiety and are avoided or endured with intense fear/anxiety, fear is out of proportion to the actual threat posed by the social situation and to the sociocultural context

- The fear/anxiety or avoidance is persistent typically lasting at least 6 months and causes clinically significant distress/impairment in social, occupational or other areas of functioning. Usually the fear cannot be explained by symptoms of another mental disorder eg panic disorder, body dysmorphic disorder, autistic spectrum or substance of abuse

*individual may be inadequately assertive or excessively submissive, may show overly rigid body posture or inadequate eye contact or speak with an overly soft voice, may be withdrawn or shy, less open in conversations and disdose little about themselves

*associated with elevated rates of school dropout and decreased employment, work productivity, socioeconomic status and quality of life. Also associated with being single, unmarried/divorced and with not having children especially among men

*often comorbid with other anxiety disorders, major depression, substance use disorders

5. AGORAPHOBIA

Marked fear/anxiety in at least two of the following situations

-using public transport (eg automobiles, buses, trains, planes, ships)

-being in enclosed places (eg shops, theatres, cinemas)

-being in open spaces (bridges, marketplaces, parking lots)

-Being outside of the home alone –standing in line or being in a crowd

One fears/avoids these situations due to thoughts that escape might be difficult or help might not be available in event of developing panic like symptoms

The situations provoke anxiety and are actively avoided or require a companion or are endured with intense fear. Fear is out of proportion to the actual threat posed by the situation and to the sociocultural context.

The fear/anxiety or avoidance is persistent typically lasting at least 6 months and causes clinically significant distress/impairment in social, occupational or other areas of functioning. Usually the fear cannot be explained by symptoms of another mental disorder eg ptsd, body dysmorhic disorder,ocd, separation anxiety disorder

*severe form can cause individual to become completely home bound and dependent on others for services or assistance to provide even basic needs. Demoralization, depressive symptoms, other anxiety disorders and substance abuse are common (eg alcohol, sedatives as inappropriate self medication)

6. GENERALISED ANXIETY DISORDER (GAD)

-There is a persistent, generalized and excessive feeling of anxiety **not matched** to any particular specific situation but rather caused by a general tendency to worry excessively about a lot of things.

-The anxiety may last for months with signs present almost continuously. The excessive anxiety and worry occurring more days than not for at least 6 months

-There is a sense of impending danger/disaster, though not specific

- There may be signs of autonomic system hyper arousal

-Typical worries include; excessive worries about work, social performance, exaggerated concern about finances, the possibility of becoming sick or being involved in something bad eg an accident.

-The person finds it difficult to control the worry. The anxiety/ worry/physical symptoms causes clinically significant distress or marked impairment in social, occupational or other vital areas of functioning

**Common symptoms of GAD include

- muscle tension,, trembling, shortness of breath, sweating, palpitations –nervousness, restlessness, feeling jittery, tense and constantly on the edge - poor concentration/mind going blank and difficulty in making decisions –irritability –easily fatigued - sleep disturbance (have <u>at least 3</u> of the symptoms)

R/o amc eg hyperthyroidism, pheochromocytoma; substances of abuse; social anxiety disorder; ocd

7. PANIC DISORDER

In most cases panic attacks occur in the absence of any identifiable stimulus

-Symptoms of panic attacks can be terrifying and distressing and may last a few minutes or longer. The symptoms (at least 4) create intense fear/discomfort and develop abruptly reaching peak within minutes

-The unpredictability of PA makes them mysterious and terrifying

-Many people with PA develop agoraphobia (fear of public places) for fear of getting an attack in public. Tend to appear in late adolescence or early adulthood (mid 20's), more frequent in females

**Common symptoms of panic attack include;

-Palpitations, pounding heart or accelerated heart rate

-Sweating -Trembling or shaking,

-Sensations of shortness of breath or smothering

-Feeling of choking -Chest pain or discomfort/tightness

-Nausea or abdominal distress

-Feeling dizzy, unsteady, lightheaded or faint,

-Derealisation/depersonalisation

-Fear of losing control or "going crazy"/ difficulty in speaking, urge to flee

-Fear of dying -Chills or heat sensations/hot flushes

-Paresthesias (numbness or tingling sensations)

Attacks may be followed by persistent concern about having another PA or their consequences eg losing control, heart attack,. Can also lead to maladaptive change in behavior related to the attack (eg avoid having panic attacks, avoid exercise, unfamiliar situations)- for at least 1 month

R/o amc eg hyperthyroidism, pheoch, cardiopulmonary disorders (heart attack/mi,asthma, mv prolapse); substances of abuse, epilepsy, hypoglycemia. Do standard physical exam,lab tests and scans eg fhmg, lft, rbs,u/e,tft, ecg, cxr, drug screen

*excessive intake of caffeine/nicotine may worsen symptoms

*20-40% have alcohol/other drug dependence

MANAGEMENT OF ANXIETY DISORDERS (Principles)

-Rule out organic or physical pathology, depressive disorder and substance abuse

-Educate about the nature of any of the anxiety disorders according to the individuals needs

-Provide training in strategies to control anxiety symptom

*-Referral to appropriate experts

-Avoid unnecessary medication (especially sedatives)

1) Biological management- various agents are effective

-Benzodiazepines (short and long acting) may be used for symptom relief.. But use for short durations to avoid dependence

-Antidepressants especially TCA's and SSRI's. have shown effectiveness in long term management of ,GAD,PD.

NB; at times co morbid features of depressive disorder occur in anxiety thus need for treatment

-Beta blockers for sympathetic hyper arousal in specific phobias eg propranolol, atenolol

-Some Antihistamines in GAD may control symptoms eg hydroxyzine

2. Psychological- various depending on clinical presentation

-Cognitive behavioral approach most effective

-Behavioral approach eg systematic desensitization, graded exposure, flooding, aversion, positive reinforcement, participant modelling

3. Social management

- Patient and family/ education

-Social support from family and relevant structures.

B) OBSSESSIVE COMPULSIVE DISORDER (OCD) and related disorders

1. OCD - usually has two components ie* cognitive/thoughts vs behavioural

Obssessions- are persistent, repetitive, intrusive and unwanted thoughts, images and urges that invade a person's consciousness causing marked distress/anxiety.

They are not simply excessive worries about real life problems

They are often abhorrent (not liked/hated) to the individual but very difficult to control or dismiss (person attempts to ignore or suppress the thoughts/images or to neutralize them with some other thoughts or actions).

Thoughts are usually recognized as originating within the individual's own mind (not thought insertion).

Thoughts focus on contamination, disasters, violence, harm to self or others, sex, blasphemy or other distressing things

Compulsions- persistent, repetitive, uncontrollable urges to perform certain acts (behavioral or mental) **but** resisted only with great difficulty/difficult to control.

-They are often responses to obsessive thoughts and function to reduce anxiety associated with the thoughts. The compulsive rituals result in temporary relief

-Rituals include; washing, checking things repeatedly, cleaning, praying, repeating words silently/lowly, counting or doing tasks in a specific and rigid order. Failure to perform the act leads to tremendous intensity of anxiety or even a panic attack.

OCD may lead to avoidance of certain objects or situations (eg dirt, not leaving house for fear of locking doors). It can lead to life disruption with frustration, and irritation to individual, friends, family, and workmates. The obsessions and compulsions cause marked distress, are time consuming (eg can take >1hr/day) and interfere with social/occupational/academic functioning.

-At some point in the disorder most individuals recognize that the thoughts and acts are excessive or unreasonable (except in children). With good, poor, absent/delusional insight

* Most have abnormal beliefs which can include inflated sense of responsibility, tendency to overestimate threat, perfectionism and intolerance of uncertainty

*co morbidity with other anxiety disorders is common, depression, up to 30% have tic disorder

*Rx- psychotherapy, medications, ect/psychosx

2. BODY DYSMORPHIC DISORDER

- Main feature is obsessive preoccupation with one or more imagined defect in physical appearance eg shape/shape of nose, width of lips which they believe looks ugly, unattractive or deformed. If a slight physical anomaly is present, the person's concern is markedly excessive/ exaggerated eg acne,

scars, wrinkles, hair, eyes, teeth, breasts, genitals. The preoccupations are intrusive, unwanted, time consuming (occurring on average 3-8hrs/day) and usually difficult to resist/control

- Compulsive behavior may develop eg obsessed with facial deformities may resort to compulsive repetitive face picking, skin digging with eventual scarring./pulling on the nose to even it out- can lead to self mutilation.

Compulsive mirror checking, episodic avoidance of mirrors, excessive grooming, camouflaging, reassurance seeking, surgery, unnecessary use of dermatological products or comparing his/her appearance with that of others in response to appearance concerns

- The preoccupation causes clinically significant distress or impairment so fxn eg drop out of school, absenteeism

- The pre occupation is not better accounted for by another mental disorder eg dissatisfaction with body size/shape/ weight in A. nervosa, somatic delusional disorder, MDD, GID,

* Average age of onset is in mid adolescence and course tends to be chronic and fluctuates over time with new imagined defects being added

* comorbidity with major depression is common, also social phobia, ocd, substance abuse

**Treatment*

- acknowledge the patient's concern

- seek additional information to determine the severity of the disorder

- Find out what the patient has done to remedy the defect, how defect has altered his/her social, occupational, academic activities

- Psycho education

- Combination of medication and cognitive behavioral therapy (eg SSRI's, TCA"s- makes patient more amenable to psychotherapy, reduce suicidal ideas, help in comorbid depression)

Hoarding disorder, trichotillomania (hair pulling), excoriation disorder (skin picking)

BODY DYSMORPHIC DISORDER

Dysmorphophobia- E. kraeplin, Freud- wolf man

- Main feature is obsessive preoccupation with an imagined defect in physical appearance eg shape of nose, width of lips. If a slight physical anomaly is present, the person's concern is markedly excessive/ exaggerated.

- Perversive subjective feeling of ugliness of an aspect of their appearance despite a nnormal or near normal appearance

- Compulsive behavior may develop eg obsessed with facial deformities may resort to compulsive face picking, skin digging with eventual scarring./pulling on the nose to even it out- can lead to self mutilation.

Compulsive mirror checking, episodic avoidance of mirrors, excessive grooming, camouflaging, reassurance seeking, surgery, un necessary use of dermatological products.

- The preoccupation causes clinically significant distress or impairment so fxn

- The pre occupation is not better accounted for by another mental disorder eg dissatisfaction with body size/shape/weight in A. nervosa, somatic delusional disorder, MDD, GID,

* Average age of onset is in mid adolescence and course tends to be chronic and fluctuates over time with new imagined defects being added

Treatment

- acknowledge the patient's concern

- seek additional information to determine the severity of the disorder

- Find out what the patient has done to remedy the defect, how defect has altered his/her social, occupational, academic activities

- Psycho education

- Combination of medication and cognitive behavioral therapy (eg SSRI's, TCA"s- makes patient more amenable to psychotherapy, reduce suicidal ideas, help in comorbid depression)

C) TRAUMA/STRESSOR RELATED DISORDERS

There is always a traumatic or stressful event(s) before onset of these illnesses; reactive attachment disorder, disinhibited social engagement disorder, ptsd, asd, adjustment disorder

1. POST TRAUMATIC STRESS DISORDER

-A long lasting anxiety response following a traumatic or catastrophic event eg violent assault; being kidnapped/car jacked; rape; held prisoner of war/mau mau/torture chambers; victims of natural or manmade disasters eg fires, floods, post election violence; terrorist attacks; witnessing life threatening events

-Usually develops within 3-6 months of the traumatic event (but can have late onset/delayed).

1. The traumatic event is persistently re experienced in thoughts, images, perceptions, dreams or even play in children

2. There is intense psychological and physiological distress at exposure to internal/external cues that symbolize or resemble an aspect of the traumatic event

3. The person develops persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness not present before the trauma (eg anhedonia, social withdrawal, restricted range of feelings like to love, sense of foreshortened future/pessimistic)

-Traumas caused by human actions eg rape and torture tend to precipitate more severe PTSD than natural disasters

- Severe symptoms of anxiety, arousal and distress that were not present before the trauma on exposure to trauma cues

-Experience of sudden flashbacks or nightmares that force them to relieve the traumatic experience is common. Many victims continue to have nightmares and are frightened when alone, outdoors or in crowds

-There are usually reports of decreased enjoyment of sexual activity long after the rape

***Diagnostic criteria (for children >6yrs, adolescents and adults)*

A) Exposure to actual or threatened, serious injury, or sexual violence in at least one of the following ways

1. Directly experiencing the traumatic event/s

2. Witnessing in person the event/s as it occurred to others

3. Learning that the traumatic event/s occurred to close family members or close friend (events are violent or accidental)

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event/s(eg 1st responders collecting human remains, police officers repeatedly exposed to details of child abuse)

B) At least one of the following intrusion symptoms beginning after the trauma

1. Recurrent involuntary and intrusive distressing memories of the traumatic event/s. in children repetitive play may occur with themes or aspects of traumatic event expressed

2. Recurrent distressing dreams whose content and/affect are related to the traumatic event/s. in children could be frightening dreams without recognizable content

3. Dissociative reactions eg flashbacks in which the individual feels or acts as if the traumatic event/s were recurring. May occur in play in children

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event/s

5. Marked physiological reactions to internal/external cues that symbolize or resemble an aspect of the traumatic event/s

C) Persistent avoidance of stimuli associated with the traumatic event/s beginning after the trauma as evidenced by at least one or both;

1. Avoidance or efforts to avoid distressing memories, thoughts or feelings about event or closely associated to it

2. Avoidance/efforts to avoid external reminders (places, people, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about/closely associated with the traumatic event/s

D) Negative alterations in cognitions and mood associated with the traumatic (beginning after event or worsened) as evidenced by at least one of the following

1. Inability to remember an important aspect of the traumatic event/s(not due to head injury, alcohol, other drugs but typically due to dissociative amnesia)

2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world -pessimistic/nihilistic

3. Persistent distorted cognitions about the cause or consequences of the traumatic event/s that lead the individual to blame self or others

4. Persistent negative emotional state eg fear, horror, anger, guilt, shame

5. Markedly diminished interest or participation in significant activities/

6. Feelings of detachment or estrangement from others

7. Persistent inability to experience positive emotions eg inability to experience happiness, satisfaction, or loving feelings

E) Marked alteration in arousal and reactivity beginning after or worsened by the traumatic event

As evidenced by at least two of the following

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people/objects

2. Reckless or self destructive behavior

3. Hypervigilance

4. Exaggerated startle response

5. Concentration problems

6. Sleep disturbance/insomnia

NB; the disturbance in b,c,d,e is more than 1 month (3 days- 1 month = ASD); causes clinically significant distress/impairment in so fxn; not due to physiological effects of drugs or another medical condition

* PTSD may actually increase vulnerability to develop other mental disorders eg women have double risk of developing depression and three times risk of developing alcohol/substance related problems in future.

*About half of adults experience a traumatic event in lifetime but only 5% males' vs 11% females develop PTSD (general) but some trauma events have higher rates eg war veterans, rape, captivity, genocide/politically motivated violence(vulnerability- pretraumatic, peritraumatic, post traumatic)

* some have complete recovery within 3 months in approximately half, while others remain symptomatic for more than 12 months to even more than 50 yrs

*It is a severe disorder and difficult to treat; > 80% have co morbid depression, drug/alcohol abuse, anxiety disorders

Rx- psychotherapy, social therapy, medications

PSYCHIATRIC EMERGENCIES

- Sudden development, life threatening, can lead to property loss and need urgent decision/actions

1) VIOLENT/ AGGRESSIVE PATIENTS

What to do – take a quick brief history from informants to identify;

--- The cause & severity of violence to self/others/property

--- Rate of onset -- precipitating factors

--- Presence & type of hallucinations, delusions

--- Maladjustments -- not feeding

Management guidelines – get help – exercise caution/ any weapons – allow for escape – identify yourself – try to calm patient; speak gently, avoid any sudden or threatening actions - listen to the patient - don't contradict or argue with the patient - don't make false promises - try to persuade patient to hand over any weapons in his/her possession - don't attempt heroics – if patient is restrained ensure there is enough help to control each limb without hurting the patient - investigations - sedate with im largactil or iv diazepam (not in head injury) –admit(strong room) and treat

Causes – substance abuse, schizophrenia, mania/ depression, epilepsy, mental retardation, personality disorders, head injuries sequelae, post partum psychosis,

2) DELIRIUM

-Acute organic confusional states caused by physical illness

Complaints– the patient is confused or agitated

- Patient may appear uncooperative or fearful

Diagnostic features – acute onset (hours-days fluctuating)

- Confusion (patient is disoriented, struggles to understand surrounding)

- clouded thinking or awareness

- Poor memory - visions or illusions, visual hallucinations

- Suspiciousness - wandering attention - disturbed sleep

- Withdrawal from others/agitation/emotional upset

- Autonomic features eg sweating, tachycardia

What to do --- take measures to prevent the patient from harming him/herself or others (restrain/sedate).

--- Presence of relatives helps reduce confusion

--- Frequently remind patient the time & place (orientation)

--- Physical exam + vital signs, investigations, **admit in medical wards**

NB- Mortality rate is high

Investigations - as per suspected illness eg infections-intracerebral vs extra cerebral (meningitis, malaria, typhoid, hiv/aids, pneumonia & uti in the elderly etc)

- Alcohol intoxication/ withdrawal eg in police custody or after RTA
- Drug intoxication, overdose or withdrawal
- Metabolic changes eg liver disease, hypoglycemia, dehydration
- Anemia, hypoxia, epilepsy

Treat the underlying illness. Use Antipsychotics sparingly

3) ATTEMPTED SUICIDE/ PARASUICIDAL

Suicide-derived from Latin word

- - a complete act
- - viewed as best way out of a problem or crisis that is invariably causing intense suffering.
- - associated with thwarted or unfulfilled needs, feelings of hopelessness, ambivalent conflicts and unbearable stress, a narrowing of perceived options, and a need for escape; the person sends out signals of distress.
- -act to kill oneself which is consciously planned

ATTEMPTED SUICIDE- incomplete acts +/- injuries.

-act of self destruction ie attempts to kill self, consciously planned, and considered as best solution for their problems

PARASUICIDE- threatening acts and no death is intended. - may lead to accidental death.

Risk factors

- Sex- males: females= 4:1 for all age groups. But for attempts is reverse and is mostly attention seeking behavior
- Age- rates increase with age. Men peaks after 45 vs women 55. *midlife crisis?
- Race- whites > blacks 2:1. rates also higher among immigrants than in natives
- Religion- rates lower in Roman Catholics than among Protestants and Jews (degree of integration and orthodoxy?)
- Marital status- marriage reinforced by children seems to reduce risk significantly. Rates among Previously married > singles (pm= separated, divorced, widowed)
- **Work- employment seems to generally reduce rate (jobless > employed). But rates also increase during economic recession, repression
- **History of suicide or attempted suicide in the family. (includes anniversary suicides)
- **Previous suicidal behavior- best indicator. Risk highest within 3/12 of 1st attempt
- **Physical health- markedly increased rates in chronic illnesses eg CNS (dementia, ms, epilepsy, head injuries), AIDS, Cancers- . L cirrhosis, loss of mobility (spinal injuries), severe burns with disfigurement in women,
- **Mental health - substance abuse/dependence eg especially alcohol, cocaine, heroine. – **NB majority (95%) who attempt or commit have a psychiatry/ psychological problem (80% depressive disorders, 10% scz, others). –
- Drugs- long term use of reserpine, some anti hypertensives, corticosteroids, some cytotoxics= symptomatic depression.
- **Poor personal, family relationships & social isolation.
- **Losses-job, finances, income, loved ones,
- **Feelings of worthless, hopelessness, helpless accompanied by guilt. Suicidal thoughts, ideas, plans, suicidal notes
- Occupation – the higher the social status the higher the risk/rate but also a fall in social status increases risk. –**Medics have higher rates than general population. –most have depression or substance dependence. – Often associated with recent professional, personal, family difficulties. –often by drug overdose (availability & toxicity knowledge)

- Others at high risk eg lawyers, law enforcement officers, insurance agents, musicians/actors

AETIOLOGY

- 1) Durkheim's theory (sociological factors)

-divided suicide into 3 social categories

a) Egoistic- b) Altruistic-

c) Anomic-

2) Freud + Menninger theories (psychological)

- Suicide is aggression turned inwards against an introjected .....

- inverted homicide because of anger towards another person.

- 3 components of hostility in suicide; wish to kill, wish to be killed, wish to die.

- 3) Biological factors.

- Genetics – suicide runs in families (also share a lot of experiences thus susceptibility) – twins studies – adoption studies – molecular genetic studies (tryptophan hydroxylase alles vs 5HT) **
- PARASUICIDE-self injury / harm
  - Usually in their 20,s
  - Cutting (delicately not coarse) is common way of injury but don't wish to die (sites), medication
  - Most claim not to experience pain
  - Alcohol and substance abuse is common
  - * NB – most have personality disorders, introverted, hostile
  - ***In majority of cases they are just crying for help

Management

A) First aid

- - outpatient treatment

- - in patient treatment depending on method used to attempt and injuries extent (medical, surgical, obs & gyn, paeds,)

    - Don't ignore suicidal ideas in outpatients+ assess high risk groups eg old, female, male, singles, previous attempt, depressed, recent loss, those with chronic illness

B) Indications for admission

-lack of strong social support, lonely ones

-injuries extent, unconscious/comatose

-suicide plan of action

-impulsive behavior eg changing mind now & then

- if has been threatening to commit then goes quiet suddenly (calm/at peace)

NB= ask patient directly about intent, plans, attempts, thoughts to suicide–

-Treatment for underlying medical/ psychiatry conditions

** If still in wards,

-constant observation and search their belongings (round clock surveillance)

-nurse assigned to monitor continuously and note/ record observations which will help doc in mgt eg sedate further

-if still high risk= consider /do ECT

Don't ignore suicidal ideas

- C) Supportive psychotherapy

*- most are going thro a crisis

- Some problems have solutions thus try to help solve them eg bursaries for school fees

- problems with no solutions = teach coping mechanisms

- Advice to run away from some problems eg boyfriend/girlfriend, look for another job

- involve family / close significants / employer

** involve counselor, psychotherapist, and social worker

- Bereavement counseling for the family if suicide occurs

Legal issues

- Law suits can arise in suicides occurring in hospital eg monitor, evaluate, security, treatment plan, treatment, follow up... (Suicide caution card)

*** Suicide attempt vs law – attempt is punishable by law

- ** Aiding and abetting suicide is punishable ie accomplice.
- CONSTITUTION OF KENYA- chapter 4 ie bills of rights.(26- right to life= every person has a right to life; a;---)
- THE LAW OF KENYA (Tudor Jackson) pg 122= suicide pacts
- -The survivor of a suicide pact has committed manslaughter (penal code, section 204) eg if

4) ALCOHOL WITHDRAWAL/ABSTINENCE SYNDROME

**revise

** revise heroine withdrawal and mgt

5) SIDE EFFECTS OF MEDICATIONS (used in psychiatry)

a) Neuroleptic malignant syndrome

- a life threatening complication with mortality rate of 10-30%

– can occur at anytime during the course of treatment

** Symptoms include

- muscular rigidity – mutism – dystonia – parkinsonian symptoms – agitation –autonomic symptoms eg sweating, high fever, increased bp, increased heart rate, -coma/death

Rx- discontinue antipsychotic – supportive mgt eg hydration, decrease temp, decrease bp, benzodiazepines, icu/hdu - monitor creatinine phosphokinase levels, wbc *– bromocriptine/dantrolene use

b) Lithium toxicity

Presents with- vomiting, abdominal pains, profuse diarrhea, severe tremors, ataxia, cardiac arrhythmias,.- seizures, confusion, dysathria, hypotension, coma

. Serum lithium levels must be maintained at 0.6-1.2meg/l.... toxic levels occur at >2meg/l

Rx- osmotic diueresis -lavage -I.C.U rx may be needed – other supportive

** Routine monitoring of serum levels, ecg, rft, tft. Maintenance dose of 300-400mg/day divided

6) STUPOR

- Depressive –catatonic in scz – manic, dissociative, malingering ** differentiate from coma eg respond to command nil, not unconscious?, respond to painful stimuli, eyes alert, physical exam normal, ix normal, may be able to recognize others,

**mgt- supportive eg ivf, medication, ECT, psychotherapy later + social therapy

7) OTHERS- eg puerperal psychosis,

MENTAL HEALTH

- Health - a state of complete physical, mental and social wellbeing and **not** merely the absence of disease or infirmity (WHO-1948).
- Mental- by dictionary "of the mind", the seat of consciousness, thought and feelings. Therefore mental health is a state of well being of the mind.** Topographical model of mind- conscious, preconscious, unconscious. ** Structural theory- id,ego,superego.
- Mental health – a state of wellbeing in which the individual realizes his/her own abilities, can cope with the normal stresses of life, can work productively & fruitfully, is able to make a contribution to his/her community (WHO). Mental health is more than the absence of mental illness thus the promotive, preventive, curative and rehabilitative aspects.

Mental health has also been defined as full harmonious functioning of the whole personality or ones ability to manage life problems and to derive satisfaction from living through the various stages of life.
Mental health is crucial to overall well being of an individual, family, community and the country and has a direct bearing on achieving millennium development goals and vision 2030.
Mental illness and disorders accounts for about **12.3%** of the global burden of disease and this is expected to rise to **15%** by the year 2020(WHO). Around 450 million people woldwide are affected by mental, neurological or behavioural problems. At least 873,000 suicide cases reported every year world wide (2392/day).
Up to 20% of children and adolescents world wide suffer from disabling mental illness and disabilities with suicide being the third leading cause of death among adolescents worldwide.
It has been noted that 50% of adult mental disorders/illness actually begin before the age of 14 years thus early detection and prevention is important.

What is mental illness/disorder?
This is a state whereby the behavior, thinking or feeling of a person significantly interferes with ones ability to function normally especially as regards to work, getting along with other people, enjoy life and take care of oneself, the family and other responsibilities.

What are the common mental illnesses and disorders?
Depression, anxiety, drugs and alcohol abuse disorders, schizophrenia, alzeimer's disease (a type of dementia), bipolar disorders and some types of epilepsy among others.
Unfortunately in most cases, people do not notice that they are sick and need to seek medical attention. Their relatives may also not be aware of the illness thus the sickness is left untreated for long periods leading to gradual deterioration in functioning of individuals.
Stigma towards those viewed to have mental illness has also contributed to reduced seeking for medical help publicly.
Mental illness causes immense suffering and patients are often subjected to social isolation, poor quality of life and increased mortality.
Mental illness affects and are affected by chronic conditions eg cardiovascular diseases, diabetes, cancer,HIV/AIDS.If not treated they result in unhealthy behavior, non compliance to prescribed medical regimes and decresed immune functioning.
Cost effective treatments exist for most disorders.
**At least one out of four patients visiting a health service centre has a mental, neurological or behavioral disorder but most of these are neither diagnosed nor treated.

Most low income and middle income countries devote **<1%** of their health budgets to mental health thus mental health policies, legislation, community care and health facilities are not given the priority they deserve… Africa- Abuja declaration on health???

Psychiatry vs Behavioural sciences

Psychiatry- is an art as well as a medical science concerned with mental processes of the individual, the interaction between the doctor, patients and the relatives, workmates in the process of identifying the problem and carrying out appropriate action.
Generally it stresses unity of the body and mind
*There is a close relation in the provision of holistic mental health services
Sociology- studies and analyses human behavior, the patterns of interactions and relations in a social context. Medical sociology is closely linked to psychiatry
It focuses on social interaction between patient and the doctor and between groups of people in hospitals or medical schools and among laymen in the community. It also examines the relation btw culture, personality traits, values and norms.
Psychology- Studies the basic psychological processes eg perception, learning, language, memory, thoughts and emotions. It also seeks to understand how these processes work.
Clinical psychology is closely related to psychiatry in that psychologists are involved in assessment of a wide range of problems eg phobias, obsessive compulsive disorders. They are also involved in treatment eg in group therapy, cognitive behavioral therapy.
Counseling psychology
Anthropology- Gives a holistic study of mankind eg origins, development, social and political organizations, religions, languages, arts and artefacts.
Medical anthropology is concerned with a wide range of biological phenomenon especially in connection with health and diseases.

Myths about mental illness?

Many myths persist about mental illness in Africa. Most people do not accept mentally ill persons even if they have been treated and are feeling better. Myths contribute a lot towards stigma and discrimination of the patient, family and even towards health care workers.

1)All people with mental illness are mentally retarded
Fact- most mental illnesses occur in people of all levels of intelligence and often even in talented creative people. Mental illness and mental retardation are entirely different conditions.
2)People with mental illness cannot work
F-people with mental illness work even if they have symptoms. People with mental illness fare better if they work.
3)People never recover from psychotic illness
F-this misconception leads to hopelessness and despair among patients and their relatives. The disorder takes many different courses with varying outcomes(complete recovery, fluctuating wellness versus relapses of illness, a few don't recover)
4)People with mental illness are violent
F- mental illness and violence are closely linked in the public mind. Generally people with mental illness are no more dangerous than healthy individuals from the same population. Only a small percentage of those with mental illness are responsible for the violent behavior that occurs in association with the illness.
5)Prison is an appropriate place for people with mental illnesss

F-In East Africa, jails and prisons typically have very inadequate psychiatric services. The mentally ill prisoners receive little or no treatment.
6)Mental illness is caused by evil spirits and witchcraft
F- many factors play a role in the development of mental illness and mostly intertwine for eventual outcome. Genetic/biological factors, social factors and psychological factors all have a role.
7) Mental illness is contagious
F-this only leads to avoidance of the mentally ill and stigmatisation of family members, mental health facilities and mental health proffessionals
8) People with mental illness are not able to make decisions about their own treatment
F- Most patients are able and eager to participate in decision making about their treatment. Most patients have mild forms of mental illnesses and even those with moderate-severe once on treatment their decision making improves.

What are the common signs and symptoms?

1) Early signs include;
- Excessive emotions like fear, anxiety and worry
- A sudden unusual belief. - Sleep disturbance
- Prolonged loss of appetite or reduced appetite
- Loss of confidence and self esteem. - Loss of interest in normal activities
- Neglect of personal hygiene and family or social responsibilities
- Inability to control drug or alcohol intake
- Inability to spend one's time, money and other resources appropriately
- Multiple shifting body pains including headaches, heaviness in the head, joint pains, back pains

2) Late signs include;
- Excessive sadness and inappropriate guilt
- Thoughts of death and suicide (feels that life is not worth living)
- Inability to socialize. –Distorted thinking
- Seeing things that other people cannot see (visual hallucinations)
- Hearing voices that others cannot hear (auditory hallucinations)
- Inappropriate emotions such as laughing when given bad news
- Loss of touch with reality and aggression
- Unusual loss of memory and judgment

The consequences of mental illness include; suffering, disability, death (suicide or physical illness, murder) unemployment, low productivity, poverty, stress on careers (burnout, compassion fatigue, depression), marital problems, intellectual and emotional damage to children, reduced access to and success of physical health programs among others.

How can Mental illnesses/ Disorders be prevented;

Several measures can be used including;
- Family support in traumatic events
- Education on harmful effects of drugs and excessive alcohol use
- Mothers to attend ante natal clinics and delivery of children in hospital to avoid brain damage
- Early detection and treatment of mental illness (secondary prevention)
- Involvement of close family members in the treatment of the mentally ill

** Primary,secondary and tertiary prevention

HISTORY OF PSYCHIATRY AND CONCEPTS DEVELOPMENT

In the pre-literature cultures and biblical times early medicine was intertwined with religion—priests served as physicians and thus illnesses were perceived as mental and reflecting a spiritual disturbance. Mentally ill were regarded as possessing supernatural powers and thought of as sacred and at times treated with respect.

1) EARLY AGES/OLD(B.C)

Hippocratic school of medicine- approached study of medicine in a holistic way where social, spiritual, physical and psychological factors were held responsible for the cause of mental disorders.
Medical concepts of mental disorders documented by hippocrates in the 4th century B.C(460-370). Interaction of 4 body humours (blood, black and yellow bile and phlegm) were considered as the causes of mental disorders
Personality was classified into 4 temperaments- sanguine, cholereic, melancholic, phlegmatic

Plato and Aristotle- 428-348BC- descibed concepts of health as harmony btw body and mind while disharmony btw the two was the cause of mental disorders.
He alienated 4 types of mental illnesses ie prophetic, telestic or ritual, poetic and erotic

2) MIDDLE AGES/ERA
-Characterised by the fall of Roman Empire, epidemics and decline in scientific thinking
-Study of mentally ill reverted to religion and superstition(demonology)
-Mental illness were regarded as punishment for sin hence torture was prescribed to exorcise demons, including burning of mental patients and witches
-Abnormal thought processs eg hearing voices and odd beliefs were attributed to the devil
*1405 A.D, the first mental hospital was opened in Valencia,Spain. Patients lived in deplorable conditions and inhimane treatments eg blood letting, inducing vomiting and pugatives continued but on a smaller scale

Paolo Zacchia (1584-1659)- advocated for rights of mentally ill patients. He wrote"Only the physician was confident to judge the mental condition of a person"
Thomas Sydenham (1624-1689)- initiated clinical approach in modern medicine by describing in detail symptoms of mild mental illness
3) MODERN/MORAL ERA of treatment of mental illness
It dates from end of 18th century and had 4 periods
Period of human reform, introduction of no restraint, hospital period, the social and community period.
Pioneers of this era included Phillipe Pinel(France), Vincenzo Chiarugi(Italy), William Tuke(Britain), Jean Etienne Dominique, Lindley Murray.
Era was characterised by restoration of dignity of mental patients through abolition of restraints and establishment of big mental hospitals with better clinical care.
There was increased realisation that mental illnesses were not restricted to any particular group in society.

i) Human Reform
Dr Phillipe Pinel- at Bicetre hospital, Paris,France. Hospital with 200 patients. In 1794, instead of blows and chains he introduced light and fresh air, cleanliness, workshops plus above all there was kindness and understanding

He insisted on good case taking and made contributions to psychiatric literature. His earlier attempts in analysis of symptoms resulted in categories like melancholia-disturbance in intelligence, mania-excessive nervous excitement without delirium, dementia- disturbance in thought process, idiocy- obliteration of intellectual faculties and affect.

Vincenzo Chiarugi- Bondicis hospital,Italy. He advocated "it is supreme moral duty and medical obligation to respect the insane individual as a person". No physical force or retraint were applied except for violent patients.

iii) Hospital Period

*seclusion vs isolation

There was modernazation of psychiatric hospitals resulting in many beneficial changes in administration, infrastructure, medical and nursing staff, psychiatric social workers, occupational therapists, psychologists

Transition to modern hospital care of mental patients was briedged by a short lived concept of- "Seclusion" NOT isolation of dangerous, impulsive patients who could not be trusted. It comprised of single and padded rooms which were locked and patients confined. It had several advantages;

-prevented struggling with the patients
-prevented serious accidents
-less need to use powerful sedatives
-eased burden and responsibility of medical and nursing staff

Later with increase in medical and nursing staff, it became evident that most secluded patients responded more positively when cared for and nursed in open wards where they could be adequately supervised.

iv) Hospital vs community

Hospitals have now established outside contacts and interests which previously did not exist like

- Presence of outpatient clinics, child guidance clinics, medico legal work
- Patient are allowed more freedom (open door system) eg wards unlocked, freedom of grounds, visits to hospital day and night, home visits
- Reduced mental patients admission rates and to maintain patients at work so long as it is compatible with their well being

<u>DEVELOPMENT IN AFRICA</u>

It seems to have followed pattern as in western culture but the changes have taken place quickly thus an overlap in stages (primitive non scientific, humanistic and scientific stages).

-Documentations in Nigeria by Prince, Lambo and Asuni (1960,1964,1972), in Kenya by Carothers, Ndetei, Muhangi()

i)Primitive non scientific and humanistic stages

The two seem to have developed concurrently,

Prince wrote that mental illnesses were attributed to supernatural powers and the spirits of dead ancestors who were punishing the sick person or the relative of the sick. Mental illness was also attributed to witchcraft and sorcery invoked by neighbours, relatives and distant clans as revenge, punishment or simply because of jealousy.

Mental illness due to physical conditions was well appreciated eg cerebral malaria, cannabis intoxication, head injury as causes of "madness".

Description of local terminologies(Nigeria) and theories of causation for mental illness which fit- schizophrenia, depression, hysteria, anxiety, epilepsy

Carothers(1953) wrote “the african has greater difficulty recognising the strangness of psychotics than the European layman” implying that some of the psychiatric phenomenon were accceptable within the african society.

Some treatments were similar to those found in western culture at the equivalent stages eg offerings to appease ancestral spirits, rituals in atonement for wrongs, craniotomy to release evil spirits (eg turkana, kisii), herbs to treat primary physical causes of madness eg malaria.
Success rate was claimed to be satisfactory in most cases
Extreme physical approach eg flogging, binding, starving, burning was hardly practised.
Tradition demanded that the mentally ill be catered for like any other sick person.
Mentally ill were taken to traditional healers for for diagnosis and treatment.
**Lambo(1966), psychiatrist used modified western practise in design of Afro psychiatric hospital in Nigeria where the sick person and his family would be admitted together for some time.

iii)Scientific stages
-Very few countries have satisfactory and adequate psychiatry services.
- Change from community care of patients to hospital/custodial care(negative therapeutic climate).
-Influence of western culture plus condemnation of local cultural methods and beliefs
*Present and future situation= mental health issues are urgent in Africa as they are in the west. Lack of resources like human , infrastructure, supplies are a major hindrance. Research in the mental health field still low

THE HISTORY OF MENTAL HEALTH IN KENYA
The Colonial Period

Little is known about mental health in Kenya before 1900. The construction of Mathari Mental Hospital in 1910 during the colonial period as a small pox isolation centre and then converted into a lunatic asylum admitting its first psychiatric patient in 1914. During the first World War,the asylum admitted insane patients from the various colonial African troops who fought for Britain, on this continent, **Dhadphale M**.(1984). Initially, psychiatric care was custodial with a staff of 9 wardens, a cook and a cleaner. Buildings were added gradually with separate wards for Africans, Asians and Europeans.

Little is known of the actual treatment between 1920 and Kenya"s independence in 1963. However, a few dates are known to be significant, in 1947 **J.G. Carothers**, a British psychiatrist working at Mathari hospital published one of the earliest prevalence studies from Kenya. He described his work as "a study of mental derangements in Africans and an attempt to explain its peculiarities, more especially in relation to the African attitude to life" . He subsequently in 1953 published a monograph entitled "The African mind in health and disease",(Carothers 1951 and WHO monograph No. 17, 1953), which generated a lot of controversy among psychiatrists all over the world and was severely criticized by many prominent authors in the field (Lambo 1955, Lewis 1961, German 1972). He postulated that there may be an anatomical difference between native Africans and Europeans in certain parts of the brain specifically; frontal lobes, thalamus and the long frontal association tracts.

In the late fifties and early sixties, after Carother"s departure from Kenya, **Margetts** was the chief psychiatrist at Mathari Hospital. He believed that the provincial physicians if trained properly at Mathari, could play a useful role in treating psychiatric cases at provincial hospitals. Therefore, he brought provincial physicians from Kisumu, Nakuru, Nyeri and Mombasa to Mathari and taught them the techniques of administering ECT and chlorpromazine. It is thus apparent that the process of decentralization was initiated as early as 1956 (Margetts 1960). Margetts further planned for the provision of mental health services outside of the capital city of Nairobi and advocated for an allocation of 10-20 percent of the beds at the provincial and district hospitals for mental patients as part of the decentralization process. He suggested that the Makerere Medical school in Uganda, then the only medical school in East Africa, emphasize the teaching of psychiatry and general mental health concepts to its undergraduates.

In 1959, a new British Mental Treatment Act which called for decentralization of mental health services was passed and two years later applied to the Kenya Colony anticipating the WHO call for decentralization by some 14 years. As a result, 6 of Kenya"s provincial hospitals added 24 bed psychiatric units. These were staffed solely by nurses and attendants, and offered custodial care only.

Post Independence

Kenya became an independent nation on 12th December 1963 and underwent a transitional period of personnel and policy change with the expatriate medical and nursing staffing being progressively replaced by Kenyan citizens. in 1965, a former British army barrack named Gilgil and situated approximately 110 kilometres west of Nairobi was converted to accommodate the patient overflow from Mathari Hospital and was until 1986 an extension of Mathari Hospital when it gained the status of an independent hospital.
At Easter, 1968, Psychiatry exploded into public awareness when 14 dangerous mentally ill criminals escaped from Mathari Hospital. The government decided to build a new maximum security psychiatric unit. The construction was completed in 1972 and the unit commissioned in 1979..

In 1968, the Nairobi University founded a school of medicine and the Department of psychiatry became part of it in 1971. It mainly taught behavioural sciences and psychiatry to undergraduate medical students. The second medical school opened in 1990 Moi University, Eldoret. The first indigenous Kenyan qualified in psychiatry in 1970 from the UK and five years later in 1975. It was not until 1982 that the Department of Psychiatry in Nairobi University started training Psychiatrists.

A division of Mental Health within the Ministry of Health was established in 1987 with its own budget and full-time staff, the division has succeeded in obtaining passage of the Mental Health Act of 1989 which replaced the pre-independence British Mental Treatment act of 1959.

SITUATION ANALYSIS
Recognizing the need to serve people close to their homes as well as the need for early intervention and follow up services, the Kenya government added mental health to the elements of Primary Health care in 1982. This was a reflection of the commitment to the

principles of the 1978 ALMA-ATA declaration that health be accessible to all by the year 2000 (WHO 1978).??
This then meant that mental health services would be provided along side other health services in keeping with principles of Primary health care.

Now, Kenya like most developing countries of Africa has basically a rural population. Indeed 70-80% of the Kenyan population is rural. Current projected population statistics estimate the total population to be in the region of 40 million people. Some 50% of these are children below the age of 15 years and 60% below 18 years. The sex distribution is roughly even.
The health situation is very similar to that described in other parts of the developing world including Africa.
In the area of mental health , there is overwhelming evidence to show that mental health problems are very prevalent in Kenya and constitute a real public health and socioeconomic problem.

Previous studies done to estimate the prevalence of psychological disorders such as those by Carothers in the colonial era have been revised upwards and today, well documented epidemiological studies consistently show that serious and often incapacitating mental illness affects 1% of the population at any given time and that about 10% of the population run a life time risk of developing them. Further research has also shown that 10-15 people per 1000 population are epileptic. most of this epilepsy results from brain damage associated with poor or none existent obstetric care, brain infections and head injuries.
The problem of the non-psychotic or the so called psycho-neurosis is even more critical. Studies consistently indicate that 20-25% of patients who attend out-patient clinics or health centres are either suffering primarily from a psychological problem or have significant psychological problems co-existing with their physical problem(Dhadphale, 1984). A study at Nairobi"s Eastlands area found 46% of the health centre attenders to be so affected (Kiima 1986,mulupi 2006). Such patients often present to clinics with physical complaints such as pain and are often dealt with inappropriately because of the inability of the health care personnel to recognize such pain as psychological.
Mental health problems among children are equally common though not usually recognized. Kang"ethe (1988) looked at children aged 5-15% attending a health centre in Nairobi and found 20% of them to have significant psychiatric morbidity. Only 10% of the total number with psychiatric morbidity were so recognized by the Primary health care workers.
The problem of alcohol and substance abuse is equally critical and the abuse has increased markedly in recent times. Cannabis,alcohol, khat, tobacco and others.

As suggested by the fore going any discussion of Kenya"s future mental health program must consider more than a single level of care .
Four such levels are currently in operation though not consistently so throughout all parts of the nation

Although referred to as being four in number the levels of care are actually three the one being the community level that combines with the district level to form the primary care level , the second is the provincial level which fits the secondary level of care as per the principles of PHC and the third is the National or central level that then fits in with the tertiary level of care of the PHC.. Devolution and county system of government may have effects on services.

AETIOLOGY OF MENTAL ILLNESS

Aetiology can be grouped into three broad categories ie biological, psychological and social factors. The three all interact in causing mental illness and responses to treatment.They are intertwined and inter related.

No single theory is sufficient to explain the development of mental illness. The adoption of Biopsychosocial model of disease causation gives a better/ adequate understanding of the disease process (G Engel).

A) Biological factors

1) Genetics- genes control various aspects of human life eg temperament, body size, intellect, biochemistry.. Study of parents, siblings, twins, close relatives

2) Biochemical/Neurochemical- neurotransmitters imbalances in specific regions of brain. Effects of serotonin, dopamine,noradrenaline, gaba, ach. The effects of hormones also vital eg testesterone, oestrogen, cortisol(steroids)

3) Physical illness, chemical intoxications, trauma of brain and brain infections may also lead to development of mental disorders, Devtal disorder in brain.

B) Psychological factors

1) Psychoanalytic theory- S freud

That all human beings are born with innate instincts which govern behavior. Unsatisfied instincts create tension within the individual and these manifest in the form of psychological illness.

2) Psychosocial theory – by Erick Erickson. It was an extension of psychoanalytic theory. It includes cultural and social dimensions. It emphasizes on the development of opposing dimensions of life eg trust vs mistrust, intimacy vs isolation, identity vs role confusion, integrity vs despair

3) Attachment theory- by Bowlby.It is based on observation that babies are totally dependent on their parents/caregivers for their survival. Development of a warm and caring relationship btw infant and caregiver is vital for the survival of the baby eg thro suckling, cuddling, smiling, looking, sleeping ie behaviors vital in nurturing. Successful interaction with the family and peers is “may be” the most

important factor in the development of social skills. Lack of adequate social attachment during infancy and childhood leads to lack of trust and difficulties in establishing lasting relationships with others in adulthood.

C) Social factors

These mainly precipitate mental illness and are usually stressful life events. The impact of these events is particularly great if the event has significant meaning to the individual. The impact is also greater for those individuals who rely on outside social support in coping with their problems. The influence of stress in precipitating mental illness is much stronger in depressive disorders.

Examples of events bereavement, divorce, loss of employment, recent promotion, fail/pass exams unexpectedly, severe life threatening illness, anniversary of death of a relative.

** Cultural theories and myths still exist in AFRICA eg witchcraft, evil spirits, punishment by ancestral spirits for evil committed, presence of a foreign body in the brain like worm, lizard as causes of mental illness. Most forms of mental disorders including depression and anxiety are not easily recognized as illnesses in African cultures/societies. This has an important effect on therapy and use of hospital facilities.

Psychological systems/factors have bearing on disease with emphasis on the past, present and anticipated factors together with motivation. They have role on impact on individual and his/her reaction to illness. Attitudes to safe or unsafe environments use of prescribed medicines, substances eg alcohol and nicotine, sexual behavior and dietary habits may affect and in turn be affected by physical conditions and socio cultural factors.

Social system put emphasis on cultural, environmental, familial, society influences on the expression and experience of illness. Role of religion, faith, belief systems in health is vital.

NB: Biopyschosocial model highlights the need for medical professionals to be thoroughly familiar with patients and clients psychological, cultural, social,

emotional responses and their interaction with health care providers rather than just making a diagnosis and prescribing medication.

PSYCHIATRIC CLASSIFICATION OF MENTAL ILLNESS

Classification attempts to bring some order into the diversity of phenomena encountered in clinical practice. It enables health professionals to communicate easily about the nature of a patient problem, prognosis and treatment.

Two main sets of classifications are used ie 1) Diagnostic and Statistical Manual for mental disorders- by American Psychiatry Association (DSM) (2) International Classification of Diseases by W.H.O.

DSM 1 in 1952 vs ICD 6, DSM II in 1968, DSM III in 1975 vs ICD 9, 1992 DSM IV vs ICD 10, 2000 DSM IV TR, 2013 DSM V

Codes and terms in ICD 9,10 are fully compatible with DSM IV. The classification divides mental disorders into types based on criteria set with defining features.

The versions DSM-IV TR vs ICD-10. Example

DSM-IV TR	ICD-10
Dementia 290 and290	Dementia F00-03
Substance related disorders 291,292,303,305,	Mental and behavioural disorders due to psychoactive substance use f10-19
Schizophrenia and other psychotic	Schizophrenia, schizotypal and

disorders 295,297,298,293,	delusional disorders f20-29
Mood disorders 296,300.4,301,311	Mood/affective disorders f30-39
Anxiety disorders	Neurotic, stress related and somatoform disorders f40-48 **f40-43
Somatoform disorders	**f44-48
Sexual and gender identity disorders	Behavioral syndromes associated with physiological disturbances and physical factors f50-59 **f52+ *f 64-66
Eating disorders	**f50
Sleep disorders	**f51 non organic sleep disorders
Personality disorders	Disorders of adult personality and behaviour f 60-69 **f60-61
Mental retardation 317-319	Mental retardation f70-79
Mental disorders due to G.M.C	

The two classifications only deal with the major psychiatric illness. DSM-iv tr and V takes a holistic approach ie biopsychosocial model. It has a multi axial approach for each diagnosis.

Multi Axial Assessment (DSM-IV TR)

There are 5 axes used in it. Each axis refers to a different domain of information that may help clinicians plan treatment and predict outcome/prognosis,

Axis 1- clinical disorders. And other conditions that may be a focus of clinical attention

Axis 2- Personality disorders and mental retardation. Defence mechanisms

Axis 3- General medical conditions

Axis 4- Psychosocial and environmental problems

Axis 5- Global assessment of functioning (GAF 0-100)

Axis 4 aspects include- 1) problems with the primary support group/family, 2) problems related to social environment eg living alone, death of a friend, discrimination, adjustment in life eg retirement 3)educational problems 4)

occupational problems 5) housing problems 6) economic problems 7) problems with the legal system 8) other environmental issues eg disasters, wars, hostilities

Axis 5 is important in planning treatment, measuring its impact, and predicting outcome. GAF is rated with respect psychological, social and occupational functioning. It is divided into 10 ranges of functioning (deciles)

100-91= superior functioning in wide range of activities. Life's problems never seem to get out of hand, is sought out by others becoz of his/her many positive qualities. No symptoms

90-81= absent or minimal symptoms eg mild anxiety before an exam. Good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than every day problems or concern eg occassional arguments

80-71= if symptoms are present they are transient and expected reactions to psychosocial stressors

70-61= some mild symptoms or some difficulty

60-51= moderate symptoms or difficulty

50-41= serious symptoms eg suicidal ideas, or serious impairment

40-31= some impairment in reality testing or communication or major impairment

30-21= behavior is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment

20-11= some danger of hurting self or others or occasionally fails to maintain minimal personal hygiene or gross impairment in communication

10-1= persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene or serious suicidal acts with clear expectation of death.

0= inadequate information

Non Axial Format (DSM-IV TR and V)

-It is also acceptable for one to simply list the appropriate diagnosis

- Record as many co existing mental disorders, general medical conditions and other relevant factors in care and treatment of the individual

- The principle diagnosis or reason for visit should be listed first

- Includes severity of illness (WHO disability assessment schedule); based on six domains-understanding and communicating/cognition, getting around/mobility, self care, getting along with people, life activities, participation in society. Scores of 1-5. Total score convert to 0-100*****

HUMAN DEFENCE MECHANISMS (ego)

These are unconscious strategies that people use to deal with negative emotions. They limit awareness so that life threatening and anxiety situations/acts can be excluded.

They are invoked automatically as psychological measures which allow stressful situations to be coped with by distorting reality.

Inadequate use of dm can lead to open/clear anxiety or depressive feelings. DMs

-don't alter the stressful situation

-have an element of self deviation/deception

-help during rough times but delay the solution seeking behavior

-are unconscious processes as opposed to other methods of coping with problems

-if it is the dominant mode of responding, it may become personality maladjustment

Narcissistic- most primitive and appear in children, psychotically disturbed and a few with anxiety states eg denial, projection

Immature- in adolescents and in some non psychotic patients eg introjections, regression, displacement, rationalization, repression

Neurotic- mature, In oc and hysterical patients or adults under stress eg sublimation.

HDM reside in the unconscious domain of ego

1. Repression

-It is considered the central and basic psychological dm. Other dms come into play when repression has failed.

-Thoughts or feelings which our consciousness find unacceptable are expelled/withdrawn—a way of dealing with unbearable aspects of inner life; so

that aggressive or sexual feelings, fantasies or desires are thrust into unconsciousness.

-It is considered to be a mental process arising from the pleasurable principle (ID) and reality principle (EGO) ie indicates that when impulses and desires are in conflict with enforced standards of conduct (superego), painful emotions arise and the conflict is resolved by repression. Hence normalcy is once again attained and sustained/maintained.

2. Denial

-Involuntary and automatic distortion of an obvious aspect of external reality.

-Eg after death of a spouse, failed exam and promotes self, when doctor informs patient that he has a terminal illness, this fact may be denied at subsequent visits even though a clear concise explanation was given which patient obviously understood.

3. Displacement

-Transfer of feelings/emotions usually of fear or anger from one person, situation or object to another.

-Eg wife who is furious and irritated by her husband for always coming home late or giving her no support with children, she vents her anger on the children but not the husband.

Employer, husband, wife, children. Husband/wife (boss), junior workmates

4. Rationalization

-Process of justifying by reasoning after the event. This is act of providing logical and believable explanations for behavior, to persuade self and others that the irrational behavior is justified and therefore should not be criticized… **sour grapes story by the hare

5. Projection

-Individual unconsciously disowns an attribute or attitude of his own and ascribes it to someone else.

-Eg. I hate you becomes you hate me, I am lazy becomes you are lazy, am gay/lesbian becomes they are gay, immoral

6. Reaction formation

-The repressed wish is warded off by its diametric/equal opposite.

Eg hate someone but eventually end up showing love/kindness towards them (but the repressed hostility can still be detected underneath the loving exterior/mask)

7. Isolation

-Dangerous memories are allowed back into consciousness but the associated motives and emotions are not recalled. The memories are isolated from their associated feelings

-Eg in people who suffered severe physical or psychological trauma like in concentration camps/mau mau, kidnap victims, torture chambers, refugee camp, rape victims, etc.

8. Sublimation

-Occurs when potentially dangerous urges are given socially acceptable expression. Sexual or aggressive impulses instead of being given free expression are sublimated to other activities which are carried out with great vigor and often with great success

E.g. some sports- wrestling, boxing, rugby; butcherman; modelling, stripping (in sexual urges)

9. Introjection

-Victim takes in and accepts the values of others (survival dm)

Eg in detention camps some prisoners deal with overwhelming anxiety by accepting the values of the enemy thro identification with the aggressor; feels powerless, oblige to demands, pleas tormentors though one is being violated. Kidnap/car jacking: **Stockholm syndrome 1973, **Ohio 2013 Ariel Castro vs 3 kidnapped women

10. Compensation

-Consists of masking of perceived weaknesses or developing certain positive traits to make up for limitations.

People who are intellectually inferior may develop the physical aspects of their bodies, e.g., academic vs sports

People who are socially incompetent may develop their intellectual capacities and spend most of their time in lonely academic pursuits, eg, up to 7 degrees

11. Identification

People who feel inferior may identify themselves with successful causes, organizations or persons in the hope that they will be perceived as worthwhile (some get symbolic status and famous, distinguished, workaholic). Helps as a dm against anxiety of inferiority

12. Idealization

The negative/bad aspects of a person are not given attention thus the person is taken to be "perfect"… e.g. lovers. Not conscious like in political sycophancy

13. Intellectualization

-Excessive use of intellectual processes to avoid emotional expression or experience, stress is excessively placed on irrelevant details and inclusions to avoid perceiving the whole. In Academics- circumstantially or beating around the bush

-closely allied to rationalization

14. Regression

-Attempting to return to an earlier libidinal phase of functioning to avoid the tension and conflict evoked at the present level of development. Eg bed wetting, thumb sucking,, speech/grooming/crying when hungry

-It reflects the basic tendency to gain instinctual gratification at a less developed period

15. Somatization

-Converting psychic derivatives into bodily symptoms and tending to react with somatic manifestations rather than psychic manifestations eg multiple pains headaches, backaches, jt pains, stomach pains

16. Others

END

****

Normal Coping strategies to stress

1. Problem focused

-Define problem –come up with alternatives –weigh the alternatives (cost and benefit) –choose among the alternatives – implement the chosen

2. Emotion focused- used when problem is uncontrollable

a) Behavioral strategies- exercising, use drugs/alcohol, venting anger, seeking emotional support from friends

b) Cognitive strategies- temporary set aside thought, change meaning of situation,

c) Others- isolating self and thinking about how badly one feels, worrying, engage in pleasant activities eg parties, sports

OPIOID RELATED DISORDERS

Heroin, methadone, morphine, pethidine, fentanyl, codeine

- Physical/physiological dependence

-taken oral, injection (iv, sc), snorted intranasally,

**C/F- euphoric high/rush, feeling warm, heaviness of extremities, dry mouth, itchy face esp the nose, facial flushing. Initial euphoria is followed by a period of sedation (nodding off). Can cause respiratory depression (brainstem)

a) Opioid intoxication

-initial euphoria followed by apathy, dysphoria; psychomotor agitation/retardation; impaired judgment -pupillary constriction (or dilatation due to anoxia from severe overdose)

-drowsiness/coma –slurred speech –impairment in attention and memory

- can have perceptual disturbance

b) Opioid withdrawal

Substances with short duration of action tend to produce short, intense withdrawal syndromes while long action substances produce prolonged but mild withdrawal syndromes.

**Heroine and morphine ws begins 6-8 hours after last dose usually after >1 week period of continuous use. Ws reach peak intensity during 2-3rd day and subside in next 7-10 days.

-dyshoric mood/irritable/depressive/restlessness –nausea/vomiting –muscle cramps, bone aches –lacrimation or rhinorrhoea –pupillary dilation, piloerection(goose flesh), sweating –diarrhea –yawning –insomnia –increased BP, tachycardia, fever (temperature dysregulation with hyper/hypothermia.

Residual symptoms eg insomnia, temp dysregulation, bradycardia and craving for opioids may persist for months after withdrawal…. Injection to clear ws??

c) Opioid induced- psychotic disorder, mood disorder, delirium, sleep disorder, sexual dysfunction

-- Overdose treatment- ensure adequate airway; tracheopharyngeal should be aspirated and airway may be inserted/mechanical ventilation. Give naloxone iv (opioid antagonist), naltrexone

-- Heroine withdrawal and detoxification; use of methadone oral 20-120mg od.+ clonidine 0.1-0.3mg tds. Methadone also for maintenance (frees from opioid dependence and hiv risk, has minimal euphoria and rarely causes drowsiness/depression, help patient re engage in useful activities)..

Psychotherapy- individual, behavioural, cogn beh, family therapy, support groups (NA), social skills training

EATING DISORDERS (Feeding and eating disorders)

FED- are characterized by a persistent disturbance of eating or eating related behavior that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning. Eg anorexia nervosa, bulimia nervosa, binge eating disorder, pica, rumination disorder, avoidant/restrictive food intake disorder, others ***** ***obesity is not a mental disorder***

ED- are disorders of eating behavior deriving primarily from an overvaluation of the desirability of weight loss that results in functional medical, psychological and social impairment. Eg AN, BN, BED, ARD

-Diagnosis involves some limits on what are dimensional features eg degree of weight loss and attitudes towards weight and shape (thinness in women vs lean muscularity in men)

- "culture bound disorders" with varying prevalence according to social norm in different cultures/countries (unlike in scz, mood disorders)

- Rarely present as sole diagnostic entities ie almost always there is comorbidity (axis I/II)

ANOREXIA NERVOSA

Anorexia- loss of appetite (Greek) vs *nervosa*- nervous origin (Latin)

*Loss of appetite rarely occurs in early stage thus term is misleading

NB; it's a syndrome characterized by three essential criteria

1. A behavior- self induced starvation/reduced food intake

2. Psychopathological- relentless drive for thinness and/or morbid fear of fatness (linked to overvalued ideas/delusion esp overvaluation of thinness)

3. Physiological symptomatology- medical s&s due to starvation eg amenorrhea

Two types exist:

Restricting type- highly food intake restricted (<500 calories/day and no fats) plus may become overactive with overuse athletic injuries.

Binge/purge type- alternates attempts at rigorous dieting with intermittent binge and /purge episode.

Purge represents a secondary compensatory for unwanted calories- induced vomiting, diuretics, laxatives, purgatives, emetics abuse

Diagnostic criteria;

a) restriction of energy intake relative to requirements, leading to a significant low body wt in context of age, sex, developmental trajectory and physical health(wt that is less than minimally normal or for children/adolescents less than minimally expected)

b) Intense fear of gaining wt or becoming fat or persistent behavior that interferes with wt gain, even though at a significant low wt

c) Disturbance in the way in which one's body wt or shape is experienced, undue influence of body wt or shape on self evaluation, or persistent lack of recognition of the seriousness of the current low body wt

d) Occurring in the last-> 3 months

**Severity

Mild- BMI of ->17 kg/m, moderate- 16-16.99, severe 15-15.99, extreme <15

BULIMIA NERVOSA

"Ox hunger" (Greek) and "nervous involvement"

- Represents in many ways a failed attempt at AN, sharing the goal of becoming very thin but occurring in an individual less able to sustain prolonged semi starvation or severe hunger.
- Repeated binge eating episodes lead to panic in privacy ie feels eating has been out of control and may lead to fatness yet wants to be thin. Large quantities of food of high calories (2000-5000cal), sweet and fatty are taken rapidly leading to guilt, anxiety, low self esteem and frequent gastric distension.
- There is compensatory behavior to avoid wt gain eg exercise(in 20%) vs purging (in 80%- vomiting, laxatives, enemas,,)
- NB: without compensatory mechanisms leads to binge eating disorder--- are obese/overwt, older(30s-50s), more likely male>female

Diagnostic criteria;

a) Recurrent episodes of binge eating. An episode being characterized by both of the following

- eating in a discrete period of time (eg within any 2hr period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances

- A sense of lack of control over eating during the episode (eg a feeling that one cannot stop eating or control what/how much one is eating)

b) Recurrent inappropriate compensatory behaviors in order to prevent wt gain

c) The binge eating and compensatory behaviors both occur at least once/week for 3 months

d) Self evaluation is unduly influenced by body shape and wt

e) The disturbance does not occur exclusively during episodes of AN

**Severity based on frequency of the inappropriate compensatory behaviors/week

Mild 1-3, moderate 4-7, sever 8-13, extreme >14

Diagnostic criteria for B.E.D

a) Recurrent episodes of binge eating. An episode being characterized by both of the following

- eating in a discrete period of time (eg within any 2hr period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances

- A sense of lack of control over eating during the episode (eg a feeling that one cannot stop eating or control what/how much one is eating)

b) The binge eating episodes are associated with at least 3 of the following

- eating much more rapidly than normal – eating until feeling uncomfortably full – eating large amounts of food when not feeling physically hungry – eating alone because of feeling embarrassed by how much one is eating – feeling disgusted with one self, depressed or very guilty afterwards

c) No Recurrent inappropriate compensatory behaviors in order to prevent wt gain as in BN/AN

d) The binge eating occurs at least once/week for 3 months

e) Marked distress regarding binge eating is present

**Severity based on frequency of binge eating/week

Mild, moderate , severe , extreme

EPIDEMIOLOGICAL RISK FACTORS RELATED TO EATING DISORDERS

Cultural- society endorsement of wt loss and dieting

Gender- female>male (2:1-3:1 in community vs 10:1-20:1 in clinical setting)

Age – peaks at early and late teen but onset can be prepubertal thro 8th decade

Prevalence- AN approximately 1% of young women; BN 2-4% of young women

Family disorders- eating disorders, affective disorders, obesity

Socio economic class- AN possibly increases with s/e class, BN is independent

Personality role- increase probability in cluster C for AN (restrictive type- perseverance, sensitivity, perfectionism, impatient) vs cluster b in BN (impulsive, extrovert in purging cycles)

Psychiatric comorbidity- very high rates >70%; affective especially depressive; anxiety disorders eg phobic, panic, ocd; substance abuse/dependence; body dysmorphic 20% in AN

Pubertal age- increase with early puberty especially pubertal obesity for girls, criticism in puberty about wt increase (shame, humiliation)

Mono:dizygotic ratio- 3:1, monozygotic twins concordance of 50-80%

Sexual orientation- increase with gay orientation, possible decrease with lesbian orientation

Rural vs urban- increase with move from rural to urban. Social- media vs society value on thinness/dieting vs obesity stigma (social praise for wt loss can be an external reinforcement)

Medical comorbidity- possible increase with DM type I

Premature mortality- upto 19% increase medical causes, closely followed by suicide. AN + DM mortality increases 10 times

Vocational/avocational risks- ballet dancers, modeling, visual media roles, appearance sports (female gymnastics, figure skating), thinness sports (jockey, cross country running,), amateur wrestling

** Etiology-BPS

SUGGESTED INVESTIGATIONS

- Complete blood count (anemia is frequent)

- Electrolytes - blood urea, creatinine - total protein and prealbumin

- Fasting glucose - serum phosphate

- Amylase if purging occurs (increase in AN,BN salivary gland amylase; pancreatic increase in alcoholism)

-ECG

-TSH, free thyroxine (decrease in AN ie euthyroid sick syndrome- tsh, total t4 and t3 but free t3/t4 unchanged)

- Testosterone and estrogen levels decrease

- Bone mineral density (x-ray) in men with wt loss vs women with amenorrhea of >3months ie there is calcium loss (osteopenia, osteoporosis).

NB; testosterone, estrogen, change in thyroid are energy conserving consequences of starvation

- Drug screen in suspected (urine/blood for alcohol, stimulants, diuretics; stool-laxatives)

- MRI,CT SCAN, PET,SPECT (decrease in total brain volume and sulci complexity, increase ventricular size- mostly reversible with 100% in white matter, grey)

DIFFERENTIAL DX

- Depression

- Seasonal affective (bpiid) with atypical in BN

- OCD (ego alien thoughts/behavior urges that are resisted and generate anxiety vs AN ego syntonic based on overvalued ideas of wt loss/fat)

- Body dysmorphic ie focus on specific part not whole body

- Substance abuse especially stimulants lead to wt loss

- IBS

POTENTIAL MEDICAL CONSEQUENCES OF A.NERVOSA

Vital signs - bradycardia, hypotension, hypothermia, poikilothermia

General – muscle atrophy, loss of body fat

CNS – generalized brain atrophy, seizures, abnormal eeg

CVS – peripheral (dependent) oedema, reduced cardiac circumference, narrowed left ventricular wall, reduced response to exercise demand,

Renal – prerenal azotemia

Haematological – anaemia, leucopenia, hypocellular bonemarrow,

GIT – delayed gastric emptying, gastric dilatation, reduced intestinal lipase and lactase

Metabolic – hypercholesterolaemia, non symptomatic hypoglcaemia, increase liver enzymes, reduced bone marrow density

Endocrine – low fsh, lh, estrogen, testosterone; low/n thyroxine; low t3, prolactin; increase cortisol, gh; partial d insipidus

TREATMENT

Goals – attain and maintain a normal healthy stable body wt,

- Stopping all abnormal eating behaviors eg food restriction, binge/purge and associated behavior eg exercise(interrupt then stop and replace with healthy habits)
- Dismantling core overvalued beliefs eg on wt/fatness
- Treat comorbid conditions eg medical, psychiatric
- Planning for ongoing relapse prevention for at least five years after acute improvement

Methods- medical, nutritional, psychotherapeutic, behavioral, pharmacological

a) A.N

Wt restoration- refeeding methods (oral, iv, ng tube) with aid of nutritionist

- appropriate for age/ht/gender or at which will restore biological health (> 50% chance to restore menses and ovulate in women /normal sexual physiology and fxn in men)

Medication- ssri's, tcaa's,

- Zn supplements 50-100mg (have more rapid wt restoration improve)

Psychotherapies- aimed at modifying and altering core pathological beliefs eg use of cognitive behavioural therapies, family therapy, and group therapy

b) B.N & BED

*Very few are admitted (suicidal, comorbidities)

- Around 15% respond to sessions (4) of psychoeducation emphasizing healthy nutrition

- Around 20% respond to self guided help program using manuals, psychoeducation, cbt

- CBT very helpful in moderate forms + ssri's eg fluoxetine

COURSE IN A.N

- Death rates 12 times higher than in normal girls.

- follow up after rx; 30% ok, 30% partially improved, 30% chronically ill, 10% died

-many continue to have chronic mood, anxiety, personality disorders

- 50% have transition from AN to BN/BED

Generally BN has higher rates of partial/full recovery than AN

PICA

- A persistent eating of nonnutritive, non food substances over a period of at least 1 month

- The eating is inappropriate to the developmental level of the individual

- The eating behavior is not part of a culturally supported or socially normative practice

- can occur in presence of another mental/medical disorder but it is sufficiently severe to warrant additional clinical attention (intellectual disability, autistic spectrum, scz, pgn)

NB; a minimum age of 2 years old is required ie helps exclude developmentally normal mouthing of objects by infants that result in ingestion

** paper,soap,cloth,hair, string, soil/clay, chalk, hair, paint, gum, metal, glass, pebbles, charcoal/coal, ash etc

Complications- intestinal obstruction, intestinal perforation, infections eg toxoplasmosis, toxocariasis, other helminthes, poisoning eg in pb based paint ingestion

*Comorbidity at times with OCD, trichotillomania, intellectual disability, autistic spectrum, scz,

Rx- psychoeducation, CBT, environmental manipulation (supervision, care planning,etc), behavioural therapy

RUMINATION DISORDER

- Repeated regurgitation of food over a period of at least 1 month. The food may be re-chewed, re-swallowed or spit out

- Regurgitation is not due to git or other medical condition eg gerd, pyloric stenosis

- No a.n, bn, bed, a/rfd

- If there is another mental condition eg intellectual disability then the rd is severe to warrant additional clinical attention

- cx; teeth decay, halitosis, indigestion,

PSYCHIATRY INTERVIEW-history and mse

-Interview is the most important tool in psychiatry

-It is used to understand the patients' problem, elicit signs and symptoms, make appropriate diagnosis, initiate treatment and predict outcome

-It offers patients an opportunity to express themselves and others in a non judgmental and non critical atmosphere

-Clinicians should know what, how, when to ask and how to interpret responses of the patient.

-History is obtained from patient, family, relatives or friends (coz in some cases the patient may not be responsive or may be confused or may give inaccurate history eg in alcoholics, scz)

-In very sick, agitated or confused patients, the observation and a brief history may be all needed to begin treatment. A more detailed history and MSE can be obtained later from relatives or patient when s/he improves

GENERAL PRINCIPLES IN INTERVIEW

1. Active observation and awareness of behavior

- it begins from the moment patient walks into consultation room=gait, physical appearance, greetings, general attitude

-focus on verbal and non verbal communication eg facial expression, hesitancy during interview, absence of eye contact, constant checking around the room

2. Assessment and evaluation is two way process

-clinician is assessing patient while patient is also evaluating your sensitivity and genuine desire to help

-good rapport and shared feelings of mutual respect and understanding

3. Acceptance of the behavior of patient- all behavior even if odd has a meaning to the patient. Accept but don't approve

4. Avoid arguments with patient

5.Dont assume you understand the patient- eg clarify your thoughts of what the patient says and feels by summarizing a number of times during interview, by repeating what the patient has said and the feeling the patient has expressed.

6. Stress on feelings- feelings of patient may be difficult for clinician to understand eg crying, suicidal. **how and when to ask questions

-focus on feelings and emotionally charged areas should be explored

-sensitive topics should be handled carefully and tactfully eg sexual life (introduce them gradually). In case of resistance these areas should be kept in mind for further discussion (later in interview or another day)

7. Focus on interpersonal relationships

-noted in family history

- Interpersonal sense of love, acceptance, security and discipline (helps reveal psychodynamic factors responsible in shaping the personality of the patient)

8. Avoid being moralistic and judgmental- a patient may come feeling guilty, anxious and expecting the worst

9. Show empathy i.e. direct identification with, understanding of experience of another person's situation, feeling and motives.//sensing the client's inner world of private personal meaning as if it were your own but without losing the "as if" quality NOT sympathy

10. Try to tolerate silence of patient- e.g. it could be thought problem or just doesn't wish to respond to your questions due to the illness or feeling aroused.

COMPONENTS OF PSYCHIATRIC HISTORY

1. IDENTIFICATION DATA

Name, age, sex, marital status, residence, religion, occupation of the patient

2. THE REFERRAL SYSTEM

Note the source- health worker, brought by family members or friends, self

-indicate main reason for referral

3. CHIEF COMPLAIN/ALLEGATIONS

-A brief statement of why the patient seeks help. It should contain the description of the problem and should be stated in patient's/relatives own words. Duration of complains and hierarchy

4. HISTORY OF PRESENT ILLNESS

-Patients problems are explored in details and in a chronological order. It should start from the time when patient started feeling discomfort which may predate on his social interactions with others both at work, home and its consequences on his family life, occupation

- should contain the psychosocial stress factors in the life of patient as well as physical illness and time relationship with the present symptoms - review of systems/ros

5. PAST PSYCHIATRIC ILLNESSES/HX- plus investigations done, results, diagnosis, treatment and outcomes

6. PAST MEDICAL ILLNESSES/MEDICAL HISTORY-

7. FAMILY HISTORY

*Nuclear vs extended-grandparents and other family members may play an important role

-For each member note-name, age, sex, ms, occupation, relationship(past and present) with the patient, current health condition

- If dead indicate age at time of death and cause

-Partial/total economic dependency of the patient, siblings, parents and how the s/he feels about it

-FHX of mental illness in nuclear and extended family

-Fhx of chronic general medical conditions

8. PERSONAL HISTORY

**The past life of the patient is reviewed with aim to get comprehensive picture of patient and to find out factors in his/her past which may explain his psychological make up, personality and present problem

a) Pregnancy, birth and early development upto 6 years

*tries to understand the early childhood development stages of patient and whether needs were met or frustrated

- was pregnancy unwanted or outside wedlock and what were the consequences on the relationship of mother and child and other family members

-problems during pregnancy and delivery and neonatal period

-Developmental milestones

-extended or nuclear family; who was closely attending to the patient's needs?

-interpersonal relationship of individual in the family unit, its cohesiveness and the socio economic situation

-significant incidents eg separation, divorce, major illness and death of significant people

-neurotic traits eg thumb sucking, nail biting, temper tantrums

-school performance?

b) 6 years to puberty

-focusing on individual sense of identity , participation in structured activities, school(performance, likes), discipline, attitudes towards authority at home and school, peer group activities and influence on patient, coping mechanisms

c) Adolescent to 19 years

*period of heightened sexual awareness

- puberty and menarche in girls, early marriage

-boys- sexual matters and masturbation related anxiety and worry about physical and mental illness

- school achievements, social relationships at home/school and other students

-professional interests and future goals

-involvement in extra curricula activities. **college

-daily activities and social contacts for those who didn't go to school

d) Occupational history

-age and which work patient first engaged in

- any income generating activities or formal employment and job changes

-nature of work, social and occupational relationships, job satisfaction, growth/promotions and improvement or deterioration in the job

-repeated absenteeism from work/ disciplinary issues or deterioration in work output eg in alcoholism, depression,scz

e) Marital history

-age of marriage, personal decision or forced/arranged marriage

-individual feeling towards the marriage

- health and personality, religion, occupation, lifestyle of the partner (play a vital part in relationship)

-children and ages, health, education achievements

f) substance/drug abuse and forensic issues

**SUMMARY of history(optional)

**GENERAL physical exam

MENTAL STATE EXAMINATION/ASSESSMENT

A great deal of it is obtained during the interview about the present/current illness

1. General appearance

- grooming, posture, gait, physical characteristics, facial expression, eye contact, motor activity

- also note state of awareness or consciousness eg fully c, drowsy, coma, stupor

2. Speech- rate, pitch/tone, volume, clarity

3.Mood- describe it eg euthymic, low/depressed, expansive, euphoric, labile, irritable

4.Affect- eg appropriate, inappropriate, flat, blunted, labile

5. Perception- illusions, hallucinations, depersonalization, derealisation

6. Thoughts

a)process and form – flow of ideas and quality eg racing/speeded, slowed down. Circumstantial, derailments, flight of ideas, neologisms,

b)alienation/control- eg thought broadcasting/echo/insertion/withdrawal

c)content- delusions, overvalued ideas, obsessions, suicidal/homicidal ideas

7.Orientation- in time,place and person

Time- time of day, day of week, date, month, year (determine with social cultural background of the patient)

Place- ask of familiar place

Person- eg his name, age,children, parents, siblings or those with him if familiar (counter check)

8.Attention and concentration

A- if can follow interview and how they answer questions or name 3 objects to patient/telephone number and repeat after interview

C- simple calculations eg serial 7 upto 65 (100-7) or serial 3 (20-3) or days of week/month backwards or simple problems

9. Memory

Registration and recall/immediate- eg give items, telephone number of 5-6 digits

Recent- eg what ate for breakfast/supper, news,

Recent past- experiences in last few days/months

Remote- more than 1 year eg important dates/years, schooling, marriage, previous important people

10. Intelligence/numeracy and abstraction- determine general level compared to education, social and cultural background. I/N- eg calculations, differences and similarities, direction of wind, reading and writing A- proverbs

11. Judgment- does patient understand harmful consequences of his/her behavior, can he/she make wise decisions eg in life threatening situations like fire, drowning, road----

12. Insight – awareness of illness, cause its implications, need for treatment

FORMULATION- summary of history, physical exam and mental state examination findings

DIAGNOSIS(multiaxial or non multiaxial) AND DIFFERENTIALS

INVESTIGATIONS- physical, psychological, social

TREATMENT PLAN-physical, psychological, social

PROGNOSIS-good or bad

PSYCHOPATHOLOGY/SYMPTOMATOLOGY

This is the study of abnormal states of mind. It is an attempt to understand the disease process of the mind in terms of signs and symptoms including their causes and how they develop

Two main schools of thought regarding it

1) Dynamic/psychoanalytic-

2) Clinical/descriptive- puts emphasis on phenomenology ie understanding of mental phenomenon in terms of signs and symptoms

It is the objective description of abnormal states of mind. It is concerned with the conscious experiences and observable behaviors and defines the essential qualities of morbid mental experiences. It includes

DISTURBANCE IN EMOTIONS

Emotion- feeling or response to sensory input from external environment or mental images

***Mood-** sustained and pervasive inward subjective feelings. The emotional state subjectively experienced by the patient. It's influenced by the patient experiences, expectations and presence of disease. It may be altered by use of psychoactive substances like alcohol and opiates. Examples of variations in mood include

1) Euthymic mood- is the normal mood

2) Depressed mood- pathological feeling of sadness/low

3) Dyshoric- unpleasant mood/foul

4) Irritable- easily angered, offended

5) Elevated- cheerful, happy mood

6) Euphoric- intense elation of mood

7) Labile- rapid changes in emotions

8) Anhedonia- loss of intense or inability to enjoy previously pleasurable activities

9) Apathy- blunted emotions associated with loss of energy and drive ...melancholy

***Affect-** it's somatic and behavioral changes i.e. the outward expression of the emotion

Irritable, Labile, appropriate, inappropriate

Blunted- reduction in intensity of outward expression

Flat- no outward signs to express the feelings

Drugs that can alter affect- cpz, haloperidol

DISTURBANCE IN THOUGHT- content, form, alienation/control

A) Disorders of content- delusions, overvalued ideas, obsessions etc

*Delusion- a false unshakable belief based on incorrect inference about external reality (firmly sustained) not consistent with a person's intelligence or cultural belief, cannot be corrected by reasoning. (The belief is not one ordinarily acceptable by other members of the person's culture or sub culture e.g. it's not an article of religious faith)

1) Grandiose delusion- inflated self worth, power, knowledge, identity or special relationship to a deity or famous person (characteristic of the now uncommon syphilitic general paralysis of the insane, but also occur in mania and schizophrenia).

2) Bizarre- involves a phenomenon that the person's culture would regard as totally implausible

3) Delusional jealousy/infidelity- that one's sexual partner is unfaithful. (Occur in people with suspicious personalities, especially when associated with alcohol abuse, in schizophrenia and in affective psychoses). *Orthello syndrome

4) Erotomania- that another person usually of higher status is in love with the individual. (mainly in schizophrenia and other organic psychoses). W>m

5) Persecutory/paranoid - the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted or conspired against. May take legal action or act in defense

6) Somatic- main content pertains to appearance or functioning of one's body. Involves function of body eg brain is rotten/melting, no stomach,

7) Hypochondriac- belief in one's illness contrary to medical evidence

8) Nihilistic- extreme pessimism eg that self/others or world is non existent or coming to an end; poverty. (Also the patient says that they or a body part is dead; occur mainly in severe depressive illnesses).

9) Reference- behavior of others refer to himself, usually of negative nature, connection with ideas of reference

*Overvalued ideas- false beliefs but less firmly held (shakable) and can be reasoned. They can occur in normal persons undergoing stressful experiences

*Obsessions - Pathological persistence of an irresistible thought or feeling that cannot be eliminated from the mind easily. Patient recognizes these as his own thoughts but he cannot get rid of them e.g. in OCD

B) Disorders of form- flow and structure thoughts

1) Neologism- new words created by a patient or a normal word used to mean a different thing

2) Word salad- several words put together with no clear meaning

3) Echolalia- repetition of words or phrases said by another person tend to be repetitive and persistent, at times mocking

4) Derailment- gradually deviates in flow of thought without blocking

5) Circumstantial- indirect speech that is delayed in reaching the point but eventually gets from original point to desired goal. Has over inclusion of details

6) Flight of ideas- rapid thought manifested by fast verbalization and shifting of ideas which tend to be connected to one another

7) Loosening of association- flow of thought in which ideas shift from one subject to another in a completely unrelated way. When severe, speech may become incoherent

8) Thought block- sudden interruption in the stream of thoughts before an idea or thought is completed.

10) Clang association- association of words similar in sound but not in meaning. The words have no logical connection

11) Irrelevant answers- not in harmony with question asked i.e. apparent ignore or not attend to question

12. Others- perseveration (in MR, Scz, or Substance use disorder)

C) Disorders of alienation/control-The thoughts are controlled by outside forces

1) Thought withdrawal- other people or forces or agents remove one's thoughts from the mind

2) Insertion- other people or forces are putting thoughts into one's mind against their wish

3) Broadcasting- one's thoughts are made known to others without being talked out by the one thinking.

4) Thought echo

DISTURBANCE IN SPEECH

1) Pressure of speech- talks a lot and rapidly and it may be difficult to follow the speech eg in mania. *Usually accompanied by flight of ideas and increased rate of speech.*

2) Poverty- scanty speech eg in psychomotor retardation or depression. Monosyllabic replies mostly …..Mutism/elective, selective

3) Alogia- inability to speak because of mental deficiency or dementia

4) Coprophasia- involuntary use of vulgar or obscene language eg in scz, tourettes disorder

5) Stuttering- frequent repetition or prolongation of a sound or syllable leading to markedly impaired speech fluency

DISTURBANCE IN PERCEPTION

Perception- process of transferring physical stimulation into psychological information. Mental process by which sensory stimuli are brought to awareness

Hallucinations vs illusions

*Illusions- arise from false interpretation of stimulus (could be a result of fantasy, intense emotion, lack of perceptual clarity or disease)

*Hallucination- false sensory perception not associated with real stimulus. It may be in any of the 5 sensory modalities- vision, touch, taste, smell, sound

1) Visual hallucination-occurs commonly in medical disorders affecting CNS but also in some psychotic patients

2)Tactile- include false perception of touch(haptic), surface sensation as in amputated limb(phantom limb) or even crawling sensations on or under the skin(formication). This occurs in substance abuse as well as other mental illnesses.

3) Olfactory- false smell. Medical conditions mostly

4) Gustatory- false taste. Medical conditions

3 and 4 occur in medical conditions affecting CNS eg epilepsy and other mental illnesses eg depression, scz

5) Auditory- hears voice/sound without any stimulus. The voices may include animal sounds, music, conversations between people or with the patient. They could be familiar or unfamiliar to the patient and could also be derogatory or pleasant. Common in psychotic disorders like scz, mania, psychotic depression

Third person auditory hallucination- voices talk among themselves about the patient; (mostly in scz).

Second person- voices talk directly to the patient (mostly in severe dcepression)

Commentary voices-talk/describe what the patient is doing/thinking

Hallucinations may be mood congruent ie consistent with prevailing mood or also incongruent

*Depersonalisation- vs- *Derealization (unreal environment)

Depersonalisation: This is often a manifestation of heightened anxiety levels. The patient does not feel his or her normal self, and may describe this unpleasant experience as if floating above their own body looking down on it. The patient may also complain of losing the capacity to feel at an emotional level. This may be one of the most marked symptoms in depressed patients.

Derealization: This often accompanies depersonalization. Patients say that their surroundings feel unreal, or grey or colorless.

DISTURBANCE IN MOTOR BEHAVIOR

Externally observable abnormal behaviors that depict psyche eg motivations, impulses, drive, instincts, and wishes. It may be observed in all forms of mental illness and include;

1) Cataplexy- sudden temporary loss of muscle tone eg in scz, narcolepsy

2) Catalepsy- an immobile position that is constantly maintained for a long time,

3) Catatonic excitement- purposeless motor over activity which sets on suddenly eg in scz

4) Catatonic stupor- marked slowed motor activity often to the point of immobility ie seeming unawareness of surrounding

4) Echopraxia- imitation of one's movements by another person

5) Mannerism-habitual involuntary movts and attitudes

6) Akathisia- subjective feeling of restlessness and need to keep on moving eg in adverse effects of antipsychotics

7) Chorea- random and involuntary quick jerking purposeless movements

8) Compulsion- an uncontrollable urge to perform an act repeatedly 9. Others-

DISTURBANCE IN ATTENTION

Attention- ability to direct one's activity

Concentration- amount of attention exerted in focusing on certain portions of an experience

Att and conc may be impaired in dissociative states, anxiety states, depressed patients etc

1) Distractability- inability to concentrate ie attention is easily diverted to other activities that are irrelevant eg in manic states

2) Trance- a dream like state when attention is focused on one thing and the person seems oblivious of his surrounding eg in hypnosis and dissociative disorders and in ecstatic religious experience

3) Selective inattention- in which one blocks away from consciousness things that generate anxiety

4) Hyper vigilance- excessive attention is concentrated on a stimulus. Often secondary to paranoid and delusional state

DISTURBANCE IN MEMORY

Memory- function by which information stored in brain is recalled to consciousness vs
Orientation- normal state of oneself and one's surrounding in terms of time, place and person

Most affected in medical illnesses that affect brain eg dementia and other degenerative disorders

Para amnesias- falsification of memory by distortion of recall; may occur in some patients going thro stressful life experiences eg terminal illness, bereavement, after alcohol abuse eg

Confabulation- unconscious filling of gaps in memory by imagined or untrue experiences that a person believes but that have no basis in fact

Déjà vu- illusions of visual recognition in which a new situation is incorrectly regarded as a repetition of previous memory

Jamais vu- false feeling of unfamiliarity with a real situation that a person has experienced

Amnesia- partial or total inability to recall past experiences

Retrograde amnesia-amnesia of events occurring before a point in time

Anterograde amnesia- amnesia of events occurring after a point in time

Memory- immediate/registration and recall, recent, recent past, remote

DISTURBANCE IN CONSCIOUSNESS

C- a state of awareness of the self and the environment. Its disturbance are often associated with apparent brain pathology eg trauma, epilepsy, narcolepsy, CNS infections, tumours. Altered states of consciousness include

1) Coma- deep/profound unconsciousness. GCS, others

2) Stupor- lack of response and unawareness of surrounding

3) Delirium- dream like change in consciousness often accompanied by an impaired reality testing. Patient may be anxious, restless, confused, hallucinations

4) Drowsiness- state of impaired awareness associated with a desire or inclination to sleep

5) Somnolence- abnormal drowsiness

SLEEP DISORDERS (sleep-wake disorders)

Sleep- a regular, recurrent, easily reversible state that is characterized by relative quiescence (inactivity/quiet) and by a great increase in the threshold of response to external stimuli relative to the waking state.

- a homeostatic function/restorative and recovery
- Crucial for normal thermoregulation and energy conservation
- Discharge of emotions, brain growth
- Maintenance of immune system

With increasing periods of sleep deprivation one gets- disorganization, disorientation, irritability, lethargy, illusions, hallucinations, delusions. Increase in plasma NA, decrease in thyroxine levels

`Sleep requirements- two groups of people

1. Long sleepers- require -> 9 hrs each night in order to function adequately. Tend to be mildly depressed, anxious, socially withdrawn.

2. Short sleepers- require-< 6 hrs each night to function adequately. They are generally ambitious, efficient, contended, socially outgoing.

Most adults fall btwn 1 and 2

Study in 2002 (1 million sample), >8.5 hrs sleep and <3.5hrs had a mortality risk of 15% greater than those who slept average of 7hrs/night??

Sleep needs generally increases in/after- exercise, increased physical activity, physical illness, pregnancy, general mental stress, increase mental activity,

Sleep wake rhythm

Excluding external clues the natural body clock follows 25hrs cycle; however with influence of light/darkness, daily routine, meal periods etc trains us to 24hrs clock

Sleep is also influenced by biological rhythms eg within a 24 hr period most adults sleep once/twice. Rhythm is not present at birth but develop in first 2 years of life.

****Two physiological states of sleep—non rapid eye movement (75%) vs rapid eye movement (25%)**

NREM-

It's characterized by

- slow PR but regular, around 5-10 beats below level of restful waking

- Slow RR - low BP than normal

- Involuntary movts with increased tone esp lower limbs

- Blood flow thro most tissues decrease

- has 4 stages

REM

- Increase PR, RR, BP and brain oxygen use/metabolism

- Almost every REM period is accompanied by partial/full penile erection (vital in evaluating causes of impotence ie organic vs psychogenic)

- increase vaginal temperature

- decreased tone, almost total paralysis of skeletal/postural muscles with no body movts

- Dreams commonly occur in this state (but can also occur in nrem- lucid/clear and purposeful)

** Cyclical nature of sleep is regular and reliable with REM occurring after every 90-100 minutes during the night.

The first rem tends to be shorter <10mins but later periods may last 15-40mins. Most long ones occur in last third of night/sleep.

Sleep patterns change over life eg neonates 50% sleep is rem while in adults its 25% (less in the elderly), neonates sleep 16hrs/day vs adults av of 8hrs

NTs- 5HT, ACH, NA, DA, melatonin, (in regulating temp and sleep duration).

TYPES/GROUPS

1. Dysomnias- insomnia,

-hypersomnia eg idiopathic, narcolepsy, sleep apnoea, kleine Levin syndrome,

- Circadian rhythm sleep disorders

2. Parasomnias- nightmares, night terrors, sleep walking, sleep talking

3. Due to amc/substances/related to another mental condition

***insomnia disorders, hypersomnolence disorder, narcolepsy, breathing related sleep disorders, circadian rhythm sleep wake disorders, nrem sleep arousal disorders, nightmare disorder, rem sleep behavioural disorder, restless legs syndrome, substance/medication induced sleep disorder (dsm-v and international classification of sleep disorders-2)

INSOMNIA

Defn- lack of sleep

- Commonest sleep disorder - prevalence rates of 10-20%

- can be primary or secondary (majority)

** Secondary insomnia like in

- Geriatric disorders – abuse of alcohol/caffeine – painful physical conditions eg ca, orthopaedic conditions, burns - structural and metabolic conditions affecting CNS eg vit b6 deficiency, dementia and other mental illnesses

- Brief episodes of insomnia often occur after anxiety or in anticipation of anxiety causing situations

* Three types of insomnia

Difficulty in falling asleep- common in anxiety

Difficulty in remaining asleep- anxiety

Early morning awakening- mood disorders (depressive, bipolar)

Rx

- If secondary, treat the underlying conditions ie will restore normal sleep pattern eg discourage alcohol/caffeine use

- Medication eg hypnotics (use for a few nights ie some can lead to dependence/withdrawal symptoms/tolerance/rebound of insomnia/impair performance during work). Benzodiazepines for 2-6 weeks tapering off, zolpidem, zaleplon

- Light therapy

- Dietary eg melatonin, tryptophan

- sleep hygiene (more vital in primary insomnia)

PARASOMNIAS

1) **Night terrors/sleep terror disorder**- occur in nrem. Males>females; familial tendencies; 1-6% in children;

- Recurrent episodes of abrupt awakening from sleep usually during the first third of major sleep and begin with a panicky scream. There is Intense fear and autonomic hyper arousal eg tachycardia, sweating, rapid breathing. Relative unresponsiveness to efforts of others to comfort the person during the episode

-no dream recall of the scaring event; anxiety/screaming/crying typically they sit up in bed; some relation to TLE (especially in adolescents/adults), sleep walking, enuresis;

-need family/individual therapy, Benzodiazepines low doses at bedtime eg diazepam

2) **Nightmares**- repeated awakenings from major sleep periods/naps with detailed partial/total recall of extremely frightening dreams usually involving threats to survival, security or self esteem. Occur in rem mostly late in night. On awakening from the dream, the person quickly becomes oriented and alert unlike in terror/epilepsy types,,,

- use TCA's/Benzodiazepines

3) **Sleep walking/talking** (somnambulism/somniloquy)- SW, repeated episodes of rising from bed during sleep and walking about, occur in nrem mostly first third of sleep. While walking, the person has a blank stare, is relatively unresponsive to efforts of others to communicate with her/him and can be awakened only with great difficulty. No recall; males> females/girls; onset at age 4-8yrs old and peaks at 12 yrs; familial tendency; prevalence of up to 15% in children

ST- common in children and adults, occurs in all stages of sleep, usually involve a few words that are difficult to distinguish, long episodes of talking involve one's concerns, alone needs no treatment

** Sleep related bruxism/tooth grinding- occurs thro out the night, 5-7% is severe enough to produce noticeable teeth damage, goes unnoticed by the patient except for occasional jaw ache in the morning, distress to bedmate/roommates who get awakened by the sound, rx with dental bite and corrective orthodontic procedures

HYPERSOMNIAS

Excessive quantity of sleep, excessive daytime sleepiness (somnolence)

1) Narcolepsy

-A syndrome characterized by daily (day/night) attacks of irresistible sleep for > 3 months. -- Attacks are associated with cataplexy in 1/4-1/2 of patients (abrupt loss of muscle tone thus may fall) or sleep paralysis and hypnagogic/hypnopompic hallucinations.

-Attacks typically occur 2-6 times/day and last 10-20 mins.

- Attacks may occur at inappropriate times eg while eating, driving, talking, during sex,,. it can lead to accidents(domestic, automobile, industrial)

Age of onset at 10-20yrs, males> females, prev of 0.02-0.16%

It persists for life but less severe in middle age

Aetiology familial?- autosomal dominant, polygenic

Investigations- EEG helpful reveals a characteristic early onset of rem sleep at night

- R/o gmc eg ,, substance abuse

Treatment- forced naps at regular time of day (helps/may cure without medication)

- Stimulants eg amphetamines (methylphenidate, modafinil-)
- Stimulants + antidepressants eg tca's, ssri's especially when cataplexy is prominent
- Psychological/ counseling and lifestyle adjustment

2) Idiopathic hypersomnia/ sleep drunkenness

- Patient unable to wake up completely until several hours after getting up.
- During this time patient is confused, disoriented (sleep drunkenness)
- Reports prolonged deep night sleep
- About ½ of them have periods of daytime automatic behavior (do things unconsciously)
- aetiology not clear
- Rx, most respond well to CNS stimulants (low doses)

3) Sleep apnea

- ceassation of airflow at the nose or mouth, apneic period lasts at least 10 seconds

- Consists of daytime drowsiness, periodic respiratory problems ---, excessive snoring at night/gasping

- Usually associated with upper airway obstruction, extreme obesity

*pure central sleep apnea- both airflow and respiratory effort (abdomen and chest) cease during the attack but begin during arousals.

*pure obstructive apnea- airflow ceases but respiratory effort increases during the attack, reverts to normal on arousal.

*mixed

Nb: considered pathological if patient has >30 episodes during the night (>6/hr)

* Unexplained deaths in adults and crib deaths in infants/children… pulmonary/cardiovascular deaths in adults and elderly

Rx- relieve cause of obstruction, wt decrease, tca's and ssri's, Patient to avoid sedatives and alcohol

4) Klein Levin syndrome

- consists of episodes of recurrent prolonged sleep (patient may be aroused), increased appetite, irritability, apathy, social withdrawal, hallucinations and delusions may occur, disorientation, loss of sexual inhibitions, returns to bed at first opportunity (alternates with episodes of normal sleep and alert waking)

- might be hypothalamic disorder thus the change in appetite

- First episodes mainly male adolescents (10-21yrs age), extreme mood changes

Rx- CNS stimulants?,. Spontaneous remission by age 40 in early onset

OTHERS

1. Circadian rhythm sleep disorder

- involves misalignment btwn desired sleep and actual sleep periods eg delayed sleep phase type, jet lag type, shift work type,

** Jet lag type- depends on length of east to west trip and individual sensitivity. Usually remits spontaneously in 2-7 days (no specific rx required). May prevent it by altering sleep and mealtimes in an appropriate direction before travelling.. Also obtaining enough sleep may help relieve the fatigue. Oral Melatonin also helps in some people

** Shift work type- in those who repeatedly and rapidly change their work schedules. Gets episodes of mixed insomnia and somnolesence plus other symptoms/somatic problems eg acidity. Symptoms are usually worse in the first few days after shifting to a new schedule. It's more severe in elderly than young adults… Doctors? Who often work 36-48hrs without sleeping can be dangerous to patients and self.

2. Restless leg syndrome/Ekbom syndrome

- feels deep sensations of creeping inside the calves whenever sitting or lying down. Usually painless but causes irresistible urge to move the legs thus interferes with sleep/falling asleep. Worse at night, Occurs in 5% of population and peaks in middle age.

-etiology not clear ?? pregnancy, iron/vit B12 anemia, renal disease

Rx- non clear. Movt and massage of legs seems to relieve, benzodiazepines, levodopa, quinine, , propronalol, valproate, carbamazepine have some benefit

*Periodic limb movement syndrome/nocturnal myoclonus

-Person is normal while awake but problems when asleep

- Abrupt contractions of certain leg muscles during sleep/leg jerks without awareness

- Extension of large toe, flexion of ankle, knee and hip

- Frequent awakenings, unrefreshing sleep and daytime sleepiness occur

SOMATIC SYMPTOM AND RELATED DISORDERS (somatoform disorders)

- A group of mental illnesses characterized by physical complaints that appear to be of medical in origin BUT cannot be well/fully explained in terms of physical disease, the results of substance abuse or by another mental disorder.

- The physical symptoms are serious enough to interfere with the patient's functioning (work, relationships, self).

- The symptoms are NOT under the patient's control(except factitious)

INCLUDES

1. Somatic symptom disorder (formerly Somatisation disorder)

2. Hypochondriasis (illness anxiety disorder)

3. Conversion disorder

4. Factitious disorder

5. Psychological factors affecting other medical conditions

6. Others- unspecified/specified

NB; due to physical complaints, most are attended/ diagnosed in general medical clinics then referred to mental health workers (after a lot of investigations, medications, operations- cost/chronicity/complications)

- Efficient/accurate diagnosis requires; medical work up (physical to r/o medical or neurological conditions), co morbidity assessment (overlap with other mental disorders)

- Female preponderance in most

1. SOMATIC SYMPTOM DISORDER

- Women >men eg lifetime prevalence of upto 2% in women (5;1)

- More common in rural areas, low socio economic status and among the educationally deprived

- Average onset age of 15 years with peak in 20's then decline/improve (late onset in older adults- likely to have occult medical illness or a depression with somatisation)

** Complex aetiology(BPS).

Assessment and diagnosis

- Review patient's medical records - Full comprehensive psychiatric history

- R/o depression (up to 50% co morbidity) and substance abuse co morbidity

- Personality disorder may predispose one to amplify somatic symptoms eg avoidant, oc, paranoid features

- Evaluate the abnormal psychosocial stressors during onset of illness or in the past (eg parental illness during childhood and effect- parent able/unable to care for the patient, physical illness and hospitalization in childhood with parental over concern/long absence from school)

- Explore patient's belief or perception about the physical symptoms

DSM dx

A. 0ne or more somatic symptom that are distressing or result in significant disruption of daily life(pains, fatigue, gastrointestinal , genitourinary,). physical complaints usually beginning before age 30 yrs and occur over a period of several years

B. excessive thoughts, feelings or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following

- disproportionate and persistent thoughts about the seriousness of one's symptoms

- persistently high level of anxiety about health or symptoms(feelings)

- excessive time and energy devoted to these symptoms or health concerns (behavior)

C. the state of being symptomatic is persistent for at least 6 months (although any one symptom may not be continuously present)

** specify; 1) with predominant pain(s) 2) persistent course characterized by severe symptoms, marked impairment, long duration (> 6 months)

** severity; mild- only 1 symptom in B, moderate- 2 or more symptoms in B, severe- 2 or more symptoms in B and are multiple somatic complains or is one severe somatic symptom

- After appropriate investigations the symptoms can't be explain by/find a general medical condition or direct effects of a substance of abuse

- When there is a related gmc, the physical complaints/ dysfunction are in excess of expected from hx,pe, lab findings

D. The symptoms are not intentionally produced/feigned (eg in malingering or factitious disorder)

DDX

- Medical conditions presenting with vague/non specific/multiple symptoms – MS, SLE, Hyperparathyroidism.. (* involvement of multiple organ systems, early onset, chronic course without cx, neg lab tests=SSD)
- SCZ with multiple somatic delusions
- Major depression/severe: Anxiety disorders eg panic attack
- Other SS related D conversion, factitious: Co morbidity- depression, anxiety, substance abuse

Course and prognosis- often chronic and debilitating

Treatment

Need to make early correct dx and communicating it to the patient in terms which he/she understands before chronicity sets in

* Reassurance

- Patient/family psychoeducation.

Reassurance very effective in those with anxiety or mild depression

** Psychosocial treatment interventions- helping the patient acknowledge the reality of stressful factors in his life, reduction of stress factors, encouraging verbal expression of distress and shaping adaptive strategies to enable him cope with future stress.

- CBT ---- used to alter dysfunctional cognitive processes and behavior. Cognitive helps patient identify associations btw thoughts and physical symptoms and modify dysfunctional beliefs

- Psychophysiology eg hypnotherapy, multifaceted relaxation training, exercise treatments (improves mood, pain threshold and sleep- increase in endorphins, growth hormone, adenocorticotropic hormone)

** Medications.

- withdraw unnecessary medications

- anxiolytics/antidepressants/mood stabilizers in co morbidity

** Doctor shopping common (due to breakdown in therapeutic relationship) but leads to or worsens chronicity.- Encourage on single identified primary health worker , regular brief visits/reviews, minimize investigations

2. ILLNESS ANXIETY DISORDER/"HYPOCHONDRIASIS"

* Characterised by a belief that a real or imagined physical symptoms are signs of a serious illness despite medical reassurance and other evidence to the contrary

- Not attention seeking or pretending (they honestly believe that they are suffering from a medical condition. The symptoms are real thus they feel misunderstood)

- Concern mostly not on the pain but rather what the symptom may imply in terms of real disease

- The physical symptoms are "normal", "subjective" eg headache, dizziness, nausea, fatigue, abdomen pain, numbness, borborygmi, bloating, palpitation, sweating BUT are misinterpreted to as more dangerous/severe than they really are.

- Presence of exaggerated health anxiety or obsessive irrational fear. Need thorough physical examination to r/o medical condition, psychosocial hx, mse.

- Patients often seek exhaustive batteries of tests, often excessive relative to their symptoms.

- Women to men = 1:1, peak in 20-30yrs age; no social status, education, marital status link;

DSM V dx

- Preoccupation with having or the idea of acquiring a serious disease based on the person's misinterpretation of bodily symptoms

- Somatic symptoms are absent or mild in intensity. if another medical condition is present or there is high risk of developing it, the preoccupation is clearly disproportionate

- There is high level of anxiety about health and the individual is easily alarmed about personal health status

- the individual performs excessive health related behavior(eg repeatedly checks his/her body for s&s of illness, internet checks) or exhibits maladaptive avoidance (eg avoids doctor appointments)

- Disturbance is at least 6 months and causes clinically significant distress or impairment in functioning

- Not better accounted for by GAD, OCD, PD,MDE, or Another somatoform disorder

RX

- need a supportive relationship with a health worker
- Need one primary medical provider/ avoid doctor shopping(also reduces unnecessary tests)
- Various psychotherapies and patient education -Medications minimal

NB; generally chronic unless the psychological factors or underlying mood disorder are addressed. Most don't acknowledge the psychological component of their illness and usually refuse mental health treatment

3. CONVERSION DISORDER (functional neurological symptom disorder)

"hysteria/conversion reaction"

*characterized by a single or more somatised symptom often a pseudo neurological one(s) ie affect motor or sensory. A disturbance of bodily functioning that doesn't conform to current concepts of anatomy and physiology of cns/pns (clinical findings provide evidence of incompatibility btwn the symptom and recognized neurological or medical conditons).

- Individual somatic symptoms represent a symbolic resolution of an unconscious psychological conflict that reduce anxiety and serve to keep conflict away from awareness (primary gain)

- Psychological factors associated with the symptoms or deficit as the initiation or exacerbation of the symptoms (and other stressors)

- Symptoms/deficits are not intentionally produced or feigned and cause clinically significant distress or impairment in functioning

*Primary vs secondary gain- sg is achieved when the patient has been removed from the uncomfortable situation by virtue of the symptom

** 11-500/100,000 pple; rural > urban, females> men 2-10:1 but much higher in children; lower social status > upper; low education levels/low iq; military personnel exposed to combat situations;

BPS- repression of unconscious instinctual intrapsychic conflicts ie symptom makes them communicate that they need special consideration /special rx.

- Learning theory; classical conditioning learnt behavior in childhood are called forth as a means of coping with an otherwise impossible situation

EG= **motor**- impaired coordination or balance, paralysis or localized weakness, seizures, aphonia, syncope/falling, abnormal gait etc. **sensory-** blindness, deafness, anesthesia of extremities etc. **visceral**- difficulty in swallowing, lump in throat, urinary retention, diarrhea, pseudocyesis,

Ddx

A) Medical conditions eg MS(with blindness-optic neurits), Mystenia gravis(with muscle weakness), myopathies, GBS(motor/sensory), polio

B) Mental conditions eg dissociative, psychotic disorders, mood disorders, factitious disorders, malingering, pain disorder, somatisation disorder

Course

-Generally self limiting usually lasting for days-weeks and may resolve spontaneously

->90% recover within one month and most don't have recurrences

- Symptom is not life threatening but the devt of complications as a result of the symptom can be debilitating.

Treatment

-need a supportive understanding relationship with a health worker, reassurance on gradual resolution with specific recommendation for exercise/physiotherapy

- psychoeducation to patient and family, CBT, anxiolytics, hypnosis/abbreaction

- Referral to mental health expert

4. PSYCHOLOGICAL FACTORS AFFECTING GENERAL MEDICAL CONDITIONS

** There is a medical condition diagnosed

Psychological factors (mostly stress related) here play a significant role in causation, precipitation, presentation, maintenance, management/rx and outcome (course, rx, increased risk, worsen).

>40% psychological/psychiatric co morbidity in patients with physical illnesses (often not noticed)

They are mediated through

- Endocrine responses to stress - Immune responses to stress

- Life events

**Examples of clinical conditions include

1. Cardio vascular system- hypertension, coronary heart disease, mitral valve prolapsed in panic disorder

2. Respiratory system- asthma, hyperventilation syndrome

3. Gastrointestinal system- gerd, pud, ulcerative colitis,

4. Skin- atopic dermatitis, psoriasis, psychogenic excoriation, hyperhidrosis,

5. Metabolic- hyper/hypothyroidism, adrenal disorders, diabetes mellitus, obesity

6. Immunological- rheumatoid arthritis, sle,

7. Dental- depressive facial pain, oral infections

8. Neurological and musculoskeletal- low back pain, migraine, tension headaches

9. Infections especially viral

10. Oncology- psychological/psychiatric inputs and interventions may influence the coping with and prognosis of some cancers

**current severity specifications*

Mild- factors increase medical risk eg inconsistent adherence with antihypertensives

Moderate- Severe- Extreme-

. FACTITIOUS DISORDERS *(artificial/false)*

- Intentional production or feigning of physical/psychological signs and symptoms of a disease

- External incentives for the behavior are absent eg economic gain, avoiding legal responsibility, or improving physical well being (unlike in malingering)

- The motivation for the behavior is to play the sick role (may move from hospital to hospital in search of care for an illness) – hospital addicts/hoboes/ professional patients

* Patient knowingly fake symptoms for psychological reasons

* They usually follow through with medical procedures, are at risk of drug addiction and may suffer from complications of multiple operations (unlike malingerers)

* Usually loners with an early childhood background of trauma, deprivation and are unable to establish close interpersonal relationships (affinity for medical system and poor maladaptive coping skills) –

* Other forms include Munchausen (severe chronic variant) and ganser syndromes, factitious disorder by proxy/***Munchausen's syndrome by proxy*** (deliberate production /feigning of physical or psychological symptoms in another person who is under that individuals care, usually mother vs a child/health worker vs inpatient/ adults- perpetrator vs victim).

Ddx- malingering, other ss disorders, neurological disorders, other physical disorders

** Clues that should trigger suspicion of F.D*

Mgt and Rx

- Appropriate index of suspicion and non judgmental confrontational plus psychiatric consultation

- redefining/reframing the factitious illness as psychiatric with continued involvement of a primary clinician + family support are vital in successful mgt ("a cry for help")

- treat any underlying psychiatric disorder esp depression, personality disorder,

- mindful of legal and ethical issues

* Psychotherapy- overall not good results thus need to focus on mgt of disorder than on a cure

DISSOCIATIVE DISORDERS

There is alteration in unitary state (self as a single human being with a single personality) which results in a lack of connection in a person's thoughts, memories, feelings, actions/behavior or sense of identity.

Are frequently found in the aftermath of trauma

Includes dissociative amnesia, d.fugue, d.identity disorder, depersonalization disorder

1. Dissociative fugue (psychogenic fugue)

-characterized by sudden unexpected travel away from home/customary place of daily activity.

- Confusion about personal identity or assumes a new identity (partial or complete) and inability to recall some or all one's past

- Perplexity and disorientation may occur

**** R/o did, gmc eg tle, substance abuse,

** cause clinically significant distress/impairment in s/o functioning

2. Dissociative amnesia

Main feature is reversible memory impairment due to psychological causes usually following a severe physical or psychological stressor

- One or more episodes of inability to recall important personal information usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness

**** R/o did, df, ptsd, asd, somatisation disorder, gmc eg tle and brain trauma, substance abuse,

** cause clinically significant distress/impairment in s/o functioning

- can have *localized amnesia* (events during a circumscribed period of time), *selective amnesia* (partial amnesia of the events), *generalized amnesia* (complete loss of memory for one's life history-rare)

- Many become chronically impaired in their ability to form and sustain satisfactory relationships. Histories of trauma, child abuse, victimization are common

- Prevalence of 1.8% (USA), male; female 1:2.6

- Duration of forgotten events can range from minutes to decades. Suicidal and other self destructive behaviors are common

- comorbidity common eg dysthymia, mdd, ptsd, personality disorder (avoidant, dependent, borderline)

3. Dissociative Identity Disorder

Formerly multiple personality disorder (dsm iv)

- A process whereby repeated dissociation may result in a series of separate entities. The entities may become the internal "personality states" of a did system. "Switching"- is the changing between these states of consciousness. These alternate states though different but are all a manifestation of a single person.
- Presence of ->2 distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to and thinking about external envt and self which may be reported by self or observed by others). * in some cultures/religion it may be described as experience of possession/spirits
- There is also inability to recall important information that is too extensive to be explained by ordinary forgetfulness (everyday life events, trauma, vital personal information)
- R/o effects of substance eg alcohol or a gms eg complex partial seizures, fantasy/imagination play in children.

*Co mobidity is high (depression, bpd, substance abuse, anxiety, epilepsy, scz, ptsd, personality disorder -avoidant, borderline)

- Often associated with overwhelming experiences, traumatic events or abuse/neglect occurring in childhood. > 70% have attempted suicide; males commonly exhibit violent/criminal behavior than female

4. Depersonalization/derealization disorder

Transient feelings of unreality (normal vs abnormal- as a symptom of a mental/physical illness)

- A change occurs in an individual's self awareness thus they feel detached from their own experiences with the self, body and mind. Periods of unreality can last days/weeks/months and can lead to distress with eventual anxiety or depression.

- there is persistent /recurrent experiences of feeling detached from, and as if one is an outside observer of one's mental processes or body (eg feeling like one is in a dream)

NB: Reality testing remains intact

-Experiences of unreality or detachment with respect to surroundings (eg individuals or objects are experienced as unreal, dreamlike, foggy, lifeless or visually distorted)

* lifetime prevalence of 2%, , mean age of onset is 16 yrs, duration of episode can vary from brief hours/days to prolonged weeks/months, association with childhood trauma but not as strong as in other dissociative disorders

*culture/religion volitionally induced experiences of dep/der can be part of meditative practices

* Co morbidities high with unipolar depression, anxiety disorders, personality disorders (avoidant, borderline, obsessive compulsive)

R/o scz, mood disorder, substance intoxication/withdrawal eg cannabis, ketamine, ectasy, hallucinogens; anxiety disorder, personality disorder, epilepsy

Treatment

- identify and eliminate from trauma if still present

- Psychotherapy/talk therapies

- Medication in psychiatric co morbidities

-hypnotherapy/abreaction

SCHIZOPRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER 2

- These includes:

(a) Schizophrenia spectrum disorder

(schizophrenia, schizotypal personality disorder, and delusional disorder)

(b) Other psychotic disorders (brief psychotic disorder, schizopheniform disorder, schizoaffective disorder)

CONT-

- Schizophrenia spectrum and other psychotic disorder are defined by abnomalities in one or more of these domains:
  - -Delusion
  - -Hallucination
  - -Disorganized thinking (speech)
  - -Grossly disorganized or abnormal motor behaviour eg catatonia
  - -Negative symptoms

DELUSION

- DEFINED AS:
- Fixed false beliefs that are not amenable to change in light of confling evidence

- TYPES (THEMES)
  - Persecutory delusion -belief that one is going to be harmed, poisoned followed or harassed by somebody, organization, or group of people
  - Referential delusion -belief that certain gestures, comments, environmental cues/events are directed at oneself, e.g. TV or Radio
  - Grandiose delusion -when one belief that he or she has exceptional abilities, wealth or fame or is very powerful or important person
  - Erotomanic delusion -when an individual believes falsely that another person is in love with him or her
  - Somatic delusion- preoccupation regarding health and organ function eg one has cancer or AIDS
  - Nihilistic delusion –involves conviction that a major catastrophe will occur

DELUSION CONT-

- BIZARRE DELUSIONS:- More common in scz
- Delusions which are not derived from life experience and are not understandable to same-culture, peers and do not derive from ordinary life experience (eg an organ has been removed and replaced by someone else organ without living any wound or scar)
- NB-Delusion that express loss of control of mind or body are bizzarre eg
  - Thought withdrawal-a belief that thought has been removed by outside force
  - Thought insertion-alien thought have been put into one's mind
  - Delusion of control –belief that one's body or actions are manipulated by some outside force
- NON BIZAREE DELUSIONS:
- Derived from life experience eg one is under survellance by police or is being followed or has a disease or an infection

HALLUCINATIONS

- DEF- Perception without an external stimuli
- Occur in any sensory modality but auditory hallucination is the most common in psychotic disorders (esp scz) usually experienced as voices whether familiar or unfamiliar and are perceived as distinct from the individual own thought and occur in clear sensorium
- Olfactory and visual are common in organic psychosis
- NB: Hypnagogic and hypnopompic hallucination that occur while falling asleep or waking up are considered as normal experience

DISORGANIZED THINKING (SPEECH)

- Disorganized thinking (formal thought disorder) infered from the individual speech.
- The individual may switch from one topic to another (derailment or loose association or flight of ideas)
- Tangentiality-unrelated answer to questions
- Incoherence or word salad or neologisms (disorganized incomprehesible speech)

GROSSLY DISORGANIZED OR ABNORMAL MOTOR BEHAVIOUR

- Ranges from childlike ‘silliness’ to unpredictable agitation
- Catatonia behaviour -marked decrease in reactivity to the environment (ranges from resistance to instruction to maintaining rigid or bizarre posture to complete lack of verbal or motor responses ie‘mutism or stupor’). It can include purposeless and excessive motor activity without obvious cause (catatonic excitement)

NEGATIVE SYMPTOMS

- Common in schizophrenia (chronic scz disorders) less prominent in other psychotic disorders. The two commonest symptoms include:

1) Diminished emotional expression eg
   - Facial expression
   - Avoidance of eye contact
   - No movement of hands, head or face that give emotional emphasis to speech
2) Avolition –decrease in motivated self intiated purposeful activities (fail to participate on work or social activities

- Others includes

3) Ologia- diminished speech output
4) Anhedonia- lack of interest in the sorrounding
5) Asociality- lack of interest in social interaction or social isolation

NB: Negative symptoms are difficult to treat as they require atypical antipsychotics which are expensive

OTHER SCHIZOPHRENIA SPECTRUM DISORDERS

- SCHIZOTYPAL PERSONALITY DISORDER
- This personality disorder is considered within schizophrenia spetrum disorder due to pervasive pattern of social and interpersonal deficit including impaired capacity for close relationship, cognitive or perception distortion and eccetricites of behaviour
- It manifests in early adulthood, but sometimes in childhood or adolescence
- NB –The abnormalities of beliefs, thinking; and perception are below the threshhood for the diagnosis of a psychotic disorder

DELUSIONAL DISORDER

- DIAGNOSTIC CRITERIA

A)The presence of one or more delusion with duration of one month or longer

B) Criteria A for schizophrenia has never been met (if hallucination is present should not be prominent and is related to the delusional theme)

c) Apart from impart of delusion, functioning is not impaired and behaviour is not bizarre or odd

d) If manic or depressive episode has occurred it is brief as compared to the duration of delusion

e) The disturbnce is not attributable to effect of a substance or another mental or medical condition

DELUSIONAL DISORDER CONT-

SPECIFY TYPES

1) Erotomanic- an individual believes another person is love with him or her. This person is usually of higher status(eg a famous individual or superior at work or a complete stranger). Effort to contact the love object of delusion is common
2) Grandiose type-delusion that one has great talent or of having made an impotant discovery or one has special relationship with a prominent individual or of being a prominent person (in which case the actual person may be regarded as an impostor
3) Jealous type- one belief the partner is unfaithful
4) Persecutory type-a person belief of being conspired against,cheated. Spied on, followed,harrassed etc---person may resort to violence against those they believe are hurting them
5) Somatic type- it involves bodily function or sensesation eg belief that one emits a foul odor, have infestation on the skin or internal parasites or certain part of the body are misshapen or ugly or that part of the body are not functioning

CONT-

❑ DIAGNOSTIC FEATURES

- Presence of one or more delusion that persist for one month or more
- Behaviour is not bizarre or odd
- Symptom of mood disorder if present are brief relative to total duration of the delusional period

❑ ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Social, marital and work problem can result from delusional beliefs
- Anger and violent behaviour can occur with persecutory, jealous and erotomanic type

CONT-

- ❑ PREVALENCE
- Life time prevalence is around 0.2%
- Most frequent subtype is persecutory
- Jealous type more common in males than females
- But generally the overall frequecy is equal in both gender

- ❑ DEVELOPMENT AND COURSE
- Global function is better than schizophrenia
- A proportion go on and develop schizophrenia
- Delusional disorder has significant relationship to both schizophrenia and schizotypal personality disorder

- ❑ DIFFERENTIAL DIAGNOSIS
- Psychotic disorder due to substance use or another medical condition
- Schizophrenia and schizophreniform disorder
- Depressive, bipolar disorder or schizoaffective disorder

TREATMENT

- PSYCHOTHERAPY
  - Individual psychotherapy more effective than group psychotherapy
  - Insight oriented, supportive, cognitive or behaviour therapies are effective

- HOSPITALIZATION
- Indicated
  - For complete, medical and neurological evalution to dertemine whether a non psychiatric medical condition is causing the delusion symptoms or
  - If patient is unable to control violent impulse related to delusional material or
  - If the patient ability to function within the family set up is compromised

- PHARMACOLOGY
- Antipsychotic drugs is the tretment of choice

BRIEF PSYCHOTIC DISORDER

- DIAGNOSTIC CRITERIA

A) Presence of one or more of the following symptoms
1) Delusion
2) Hallucination
3) Disorganized speech (derailment or incoherence)
4) Grossly disorganized or catatonic behaviour

B) Duration of symptom at least one day but <one month

C)R/O substance or medical condition

- SPECIFY
  - With marked stressor (if the symptom appear after a stressful event)
  - Without marked stressor (symptom not associated with a stressor)
  - With postpartum onset (within 4 week postpartum)
  - With catatonia

DIGNOSTIC FEATURES

- Sudden onset of positive psychotic symptoms (eg delusion, hallucination, disorganised speech or grossly abnormal psychomotor behaviour including catatonia)
- Episode lasts at least one day but less than one month
- The disturtances is not better explained by mood or other psychotic disorder or psychotic disorder due to use of a substance or due to another medical condition

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individual with brief psychotic episode experieces emotional turmoil or overwhelming confusion
- There is an increased risk of suicidal behaviour during the acute episode

CONT-

- PREVALENCE –account for 9% of first onset psychosis
- Two fold more common in female than in males

- DEVELOPMENT AND COURSE- begins in adolescence or early adulthood (return to premorbid level of functioning within one month)

- RISK FACTORS
- Temperamental eg, pre-existing personality disorders and traits
- Negative affectivity eg, suspiciousness may predispose the individual to brief psychotic episode

- DIFFERENTIAL DIAGNOSIS-

i. Other medical condition-physical examination, history and labwork important
ii. Substance related disorder- toxicology test/history important
iii. Other psychotic disorders- duration of symptom crucial
iv. Malingering and factitious disorders- symptom are intentionally produced

TREATMENT

- HOSPITALIZATION
- Acutely psychotic patient may need brief hospitalization for evalution and protection
- For assessment of danger to self or others

- PHARMACOTHERAPY
- Two major class of drugs are used
  - TYPICAL antpsychotic drugs such as high potency eg haloperidol or
  - ATYPICAL antipsychotics eg risperidone are effective
- Benzodiazepines can be used for short time treatment of psychosis

- PSYCHOTHERAPY
- To deal with psychosocial stressors which could have precipitated the psychotic episode
- Exploration and developing of coping strategies
- To help the patient deal with loss of self esteem and regain self confidence

SCHIZOPHRENIFORM DISORDER

- DIAGNOSTIC CRITERIA

A) Two or more of the following symptoms are present during one month period (or less if succussesfully treated) at least one of these must be 1,2 or 3

1) Delusion
2) Hallucinations
3) Disorganised speech (eg frequent derailment or incoherence)
4) Grossly disorganised or catatonic behaviour
5) Negative symptom (diminished emotional expression or avolition)

B)Symptoms last at least one month but less than six months

C)R/O depression bipolar disorder with psychotic features

D)The distubance is not attributable to the physiological effect of a substance or another medical condition

CONT-

- DIAGNOSTIC FEATURES-Symptoms are similar to schizophrenia distinguished by total duration of symptoms
- Episodes of illnes last between 1-6 months with fully recovery
- If symptom persist for more than 6 months a diagnosis of schizophrenia is made
- No criteria requiring impairment in social and occupational functioning

- DEVELOPMENT AND COURSE-Similar to schizophrenia
- 1/3 recover within 6months
- 2/3 progresses to schizophrenia or schizoaffective disorder

- DIFFERENTIAL DIAGNOSIS-
- Other mental disorders,
- Substance induced psychosis and
- Medical conditions with psychosis

TREATMENT

- HOSPITALIZATION
- To allow effective assessment, treatment and supervision of patient behaviour
- Treatment with ant psychotics last 3 – 6 months
- Even if the pt improves after one month, treat for at least 3 months
- Patient respond to antpsychotics better than those with schizophrenia 75% as compared to 20% of schizophrenia within 8 days
- ECT is indicated especially those with marked catatonia or depressed features
- Most patient progresses to schizophrenia despite treatment

SCHIZOPHRENIA

- DIAGNOSTIC CRITERIA

A)Two or more of the following symptoms (each present for a significant portion of time during 1 month period unless successfuly treated. One of these must be 1, 2 or 3

1) Delusion

2) Hallucination

3) Disorganized speech, frequent derailment or incoherence

4) Grossly disorganised or c atatonic behaviour

5) Negative symptoms eg diminished emotional expression or avolition

B) For a significant portion of time during the disturbance the level of functioning in one or more major areas such as work, academic, interpersonal relationship or selfcare is below the level achieved prior to the onset

C) Symptoms last >6months

D) R/O schizoaffective and mood disorders with psychotic features, no active depressive or manic episode concurrently with active phase symptoms and if they had occured they have been present for a short duration

E) The distubance is not due physiological effect of a substance or another medical condition

- If there is a hx/o communication or autism spetrum disorder the diagnosis is made if there is prominent delusion or hallucination

DIAGNOSTIC FEATURES

- At least there should be a clear presence of delusion, hallucination or disorganized speech. Grossly disorganized or catatonic behaviour and negative symptoms may also be present
- Two of these symptoms must be present for a significant portion of time during one month period or longer
- Schizophrenia involves impairment in one or more areas of functioning
- If the distubance begins in childhood or adolescence the expected level of functioning is not attained
- Signs of distubance must persist for a period of 6 month

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Schizophrenic pt may display inappropriate affect eg laughing in the absence of appropriate stimuli, grimacing, lack of facial expression, etc
- Dysphoric/foul/unpleasant mood- that can take the form of anger, restlessness, depression
- Distubed Sleep pattern –sleeping during the day and night time activity
- Perception problem –depersonalisation or derealization
- Cognitive impairment which include problem in memory or language function, slow processing of information, concentration and attention span
- Lack insight or awareness of the disorder-common prediction of non adherence to treatment, higher relapse rate, poorer course of illness, aggression and poor psychosocial functioning
- Hostility and aggression may occur especially in younger male or for individual with a past history of violence or non adherence with treatment or, substance use

CONT-

- Differences are evident in muiltiple brain region between group of health individual and person with schizophrenia from-

i. Neuroimaging- CT scan/MRI- lateral and third venticular enlargement

ii. Neuropathology- postmortem show decrease in size of limbic system which control emotions ie amgydala, the hippocampus and parahippocampus gyrus. Other affected areas include basal ganglion and cerebellum which control movements and most schizophrenic pts have movement disorders which include awkward gait, facial grimacing and stereotypies movement

iii. Cellular architecture ie, white matter connectivity and grey matter volume especially in the prefrontal and temporal cortices

iv. Reduced overall brain volume has been observed as well as increased brain reduction with age

v. Common neurological impairment includes motor coordination, left-right confusion

vi. In addition, minor physical anomalies of the face and limbs may occur

PREVALENCE

- Life time prevalence is approximately 0.3-0.7%
- There is variation across race, ethnicity and across countries, geographic origin for immigrants and children of immigrants
- Males have a poorer outcome, early age of onset and more negative syptoms
- Inclusion of more mood symptoms and brief presentation is associated with better outcome
- Show equivalent risk for both sexes

DEVELOPMENT AND COURSE

- Onset late teens rare prior to adolescence
- Peak age of onset for 1st psychotic episode early to mid 20s for males and in the late 20s for females
- Earlier age of onset is a prediction for worse prognosis
- 20% have favourable outcome and may recover completely
- Most individuals with schizophrenia may remain chronically ill with exacebations and remission of active symptoms while other have a course of progressive deterioration
- Psychotic features of schizophrenia diminish over time probably due to decreased dopamine activity associated with age
- Negatives symptoms may increase and are closely related to poor prognosis
- Late onset case after age 40 are more common in female who may have married-characterised by psychotic feature with preservetion of affect and social functioning
- NB: There's deteriation after every attack episode

RISK AND PROGNOSTIC FACTORS

- Environmental -season of birth has been linked to schizophrenia (late winter/early spring in some location and summer for the deficit form of disease)
- High incidence in children growing in urban environment and for some minority ethnic gp
- Genetic and physiological –strong genetic factor runs in families
- Pregnacy and birth complication -hypoxia. Greater paternal age are associated with higher risk of schizophrenia for the developing fetus
- Other maternal and prenatal adversities associated with schizophrenia include malnutrition, maternal diabetes, stress, and infection

SUICIDE RISK

- Approximately 5-6% of pt die by suicide
- 20% attempt suicide on one or more accasion
- Many more have significant suicidal ideation
- Suicidal behaviour is a response to hallucination to harm onself or other
- Commoner in young males with comorbid substance use
- Other risk factors includes having depressive symptoms, feeling of hopelessness or being unemployed
- The risk is higher also in the period after a psychotic episode or hospital discharge

FUNCTIONAL CONSEQUENCES OF SCZ

- Significant impairment in academic, social and occupational functioning
- Making educational progress and maintaining employment is difficult
- Most individuals are employed at lower level than their parents
- Mostly men do not marry and have limited social contact outside of their family

DIFFERENTIAL DIAGNOSIS

- Major depressive and bipolar disorder with psychotic features –if delusion or hallucination occur exclusively during a mojar depressive or bipolar disorder a diagnosis of depressive or bipolar disorder with psychotic features is made
- Schizoaffective disorder – a major depressive or manic episode occur concurrently with acute phase symptoms of psychosis
- Schizophreniform- symptoms last <6months
- Brief psychotic disorder- syptpms last <1month
- Delusional disorder- no other symptoms of psychosis
- Schizotypal personality disorder have subthreshold symptoms
- Obsessive compulsive disorder-preoccupational may reach delusional propotion but have prominant obsession and compulsion
- Ptsd—history of a traumatic event
- Autism sd and communication disorder-have deficit in social interation with repetitive and restricted behaviour and other cognitive or commmunication deficit

COMORBIDITY

- Substance use disorder especially tobacco >50% schizophrenic pts smoke cigarettes
- Anxiety disorder, obsessive compulsive disorder and panic disorder higher than in the general population
- Schizotypal or paranoid personality may precede the onset of schizophrenia
- Life expectancy is reduced in schizophrenia because of the associated medical condition eg weight gain-diabetes

TREATMENT

- Antipsychotic medication is the main stay of treatment for schizophrenia
- Psychosocial intervention is also important
- Combination of both mode of treatment is more beneficial than either treatment used alone

- HOSPITALIZATION
- Indicated for dignostic purposes
- Stabilization of medication
- Patient safety (because of suicidal or homicidal ideation)
- Grossly disorganised or inappropriate behaviour
- Inability to take care of basic needs (food, shelter, clothing, etc)
- Establishing an effective association between the pt and the community support system is a primary goal of hospitalization

CONT-

- DRUGS
- Antipsychotic drugs introduced in 1950 treat schizoprenia symptoms but do not cure the disorder
- 2 classes of drugs:

1) Typical: Dopamine receptor antagonist- these are effective particurlaly for the +ve syptoms eg delusion but not on –ve syptoms
- They cause annoying and serious adverse effects
- The common annoying side effect includes akathisia and parkinsonism like symptoms of rigidity and tremas
- Serious adverse effects include tardive dsykinesia and neuroleptic malignant sydrome

2) Atypical: Seretonin-dopamine antagonist- have minimal or no extrapyramidal side effects
- They are effective in treating –ve and +ve symptoms of schizophrenia
- These drugs include clozapine, risperidone, quetiapine, olanzapine, sertindole, etc.

CONT... OTHER BIOLOGICAL /PHYSICAL THERAPY

- ECT- for catatonic patient or pt who can not take drugs or pt who have been ill for **less** than **two years** (**acute** schizophrenia)
- Psychosurgery may be tried for severe intractable disease

CONT... PSYCHOSOCIAL THERAPY

- Aimed to increase :
- Social abilities
- Self sufficiency
- Practical skills
- Interpersonal communication in schizophrenic patient

CONT-

- SOCIAL SKILL TRAINING – most in –ve symptoms
- This addresses symptoms seen in scz patient such as:

- Poor eye contact
- Unusual delay in response
- Odd facial expression
- lack of spontanuity in social situation
- Inaccurate perception or lack of perception of emotion in other people
- These problems are addressed through behaviour skills training by use of video tapes of others or role playing also helps
- This reduce the relapse rate and need for hospilization

CONT-

- FAMILY THERAPY- Discuss with the family and patient and help them to learn about schizophrenia
- Relatives should not ignore psychotic episode and appropriate therapy should be administered
- Excessful expressed emotion is detrimental to patient healing
- GROUP THERAPY- Should focus on real life plans, problems and relationships
- It helps in reducing social isolation, increasing sense of cohesiveness and improving reality testing for patient with schizophrenia

CONT-

- COGNITIVE BEHAVIOUR THERAPY
- Aimed at improving cognitive distortion, reduces distractibility and corrects errror in judgement
- It may help in reducing hallucination and delusion in patient who have insight into their problem

- INDIVIDUAL PSYCHOTHERAPY
- The effects of individual psychotherapy are additive to pharmacotherapy treatment
- Psychotherapy for schizophrenia patients should be thought in teams of decades rather than sessions month or years
- Schizoprenic patients who are able to establish therapeutic alliance are likely to have a good outcome

SCHIZOAFFECTIVE DISORDER

- Diagnostic criteria

A) An uninterrupted period of illness during which there is a major mood episode (major depression or manic) concurrent with criteria A of schizophrenia

B) Delusion or hallucination for 2 or more weeks in the absence of a major mood episode during the life time of the illness

C) Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portion of the illness

D) The disturbance is not attributable to effect of a substance of abuse/medication or another medical condition

- Specify
  - Bipolar type –manic episode is part of presentation, major depressive episode may also occur
  - Depressive type- only major depressive episode is part of presentation

PREVALENCE

- Affects 0.3% of population
- More common in females
- It’s 1/3 as common as shizophrenia

DEVELOPMENT AND COURSE

- Age of onset adolescence to late in life
- Prognosis better than schizophrenia but worse than mood disorder
- Schzoaffective disorder manic type is more common in young adult and depressive type is more common in older adults

RISK AND PROGNOSTIC FACTORS

- Genetic and physiological factors- there is an increased risk for schizoaffective disorder in first degree relatives with schizophrenia or bipolar disorder

Differential diagnosis

- Other mental disorders and medical conditions
- Psychiatric disorders which manifest with psychotic and mood symptoms eg substance induced mental illness
- Schizophrenia – is distinguished from schizoaffective due to criteria C (ie symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portion of the illness)
- Mood disorders with psychotic features is distinguished by criteria B (ie prominent delusion or hallucination for two or more weeks in the absence of a major mood episode during the life time duration of the illness)

COMORBIDITY

- Patients diagnosed with schizoaffective disorder also may have substance use disorder or anxiety disorder

TREATMENT

- DRUGS
- Mood stabilizers are the main stay of treatment for schizoaffective disorder
- Can be used in combination with antipsychotics

- ECT can also be considered

- PSYCHOTHERAPY
- Patient benefit from a combination of family therapy , social skill training and cognitive rahabilitation
- It is important to explain to the patient the psychiatric difficulties in deciding the diagnosis and prognosis of schiaffective disorder

SUBSTANCE/MEDICATION INDUCED PSYCHOTIC DISORDER

- Diagnostic criteria

A) Presence of one or both of the following symptoms:

- Delusion
- Hallucination

B) Evidence from history, physical examination or laboratory finding of the following:

1) The syptoms developed during or soon after substance intoxication or withdrawal or exposure to a medication
2) The involved substance/medication is capable of producing the symptoms in criteria A

C) The disturbance is not better explained by a psychotic disorder that is not substance /medication induced

D) The disturbance does not occur excussively during the course of delirium

E) The disturbance causes clinically significant distress or impairment in social occupational or other important areas of functioning

CONT-

- SPECIFY- With onset during intoxication or onset during withdrawal

DIAGNOSTIC FEATURES

- The essential features of substance /medication induced psychotic disorder are prominent delusion and /or hallucination that are due to the physiological effect of a substance/ medication
- Substance /drug induced psychosis is distinguished from primary psychosis from history, physical examination and lab investigation, or presence of features atypical of primary psychosis eg onset after 35 years with no previous history
- A diagnosis of primary psychotic disorder is made if syptoms persist for more than 4 weeks after ceasation of substance /medication use or a history of prior primary psychotic disorder

ASSOCIATED FACTORS SUPPORTING DIAGNOSIS

- Psychotic disorder occur in association with intoxication with the following classes of substances:
  - Alcohol
  - Cannabis
  - Hallucinogens
  - Inhalants
  - Sedatives and hypnotics
  - Anxiolytics
  - Stimulants including cocaine

ASSOCIATED FACTORS SUPPORTING DIAGNOSIS

- Psychotic disorder can occur in association with the withdrawal of the following class of substances:
  - Alcohol,
  - Sedatives & hypnotics
  - Other medicines involved include anesthetics, analgesics, antconvulsant, antihistamines, corticosteroid, antinflmmatory, antdepressant and disulfiram

PREVALENCE

- Prevalence in the general population is unknown
- Between 7 and 25% presenting with first episode of psychosis in different setting have substance/medication induced psychosis

DEVELOPMENT AND COURSE

- The intiation of the disorder varies with substance used eg high dose of cocaine may produce psychosis within minutes whereas days or weeks of high dose alcohol or sedative use may be required to produce psychosis
- Prolonged use of alcohol is associted with visual or auditory hallucination
- Persecutory delusion develops after amphetamine or other sympathomimetic use
- Hallucination of bugs or vermin crawling in or under the skin is associated with cocaine use
- Cannabis is associated persecutory delusion, marked anxiety emotional lability and depersonalization
- Substance induced psychosis may persist when the offending agent is removed sometimes for weeks or longer despite treatment with neuroleptic medication

FUNCTIONAL CONSEQUENCES OF SUBSTANCE INDUCED PSYCHOSIS

- The condition is severely disabling and it causes significant impairment in all areas of functioning
- However the disorder is typically self limiting and resolves upon removal of the offending agent

DIFFERENTIAL DIAGNOSIS

- Substance intoxication or substance withdrawal –individual intoxicated with stimulants may experience altered perception and they recognise as drug efffect,if reality testing remain intact ie someone know it is the effect of substance and neither believes or act on it- a dignosis of substance intoxication or withdrawal is made with perceptual disturbances
- Primary psychotic disorder-distinguished from history , physical examination and lab findings
- Psychotic disorder due to another medical condition-distinguished from the history, physical examination laboratory investigation or radiological exams

PSYCHOTIC DISORDER DUE TO ANOTHER MEDICAL CONDITION

- Diagnostic criteria

A) There is evidence from history, physical examination or lab finding that the disturbance is due to pathophysiological effect of a medical condition

B) The disturbance is not better explained by another psychotic disorder

C) The disturbance is not due to delirium

D) The disturbance causes significant distress or impairment in social, occupational or other important areas of functioning

- Specify- code based on predominant symptoms- with delusion or hallucination depending on the predominant symptoms eg psychotic disorder due to malignant lung neoplasm with delusion

DIAGNOSTIC FEATURES

- Essential feature of a psychotic disorder due to another medical condition are prominent delusion or hallucination that are attributable to the physiological effect of a medical condition
- Hallucination can affect any sensory modality ie visual, auditory gustatory, tactile or olfactory
- Olfactory hallucination is associated with temporal lobe epilepsy
- Delusion may have several themes including somatic, grandiose religious and most commonly persecurtory
- Consideration necessary for determining the psychosis is due to medical condition include:
  - Presence of temporal association between onset, exacerbation or remission of a medical condition and that of psychotic disorder, or
  - Presence of features that are atypical of a psychotic disorder eg atypical age of onset >35years, presence of visual or olfactory hallucination

DEVELOPMENT AND COURSE

- Psychotic disorder due to a medical condition may be a single transient state, or may be reccurent or cycling with exacerbation and remission of the underlying medical condition
- Treatment of the undrlying medical condition often results in resolution of psychosis but sometimes may persist long after the medical event and may assume a long term course eg psychosis due to focal brain injury, multiple sclerosis or chronic interictal psychosis of epilepsy
- Young age are more affected by epilepsy, head trauma, autoimmune and neoplasic disease of mid life and older age group
- Older age group are more affected by stroke disease, anoxia disease and muiltiple system comobidity

PREVALENCE

- Prevalence difficulty to estimate given the wide variety of underlying medical etiology
- Life time prevalence is estimated to range from 0.21-0.54%
- Age >65yrs prevalence is 0.74%
- Medical conditions commonly associated with psychosis include –
- Untreated endocrine and metabolic disorders
- Autoimmune disorder eg systemic lupus erytheromatosis
- Autoimmune encephalitis
- Temporal lobe epilepsy
  - Psychosis due to epilepsy has been further differentiated into ictal, postictal and interictal pychosis
  - Most common of this is postictal psychosis observed in 2-7.8% of epileptic patients

DIFFERENTIAL DIAGNOSIS

- Delirium – if hallucination and delusion occur in delirium, a separate diagnosis of a psychotic disorder due to medical condition is not given
- Substance induced psychotic disorder- symptoms occur shortly after (4 weeks of substance intoxication or withdrawal
- Psychotic disorder- no specific and direct causative physiological mechanism is demostratable associted with medical condition
- (auditory hallucination that involve voices speaking complex sentences are more characteristic of schizophrenia
- Visual or olfactory hallucination are commonly associated with psychosis due to a medical condition

CATATONIA

- Catatonia can occur in several disorders including mental (neurodevelopmantal, depression, bipolar, schizophrenia) or medical (cerebral folate deficiency)
- Catatonia is not a dignosis as an independent class in DSM 5 but recognizes:

a) Catatonia associated with another medicall condition

b) Catatonia associted with another mental disorder

c) Unspecified catatonia

- The essential feature of catatonia is a marked psychomotor disturbance that may involve decreased motor activity, decreased engagement during interview or excessive and perculier motor activity

CATATONIA ASSOCIATED WITH ANOTHER MENTAL DISORDER

- A – The clinical picture dominated by 3 or more of the following symptoms

1) Stupor (ie no psychomotor activity, not actively relating to environment)
2) Catalepsy (ie passive induction of posture held against the gravity)
3) Waxy flexibility (ie slight, even resistance to positioning by examiner)
4) Mutism (ie no, or very little, verbal response)
5) Negativism (ie opposition or no response to instruction or external stimuli)
6) Posturing (ie spontaneous and active maintanance of a posture against gravity)
7) Mannerism (ie odd, circumstantial caricature of normal actions)
8) Stereotypy (ie repetitive, abnormally frequent, non goal directed movements)
9) Agitation, not influenced by external stimuli
10) Grimacing
11) Echolalia (ie mimicking another's speech)
12) Echopraxia (ie mimicking another's movements)

CATATONIC DISORDER DUE TO ANOTHER MEDICAL CONDITION

- 3 or more of the 12 symptoms

B) There is evidence from the history, physical examination or laboratory finding that the disturbance is the direct pathophysiological effect of another medical condition

c) The disturbance is not better explained by another mental disorder

D) The disturbance does not occur excussively during the course of a delirium

E) The disturbance causes clinically significant distress or impaiment in social, occupational or other important areas of functioning

- Coding note- include the name of medical condition eg catatonic disorder due hepatic encephalopathy

DIFFERENTIAL DIGNOSIS

- Diagnosis not made if catatonia occurs exclusively during the cause of delirium or neuroleptic malignant syndrome
- If the individual is taking neuroleptics, consideration should be given to medication induced movement disorder

UNSPECIFIED CATATONIA

- Symptom of catatonia present but the underlying mental or medical condition is not clear, full criteria for catatonia is not met or there is insufficient information to make a more specific diagnosis (eg in an emergency room setting)

OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER

- This category applies when there is psychotic symptoms which do not meet the criteria for any of the psychotic disorder and the disturbances causes clinically significant distress or impairment in social, occupational or other important areas of functioning
- Eg persistent auditory hallucinations without any other feature
- Delusion with overlapping mood episode
- Attenuated psychosis syndrome eg symptom are less severe and more transient and insight relatively maintained
- Delusional syptoms in partner of an individual with delusional disorder

UNSPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER

- In case where there are symptoms but no sufficient information to make a dignosis (eg in emergency room setting)

THE END

- THANKS

CHILDHOOD DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDER

- Involve emotional and behaviour problems that violate the right of others e.g. aggression (to human or animals), destruction of properties, e.t.c, or bring the individual into conflict with society norms or authority figures.
- Used to be disruptive disorders in DSM IV
- They include-

1) Oppositional defiant disorder

2) Intermittent explosive disorder

3) Conduct disorder

4) Antisocial personality disorder

5) Pyromania

6) Kleptomania

OPPOSITIONAL DEFIANT DISORDER

- Don't follow orders, disobedient
- Diagnostic criteria:

1) A pattern of angry/irritable mood
2) Augumentative/defiant behaviour
3) Vindictiveness

- Syptoms last at least 6 months and have 4 symptoms from any of the symptoms indicated below exhibited during interaction with at least one individual who is not a sibling

CONT-

- Angry/irritable mood:

1) Often loses temper
2) Is touchy or easily annoyed
3) Is often angry and resentful

- Arqumentative/defiant behaviour:

4) Often argues with authority or for children and adolescence with adults
5) Defies or refuses to comply with adult's request or rules
6) Deliberately annoys others
7) Often blames others for his or her mistakes or misbehaviour

- Vindictiveness:

8) Has been spiteful or vindictive at least twice within the past 6 months

CONT-

B) The disturbance in behaviour cause distress in the individual or others e.g. Family or peer group; it imparts negatively on social, educational or other important areas of functioning

C)The behaviour is not due to a psychotic disorder, substance use or mood disorder

CLASSIFICATION

- Mild -symptoms are confined to only one setting (eg at home, school, work or with peers)
- Moderate- symptoms present in at least 2 settings
- Severe –symptom present in 3 or more settings
- PREVALENCE
- Ranges between 1%-11%
- Varies with age and gender
- More common in males
- Occur in all countries that differ in race and ethnicity
- COURSE
- Appear in pre-school yrs, rarely in adolescence
- Often precedes conduct disorder

Risk factors

- Temperamental eg those with difficulties in controlling their emotions, or poor frustration tolerance
- Environmental -harsh, inconsistent or neglectful child rearing practices
- Genetic and physiological factors eg low heart rate, abnomalities in the prefrontal cortex and amygdala

CONT-

- DIF DIAGNOSIS
- Conduct disorder- has aggression towards people or animals and destruction of properties
- ADHD-hyperactivity, inattention and impulsity
- Mood disorder –low/elevated mood, poverty or pressure of speech
- Disruptive mood dysregulation disorder- temper outburst is chronic
- Intermittent explosive disorder-have higher rate of anger and serious aggression

- COMORBIDITY
- May precedes conduct disorder
- Anxiety disorder, depressive disorder and substance use disorder

CONT-

- Treatment-behaviour therapy and parental counselling-selectively reinforcing, rewarding and praising appropriate behaviour and ignoring or not reinforcing undesired behaviour

INTERMITTENT EXPLOSIVE DISORDER

- DIAGNOSTIC CRITERIA

A) Recurrent outburst due to inability to control agressive impulses. Alternate periods of agressiveness and calmness. Manifested by either:

1) Verbal aggression eg temper tantrums, verbal auguments or fights or physical aggression torward property, animals or other people which occurs twice weekly for a period of 3 months. The physical aggression does not result in damage or destruction of property or injuries to animal or individual; OR

2)Three behaviour outburst which involve damage or destruction of property or injury against animal or individual occuring within 12 months period

B)The magnitude ofaggressiveness expressed during outburst is out ofproportion to the provocation or psychosocial stressor

C)The reccurent outburst are not premeditated and not meant to achieve any objective eg money, power, etc

D) The aggressive outburst causes significant distress in the individual and impairment in important areas offunctioning, interpersonal functioning or legal cosequences

E) Chlonological age of onset 6 years

F) Rule out other mental disorder, substance use disorder or medical condition

CONT-

- PREVALENCE
- 1yr prevalance rate 2.7%
- Most common in late childhood or adolescence rare after age 40
- Common in persons with secondary education or below
- Higher in males in some studies/equal rates in others

- RISK FACTORS
- Environmental- history of physical or emotional trauma in the 1st two decade of life
- Genetic and physiological- commmon in twins (in monozygotic twins) and 1st degree relatives

CONT-

- CONSEQUENCES OF INTERMITTENT EXPLOSIVE DISORDER
  - SOCIAL-loss of friends or marital instability
  - OCCUPATIONAL-demotion or loss of employment
  - FINANCIAL LOSS -value of object destroyed
  - LEGAL-civil suit due to aggressive behaviour towards others or destruction of property
- *DIFFERENTIAL DIAGNOSIS
- Substance use disorder, mood disorder, psychotic disorder and personality disorder (antsocial or border line personality)
- COMORBIDITY
- Depressive disorder anxiety disorder.
- Substance use disorder
- ADHD
- Personality disorder
- Treatment –behaviour therapy and antipsychotics

CONDUCT DISORDER

- DIAGNOSTIC CRITERIA

A) Essential features of conduct disorder includes-

B) A repetitive and persistant pattern of behaviour in which the basic right of others are violated

1) Or major age appropriate societal norms are violated as manifested by at least 3 of the following 15 criteria in the past 12 months with at least one criteria present in the last 6 months

CONT-

- Aggression to people and animals

1) Often bullies, threatens or intimidates others
2) Often intiates physical fights
3) Has used a weapon that can cause serious physical harm to others (eg a broken bottle, a knife or a gun)
4) Has been physically cruel to people
5) Has been physically cruel to animals
6) Has stolen while confronting a victim (eg mugging, purse snatching or armed robbery)
7) Has forced someone into sexual activity

CONT-

- Destuction of Property

8) Has deliberately engaged in fire setting with the intention of causing serious damage

9) Has deliberately destroyed others property (other than fire setting)

- Deceit Fulness or Theft

10) Has broken into someone else house, building or car

11) Often lies to obtain goods or favour or to avoid obligation (ie cons others)

12) Has stolen items of non trivial value without confronting a victim (shop lifting but without breaking and entering eg forgery)

- Serius Violation of Rules

13) Often stays out at night despite parental prohibition beggining before age 13 yrs

14) Has run away from home overnight at least twice while living in the parental home without returning for a lengthy period

15) Is often truant from school beggining before age 13yrs

CONT-

- B) The disturbance in behaviour causes clinically significant impairment in social, academic or occupational functioning
- C)If the individual is 18yrs or older criteria for antsocial pesonality disorder is not met

CONT-

- TYPES
- Childhood onset types- symptoms prior to age 10
- Adolescence onset types-symptom start after age 10
- Unspecified type- onset of symptom is not clear (ie before or after 10yrs)

- SEVERITY
- Mild-few symptoms in excess of those required to make the diagnosis and behaviour causes minor harm to others eg lying truancy, staying out without permission
- MODERATE- symptom are intermidiate eg stealing without confronting a victim
- SEVERE- many symptoms above those required to make the diagnosis and the behaviour causes cosiderable harm to others eg forced sex, use of weapons, stealing while confronting a victim or breaking and entering

PREVALENCE

- One year population prevlence ranges between 2%-10%
- Common in all countries that differ in race and ethnicity
- Higher in males than in females
- Onset rare after age of 16 years
- Course is variable
- Disorder may remit in adulthood
- Early onset has a poorer prognosis and higher substance use disorder and criminality

RISK AND PROGNOSTIC FACTORS

1) TEMPERAMENTAL

- Difficulty uncontrolled infant temperament
- Lower than average intelligence

3) COMMUNITY LEVEL

- Peer rejection
- Association with deliquent peer group
- Neigbourhood exposure to violence
- NB Both risk factors contribute to childhood onset type

2) ENVIRONMENTAL

Family level risk factors includes:

- Parental rejection or neglect
- Inconsistent child rearing practices
- Harsh discipline
- Physical or sexual abuse
- Lack of supervision
- Institutional living
- Frequent changes of caregivers
- Large family size
- Parental criminality or substance abuse

CONT-

- GENETIC AND PHYSIOLOGICAL FACTORS
- -Common in 1st degree relatives
- In parent with alcohol use disorder, depression, bipolar disorder, schizophrenia, or biological parents with ADHD or conduct disorder
- Slow resting heart rate is noted in individual with conduct disorder as compared to those without disorder and this maker is not a characteristic of any other mental disorder
- Reduced fear conditioning particularly low skin conductance (hair follicles or sweating) is well documented. Thus they are fearless

CONT-

- Gender related issues

- Males exhibit fighting, stealing, school discipline problems, physical aggression, relational aggression (behaviour that harm others)
- Females exhibit truancy, running away from home, substance use and prostitution

DIFFERENTIAL DIAGNOSIS

1) ODD –less severe in nature, no aggression toward individual or animals, no destruction of properties
2) ADHD- no violation of society norms or rights of others (both diagnosis can be given)
3) Depression and bipolar disorder –irritability and aggression accurs (but have other symptoms)
4) Intermittent explosive disorder (both have high rate of aggression). But aggression in IED is limited to impulsive aggression and is not premeditated and is not aimed at achieving some tangible objective eg money, power or intimadition

COMORBIDITY

- ADHD and ODD are common comorbid and predicts worse prognosis
- Antsocial personality disorder violates right of others and often meet criteria for conduct disorder
- May occur with mood disorder, substance use disorder or anxiety disorder
- May have hearing or communication disorder

TREATMENT

- Psychotherapy- Behaviour modification
- Pharmacotherapy
- PSYCHOTHERAPY- group and family therapy are important; also parental training on how to handle children (this would produce better result than individual psychotherapy)
- BEHAVIOUR MODIFICATION-cognitive behaviour modification in the child and parent management training in combination may produce desired effect
- PHARMACOLOGY- antipsychotic drug eg haloperidol or, mood stabilizers eg lithium, carbamazapine are effective in controlling aggressive behaviour
- OTHER DRUGS- are used to treat comorbid psychiatric disorder eg stimulant in ADHD; antidepressant for depressed pt, Gabapentin

PYROMANIA

- Diagnostic criteria

A) Deliberate and purposeful multiple episodes of fire setting

B) Tension or affective arousal before the act

C) Fascination with fire, interest and curiosity about the fire or attraction to fire and its situational context (eg paraphrenalia used and consequences, etc, individual are often regular watchers of fire at their neighbourhood, may set false alarm and derive pleasure from institution, equipment and personnel associated with fire, spend time in fire department or even become fire fighters

D) Pleasure, gratification or relief when setting fires or when witnessing or participating in the aftermath

CONT-

E)The fire setting is not done for monetary gain or as an expression of sociopolitical ideology or to conceal criminal activity or in response to a delusion or hallucination or impaired judgement or substance intoxication

F)The fire setting is not better explained by conduct disorder or a manic episode or antsocial personality disorder

PREVALENCE

- Prevalence in the population is unknown
- Age of onset unknown
- More common in males especially those with poor social skill or those with learning difficuilties

Differential diagnosis

- Other causes of fire settings eg profit .sabotage or revenge,to conceal a crime, make a political statement eg terrorism or protest or attract attention or recognition
- Fire setting may also occur as part of developmental exprimentation in childhood eg playing with matches , lighters or fire
- Other mental disorder eg conduct disorder, a manic episode,or antsocial personality disorder or due to a delusional or hallicination in schizophrenia

COMORBIDITY

- Substance use disorder
- Gambling disorder
- mood disorder
- Conduct disorder

KLEPTOMANIA

- Diagnostic criteria

A) Inability to resist impulses to steal object that are not needed for personal use or for their montary value

B) Increasing sense of tension immediately before commiting the theft

C) Pleasure, gratification or relief at the time of commiting the theft

- The stealing is not committed to express anger vengerance and is not in response to a delusion or a hallucination

D) The stealing is not better explained by conduct disorder, a manic episode or antsocial personality disorder

Nb –the objects are usually of little value to the individual who could have afforded to pay for them and often give them away or discard them or return them

ASSOCIATED FEATURES

- Individual with kleptomania tries to resist the impulse to steal and they are aware the act is wrong and senseless
- They fear being apprehended and often feels depressed or guilty about the thefts
- Neurotransmitter pathways associated with behavioural addiction including those associated with the serotonin, dopamine and opioid systems appear to play a role in kleptomania

PREVALENCE

- Occur in about 4- 24 % of individual arrested for shoplifting
- In general population approximately 0.3-0.6%
- Females outnumber males3.1

COURSE

- Age of onset variable but often begins in adolescence rarely in late adulthood
- it sporadic with brief episodes and long periods of remmission
- The disorder may continue for years despite muiltiple convictions for shoplifting

RISK FACTORS

- Kleptomania individual have high chance of havig 1st degree relatives with obsessive-compulsive and substance use disorder than in the general population

DIFFERENTIAL DIAGNOSIS

- Ordinary theft which is deliberate and motivated by the usefulness of the object or its monetary worth
- Some adolescence may steal as an act of rebellion or as a rite of passage
- Antsocial personality disorder
- Psychosis or mood disorder(as a result of delusion or hallucination
- Neurocognitive disorder

COMORBIDITY

- Kleptomania is associated with compulsive buying as well as depresion and bipolar disorder, eating disorder particularly bulimia nervosa, personality disorder and substance use disorder

OTHERS

A) Specified disruptive impulsive and conduct disorder

- Significant impairment in social, occupational and other important areas of functioning but does not fit in any of the diagnostic disorder

B) Unspecific disruptive impulse control disorder- criteria is not met for any of the disorder

THE END

- THANKS

OBSESSIVE COMPULSIVE AND RELATED DISORDERS

- These include:

1) Obsessive compulsive disorder
2) Body dysmophic disorder
3) Hoarding disorder
4) Trichotillomania (hair pulling)
5) Excoriation disorder (skin picking)
6) Substance/medication induced obsessive compulsive and related disoder
7) OC and RD due to another medical condition
8) Specified and unspecified OC and RD

CONT-

- OCD is characterised by the presence of obsession and /or compulsions
- Obsessions –are reccurent and persistent thoughts ,urges or images that are experienced as intrusive and unwanted
- Compulsion – are repetitive behaviour or mental act that an individual feels driven to perform in response to an obsession or according to rule that must be applied rigidly

CONT-

- DIAGNOSTIC CRITERIA

A) Presence of obsession, compulsion or both

Obsession are defined by 1 and2

1) Reccurent and presistent thoughts ,urges or images that are exprienced ,at some time during the disturbance, as intrusive and unwanted, and in most individuals cause marked anxiety or distress
2) The individual attempts to ignore or suppress such thoughts, urges or images,or to neutralize them with some other thought or action (ie performing a compulsion

CONT-

- Compulsion are defined by 1 and2

Repetitive behaviours (eg handwashing, ordering, counting,repeating words silently) that individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly

2) The behaviour or mental act are aimed at preventing or reducing anxiety or distress or preventing some dreaded event or situation

CONT-

B)The obsessions or compulsion are time consuming (eg take more than one hour per day or cause clinically significant distress or impaiment in social, occupational or other important areas of functioning

C) The obsessive- compulsive symptoms are not attributable to the physiological effect of a substance or a medical condition

D)The disturbance is not due to another mental disorder

Specify if

with good or fair insight- the individual recognizes that the OCD beliefs are definitely or probably not true or that they may or may not be true

With poor insight- the individual thinks the OCD beliefs are probably true

With absent insight/delusional beliefs- the individual is completely convinced that the OCD beliefs are true

Specify if

Tic related –the individual has a current or past history of a tic disorder(about 30% of pt with OCD have a life time tic disorder especially males)

DIAGNOSTIC FEATURES

- The essential features of OCD are the presence of obsession or compulsion
- Obsession are repetitive and persistent thoughts(eg contamination) images(eg of violent or horrific scene) or urges (eg to stab someone)
- They are not pleasurable and are experieced involuntary, they are intrusive and unwanted and causes marked distress and anxiety in most individuals
- The individual tries to ignore or supress them (eg by avoiding triggers or using thought suppression or to neutralize them with another thought or action (eg perfoming a compulsion)

CONT-

- Compulsion (or rituals) are repetitive behaviour eg washing ,checking praying or mental acts) the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly(eg the individual believes the house will burn down if the stove is not checked 10 times

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- The specific content of obsession and compulsion varies among individual
- But certain themes are common including those of cleaning(contamination obsession and cleaning compulsion) individual may avoid public situation (restaurants,public washroom for fear of contamination
- Other individual themes includes symmetry(symmetry obsession and repeated ordering compulsion

PREVALENCE

- 12 months prevalence rate in USA is 1.2 %
- Internationally prevalence rate is 1.1- 1 .8%
- Females are affected at a slightly higher rate than males in adulthood
- Although males are more commonly affected in childdhood

DEVELOPMENT AND COURSE

- In USA mean age of onset of OCD is 19.5 years and 25% of cases start at 14yrs
- Onset after 35yrs is unusual but does occur
- Males have on ealier age of onset than females nearly 25% of males have onset before age 10yrs
- The onset of OCD is usually gradual and if untreated it has a chronic course
- Some individual have episodic course and a minority have a deteriorating course
- Without treatment remission rates in adult are low about 20% for those evaluated 40 yrs later
- The course of OCD is complicated by co-occurence of other disorder

RISK AND PROGNOSTIC FACTORS

- TEMPERAMENTAL

Greater internalizing symptom, higher negative emotionality and bahaviour inhibition in childhood are possible temperamental risk factors

ENVIRONMENTAL

Physical or sexual abuse in childhood and other stressful or traumatic events have been associated with an increased risk for developing OCD

GENETIC AND PHYSIOLOGICAL

Common in 1st degree relative(about twice as compared to general population)

Higher rate in monozygotic twins

FUNCTIONAL CONSEQUENCES OF OCD

- Reduced quality of life and high level of social and occupational functioning impairment
- Impairment is due to time spent obsessing and compulsion also restrict functioning
- Health issues- those with contamination obsession may avoid hospital or doctor for fear of contamination when sick or may develop skin lesion due to excessful washing
- Obsession by symmetry can derail timely completion of school or work project because the project/work never feels "just right" potentially resulting in school failure or job loss
- ½ of pt with OCD have suicidal thought
- ¼ attempt suicide

DIFFERENTIAL DIAGNOSIS

- Anxiety disorder- obsession do not involve real life concern as it happen in anxiety disorder
- Major depressive disorder- in MDD thought are mood congruent and not necessarily experienced as intrusive or distressing
- Other obsessive-compulsive and related disorder- differentiated by the characteristic features
- Eating disorder – obsession is concerned about weight and food
- Tics and steretyped movements- do not follow obsession or are not aimed at neutralizing obsessions
- Psychotic disorder-some individual with OCD have poor insight or even delusional OCD beliefs but do not have other psychotic features
- Other compulsive like behaviour eg gambling or substance use(but in this case person usually derives pleasure from activity and may wish to resist it only because of its da ngerous consequences
- OCPD – no intrusive thoughts and compulsion

COMORBIDITY

- 75% -Anxiety disorder(eg panic disorder, social anxiety disorder, GAD)
- 63% have depressive or bipolar disorder
- 23-32 % have OCPD
- 30% have life time tics disorder especially males

TREATMENT

- Combination of pharcotherapy and behaviouh therapy
- Pharcotherapy
- SSRI-fluaxetine, citapram escitalopram fluvoxamine,paroxetine, and sertraline or
- TCA- Clompramine(anafranil)
- Other drug includes- carbamazepine,sodium valproate, or lithium can augment the therapeutics effectof SSRI or TCA

BEHAVIOUR THERAPIES

Very effective and long lasting

The principal behaviour approaches in OCD are exposure and response prevention

Desentization

Thought stopping

Flooding

implosion therapy and

Aversive condiotioning

In behaviour therapy pt must be committed to improvement

CONT-

- PSYCHOTHERAPY

Insight oriented psychotherapy

Supportive psychotherapy

Family therapy-helps reduce marital discord and in building a treatment alliance with family member and helps them understand the condition

Group therapy-provide support systems for the patient

Physical therapy –severely sick patient ECT may be considered

Psychosurgery- may also be considered if all other methods fails eg cinguletomy effective in 20- 30%

BODY DYSMOPHIC DISORDER

- DIAGNOSTIC CRITERIA

A) Preoccpation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others

B) At some point during the course of the disorder, the individual has performed repetitive behaviour(eg mirror checking,excessive grooming, skin picking,reassurance seeking)or mental act(eg comparing his or her appearance with that of others) in response to appearance concerns

C) The preoccupation causess clinically significant distress or impairment in social,occupational, or other important areas of functioning

D) The appearance preoccupation is not better explained by concern with body fat or weight in an individual whose symptoms meet diagnostic criteria for eating disorder

CONT-

- SPECIFY IF

With good or fair insight-the individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true

With poor insight- the individual thinks that the body dysmophic disorder beliefs are probably true

with absent insight or delusional beliefs-the individual is completely convinced that the body dsymorphic disorder beliefs are true

DIAGNOSTIC FEATURES

- Individual with BDD are preoccupied with one or more perceived defects or flaws in their physical appearance which they believe look ugly, unattrative, abnormal or deformed
- The perceived defect are not observable or appear only slight to othe individuals
- The concern range from looking unattractive or not right to looking hideous or like a monster
- Preoccupation can focus on one or many body parts mostly the skin (acne ,wrinkles ,paleness etc) hair (eg thinning, colour, excessive) nose(eg size or shape)
- Some individual are concerned about perceived asymmentry of body areas
- The preoccupation are intrusive, unwanted, time consuming(occuring on average 3-8 hours per day and are usually difficult to resist or control

CONT-

- Excessive repetitive-behaviour or mental act which are time consuming and difficult to resist or control eg comparing appearance with that of other individuals, repeatedly checking perceived defects in mirrors or other reflective surfaces or examining them directly
- Excessively grooming eg combing, styling, shaving make up or use of hat
- Seeking reassurace about how the perceived defect look,touching disliked area to check them ,excessively exercising or weight lifting and seeking cosmetic procedures

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- many people with BDD have ideas or delusion of reference that otherpeople take special notice of them or mock them because of how they look
- The condition is associated with high level of anxiety,social phobia,social avoidance, depressed mood and low self esteem
- many individual are ashamed of their appearance and majority of them receive cosmetic treatment to try to improve their perceived defects
- BDD appear to respond poorly to such treatment(dermatological and surgical) and sometimes become worse
- Some individual take legal action or are violent toward the clinician because they are dissatified with the cosmetic outcome

PREVALENCE

- The point prevalence among adult is 2.4%(2.5% in females and 2.2% in males)
- The current prevalence is 9- 15 % among dermatology patients
- 3-16% among cosmetic surgery patients
- 10% present for oral and maxillofacial surgery

DEVELOPMENT AND COURSE

- Mean age of onset 16-17 yrs
- Median age of onset 15yrs
- Most common age of onset 12-13yrs
- 2/3 have onset before 18 yrs
- The disorder is chronic although improvement is likely when evidence based tretment is received
- The clinical symptoms are similar in children, .adolescence and adults and onset of symptoms is gradual

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL

BDD – is associated with high rates of childhood neglect aand abuse

GENETIC AND PHYSIOLOGICAL

The prevalence of BDD is elevated in 1st degree relatives

CONT-

- SUICIDE RISK
- Very high due to their perceived body defects
- FUNCTIONAL CONSEQUENCES OF BDD

Have difficulties in psychosocial functioning ,quality of life due their appearance concern

Impairment may range from moderate (eg avoidance of some social situation to extreme and incapacitating(eg being completely house bound)

20% of youth may drop out of shool due to perceived symptoms

DIFFERENTIAL DIAGNOSIS

- Normal appearance concern and clearly noticeable physical defect are not diagnosed as BDD
- Eating disorder- concerned about being fat or gaining weight
- Other obsessive- compulsive and related disorder(BDD focus only on appearance)
- Major depressive disorder (depressive symptoms are common in pt with BDD)
- Social anxiety and avoidance are commom in BDD because of concern about appearance
- Psychotic disorder (have other psychotic symptoms)

COMORBIDITY

- Social anxiety disorder(social phobia)
- Obsessive compulsive disorder
- substance related disorder

TREATMENT

- Treatment of pt with BDD with surgical,dermatological and other medical procedures is always unsuccessful
- TCA,SSRI,and MAOIs have been found to reduce symptoms in at least 50% of patients
- Coexisting mental disorder eg depression or anxiety disorder should be treated appropriately

HOARDING DISORDER

- DIAGNOSTIC CRITERIA

A) Persistent difficulty discarding or parting with possessions,regardless of their actaul value

B) This difficulty is due to perceived need to save the items and to distress associted with discarding them

C) The difficulty discarding possession resultsi In the accumulation of possessions that congest and clutter active living areas and substancially compromise their intended use.if the living areas are unclutted,it only because of the intervention of third parties(eg family members cleaners or authorities

D) The hoarding causes distress or impairment in social occupational or other important areas of functioning(including maintaining a safe environment for self and others

E) The hording is not betterexplained by another medical codition (eg brain injury ,cerebral vascular accidents ,prader willi sydrome)

F) The hoarding is not due to delusion or hallucination associated with a psychotic disorder

CONT-

- SPECIFY IF
- With excessive aquisition-if difficulty discarding possession is accompanied by excessive acquisition of items that are not needed or for which there is no available space
- SPECIFY IF
- With good or fair insight – the individual reognizes that hoarding related beliefs and behaviours(pertaining to difficulty discarding, clutter, or excessive acquisition are problematic
- With poor insight-the individual is mostly convinced that hoading related beliefs and behaviours(pertaining to difficulty discarding items, clutter or excessive acquisition)are not problemaatic despite evidence to the contrary
- With absent insight /delusional beliefs- the individual is completely convinced that hoading – related beliefs and behaviours(pertaining to difficulty discarding items clutter or excessive acquisition) are not promblematic despite evidence to the contrary

DIAGNOSTIC FEATURES

- The essential features of hoarding disorder is persistent difficulties discarding or parting with possession regardless of they actual value
- Discarding is in form of throwing away, selling, giving away or recycling
- Individual try to avoid being wasteful, fear of losing important information
- The most commonly served items are newspaper ,magazines ,old clothing, bags, books or mails
- The nature of items are those most people consider useless
- The individual accumulate large numbers of items and may fill up active living areas to the extent that their intended use is no longer possible (eg may not be able to cook in the kitchen,sleep in his or her bed or sit on a chair

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Some individual with hoarding disorder live in unsanitary condition due to severely cluttered spaces
- Animal hoarding- can be defined as the accumulation of a large number of animals and failure to provide minimal standard of nutrition, sanitation and veterinary care
- Most individual who hold animals also hoard inanimate object

PREVALENCE

- Has greater prevalence in males
- Its more common in older adult (age 55-94yrs) compared to younger adults (ages 34- 44yrs)

DEVELOPMENT AND COURSE

- Start early in life and spans well into the late stages of life
- May start at age 11- 15yrs interferes with everyday functions,by mid 20"s and causes clinically significant impairment by min 30s and become worse by 50yrs
- Thus the severity of hoarding increases with each decade of life

RISK AND PROGNOSTIC FACTORS

- TEMPERAMENTAL

Indeciveness is a prominent feature of individual with hoarding disorder and their 1st degree relatives

ENVIRONMENTAL

Individual who are exposed to stressful and traumatic life events

GENETIC AND PHYSIOLOGICAL

Hoarding behaviour is familial with about 50% of individual who hoard reporting having a relative who also hoards

Concordance rate in twin is 50%

FUNCTIONAL CONSEQUENCES OF HOARDING DISORDER

- Clutter impairs basic activities such as moving through the house,cooking, cleaning ,personal hygiene and even sleeping
- Appliancies may be broken and utilities such as water and electricity may be disconected as access for repair work is difficult

DIFFERENTIAL DIAGNOSIS

- Other medical condition- injuries in cingulate cortex and part of prefrontal cortex is associted with hoarding or accumulation of object
- Neurodevelopmental disorder- autism spetrum disorder or intellectual disability disorder tend to hoard items
- Schizophrenia and other psychotic disorder-hoarding could be due to a delusional disorder
- Obsessive compulsive disorder- hoarding can be due to obsession or compulsion.But in OCD the behaviour is generally unwanted and highly distressing and the individual experiences no pleasure or reward from it

COMORBIDITY

- 75% of individual with hoarding disorder have comorbid anxiety or mood disorder
- Most common is major depressive disorder upto 50%
- 20% have OCD

TREATMENT

- PHARCOTHERAPY -SSRI ,TCAs are useful in pt with hoarding disorder
- Augmentationof this drug with carbamazepine ,lithium or antpsychotic may be effectve
- PSYCHOTHERAPY

Insight oriented pschotherapy

Behaviour therapy and family therapy

TRICHOTILLOMANIA(hair pulling disorder)

- DIAGNOSTIC CRITERIA

A) Recurrent pulling out of one's hair,resulting in hair loss

B) Repeated attemptsto decrease or stop hair pulling

C) The hair pulling causes clinically significant distress or impairment in social,occupational or other important areas of functioning

D) The hair pulling or hair loss is not attributable to another medical condition(dermatological condition)

E) The hair pulling is not better explaned by the symptoms of another mental disorder

DIAGNOSTIC FEATURES

- The essential feature of the disorder is a reccurent pulling out of ones own hair from any region eg scalp, eyebrows and eye lids .Less common site includes axillary,facial etc
- Hair pulling may occur in brief episode scattered throughout the day or

Can be sustained for hours less frequently and such hair pulling may endure for months or years

- The behaviour lead to hair loss and individual attempt to stop the habbit and may use makeup to conceal hair loss

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Hair pulling may be accompanied by a range of behaviour or rituals involving the hair (eg individual may search for a particular kind of hair to pull, such as texture or colour or may pull in a specific way making sure the root comes out intact,may examine it tactifully between the finger or manipulate orally other may swallow it
- Hair pulling may be preceded by emotional state eg anxiety or boredom or a sense of tension and individual may experience a sense of gratificaation,pleasure or a sense of relief when the hair is pulled out

CONT-

- PREVALENCE
- Prevalece in the general population is 1-2% females are more frequenly affected than males at a ratio of 10: 1
- DEVELOPMENT AND COURSE

Hair pulling may be seen in infants but this behaviour resolves

Has onset during puberty and has a chronic course

Site of hair pulling may vary with time

Symptom may worsen in females due to hormonal changes(eg menstruration ,perimenopause

For some people the disorder may come and go for weeks,months or years at a time

RISK AND PROGNOSTIC FACTORS

- GENETIC AND PHYSIOLOGICAL FACTORS

The disorder is common in individual with OCD and 1st degree relatives than in the general population

FUNCTIONAL CONSEQUENCES OF TRICHOTILLOMANIA

- It is associated with with distress as well as with social and occupational impairment
- There may irriversible damage to hair growth and quiality
- Swallowing of hair trichophagia) may lead to bowel obstru ction, abdominal pain,nausea and vomiting and even bowel perforation

DIFFERENTIAL DIAGNOSIS

- Normative hair removal/manipulation

Trochotillomania is not dignosed if hair removal is performed for cosmetic reason or in individual who twist and play with their hair

Other absessive compulsive disorder and related disorder- individual with OCD and symetry concern may pull out hair as part of their symmetry rituals and individual with body dsympohic disorder may remove body hair that may perceive as ugly or abnormal

Neurodevelopmental disorder-individual may have steretypies hair pulling

Psychotic disorder- may pull hair inresponse to a delusion or hallucination

Another medical condition-(eg inflammation of the skin or other demartological condition) or other cause of alopecia(differentiated by skin biopsy)

substance-related disorder- hair pulling may be excerbated by certain substance eg stimulant but rarely causes persistent hair pulling

COMORBIDITY

- Mojar depressive disorder
- Excoriation(skin pulling disorder)
- Nail biting

TREATMENT

- No consensus exist on the best treatment modalities for trichotillomania
- Treatment involve psychiatrist and dermatologist in a joint endeavor
- Psychopharcological used to treat psychodermatological disorder includes topical steroids , and hydroxyzine hydrochloride (atarax) has anxiolytic and antihistamine properties
- Whether depression is present or not antdepressant agents can lead to dermatological improvement
- Other , drugs includes

lithium, buspirone clonazepam

- Behaviour treatment includes

Biofeedback,self monitory,desensitization and habbit reversal

insight oriented psychotherapy,hypnotherapy and behaviour therapy are also effective

EXCORIATION (SKIN PULLING DISORDER)

- DIAGNOSTIC CRITERIA

A) Reccurrent skin picking resulting in skin lesion

B) Repeated attempts to decrease or stop skin picking

C) The skin picking causes clinically significant distress or impairment in social ,occupational and other important areas of functioning

The skin picking is not attributable to the physiological effect of a substance(eg cocaine) or a medical condition(eg scabies)

E) The skin picking is not better explained by symptoms of another mental disorder(eg delusion or tactile hallucination in psychotic disorder)

DIAGNOSTIC FEATURES

- The essential feature of this disorder is recurrent picking of one's skin commonly on the face arms and hands
- Individual may pick at health site or at minor skin irregularities or lesion such as pinmples
- Most people use finger nails, may use tweezers ,pin or other objects
- In addition to skin picking there may be skin squeezing or biting
- Indvidual may spend several hours per day picking skin which may continue for months or years
- The picking lead to skin lesion and it causes clinically significant distress or impairment in social occupational and other important areas of fuctioning

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Skin picking may be accompanied by a rage of bahaviour or rituals involving skin or scalp
- The individual may examine,play with or swallow the skin pulled
- Skin picking may be preceeded by anxiety or boredom or by increasing sense of tension and may lead to gratification, pleasure or a sense of relief when the skin or scalp has been picked
- Skin picking does not occur in the presence of other individual except immediate family members
- Some individual report picking the skin of others

PREVALENCE

- Prevalence for excoriation disorder in adults is 1.4%
- ¾ of individual with the disorder are females

DEVELOPMENTAND COURSE

- Onset during adolescence often commonly coinciding with or following the onset of puberty
- The disorder freqently begin with a dermatological condition such as acne
- Sites of skin picking may vary over time
- The usual course is chronic with waxing and waning if untreated
- For some individual the disorder may come and go for weeks, months or years at a time
-

RISK AND PROGNOSTIC FACTORS

- GENETIC AND PHYSIOLOGICAL

Common in individual with OCD and their 1st degree relative than in the general population

FUNCTIONAL CONSEQUENCE OF EXCORIATION DISORDER

- Excoriation disorder- is associated with distress as well as with social and occupational impairment
- Majority of individual with this disorder spend at least 1 hour per day picking,thinking about picking and resisting urges to pick
- Medical complication includes tissues damage,scarring and infection and can be life threatening

DIFFERENTIAL DIAGNOSIS

- Pschotic disorder

skin picking may occur in response to a delusion or tactile hallucination (ie formication) in psychotic disorder

Other obsessive- compulsive and related disorder- excessive washing in response to contamination obsession may lead to skin lesion

Skin picking may occur in patient with BDD due to apppearance concern

Neurodevelopmental disorder-steretypic movement disorder may be characterised by repetitive self injurious behaviour

Other medical condition (eg scabies)

Substance /medication induced disorders – certain substance eg cocaine may induce skin picking

COMORBIDITY

- Other disorder includes OCD and trichotillomania
- Major depressive disorder

TREATMENT

- Combination of pharmacotherapy and behaviour therapy
- Similar to the management of trichotillomania

SUBSTANCE/ MEDICATION INDUCED OBSESSIVE COMPULSIVE DISORDER

- DIAGNOSTIC FEATURES

The symptoms are atributable to the effect of sustance (eg drug of abuse,or medication

The symptoms usually develops during or soon after substance intoxication or withdrawal or exposure to a medication or toxin

The symptom usually remit or improve within days to several weeks to one month (depending on the half life of a substance / medication

OBSESSIVE COMPULSIVE DISORDER AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION

- The symptoms are attributable to the direct pathophysiological effect of a medical condition
- The judgement that the symptoms are best explained by a medical condition must be based on evidence from the history , physical examination or laboratory findings

OTHER SPECIFIED OBSESSIVE COMPULSIVE AND RELATED DISORDER

- They are symptoms chacteristics of obsessive compulsive and related disorder that causes clinically significant distress or impaiment in social occupational and other important areas of functioning but do not meet full criteria for any of the disorder dignostic class
- This includes
- Body dysmorphic disorder with actual deformity /flaws and is clearly observable by others

Unspecified obsessive-compulsive and related disorder

- Symptoms related to this disorder causes distress or impairment in social ,occupational and other important areas of functioning but do not meet the criteria for any of the disorder or there is no sufficient information to make a more specific diagnosis (eg in an emergency room settings

THE END

- THANKS

PERSONALITY DISORDERS

- A personality disorder is an enduring pattern of inner experince and behaviour, that deviates markedly from the expectation of the individual cultures, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment
- 12 personality disorders are included in DSM 5

CONT-

- The personality disorders are grouped into 3 clusters based on descriptive similarities

1)CLUSTER A-Include: paranoid, schizoid and schizotypal personality disorder

2)CLUSTER B – Includes: antisocial,borderline, histrionic and narcissistic personality disorder

3) CLUSTER C- Includes: avoidant, dependent and obsessive compulsive personality disorder

4) OTHERS- Includes personality change due to a medical condition, specified and unspecied personality disorder

CLUSTER A

a) Paranoid
b) Schizoid
c) Schizotypal

- Individuals often perceived as **odd and eccentric**

PARANOID PERSONALITY DISORDER

- Individual with PPD have a pervasive **distrust and suspiciouness** of others beginning in early adulthood and present in a variety of context as indicated by four or more of the following:

1) Suspects without sufficient basis that others are exploiting, harming or deceiving him or her

2) Is preoccupied with unjustified doubt about the loyalty or trustworthness of friends or associates

3) Is reluctant to confide in others because of fear that the information will be used maliciously against him or her

4) Reads hidden demeaning or threatening meaning into benign remarks or events

5) Persistently bears grudges (ie is unforgiving of insults, injuries or slights)

6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack

CONT-

7)Has reccurent suspicion without justification regarding fidelity of a spouse or sexual partner

B) The symptoms do not occur excusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features or another psychotic disorder and is not attributable to the physiological effect of another medical condition

DIAGNOSTIC FEATURES

- The essential features of PPD is a pattern of distrust and suspeciouness of others
- Individual with this disorder assume that other people will exploit, harm or deceive or attack them any time without reason
- Individuals are preaccupied with unjustified doubts about loyalty or trustworthiness of their friends or associate
- They are reluctant to confide in or become close to others because they fear that the information they share will be used against them
- They may refuse to answer personal question saying that the information is nobody's business, and bear grudges and are unwilling to forgive
- They have pathological jealous often suspecting their spouse or sexual partner is unfaithful without adquate justification

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individuals with PPD are difficult to get along with, have problem with close relationship, are hypervigilant for potential threat, are cold and lack tender feelings
- They blame others for their own short coming, have excessive need to be self sufficient because they lack trust in others
- In response to stress they may experience very brief psychotic episode and may appear as premobid symptom of delusional or schizophrenia

DEVELOPMENT AND COURSE

- PPD may be aparent in childhood and adolescence with poor peer relationship, solitariness, underachievement in school and peculiar thoughts
- These children appear odd and eccentric and attract tearsing
- It is more common in males

RISK AND PROGNOSTIC FEATURES

- GENETIC AND PHYSIOLOGICAL FACTORS
- Common in first degree relatives with schizophrenia and delusioanal disorder (persecutory type)

DIFFERENTIAL DIAGNOSIS

- Other mental disorders with psychotic features
- Substance use disorder (history and lab test)
- Personality change due to medical condition (history, physical examination and lab radiological exams important)
- Other personality disorders -distinguished by characteristic features (a diagnosis of muiltiple personality disorder can be made)

TREATMENT

- PSCHOTHERAPY
- Treatment of choice
- Therapist should be straight forward when dealing with this patients
- An honest apology when wrong and not excuses is required (eg when late for appointment)
- They do fit in a group therapy and individual psychotherapy is indicated which rquires a professional and not overly warm style from therapist
- PHARMACOTHERAPY
- Useful in dealing with agitation and anxiety such as diazepam but accasionally antpsychotics eg haloperidol is indicated in managing severe agitation and delusional thinking
- Antpsychotic Pimozide is useful in reducing paranoid ideation in some patients

SCHIZOID PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A)A pervasive pattern of detachment from social relationship and restricted range of expression of emotion in interpersonal setting, beginning in early adulthood (Antisocial) as indicated by four or more of the following:

1) Neither desires or enjoys close relationship including been part of the family

2) Almost always chooses solitary activities

3) Has little if any interest in having sexual experiences with another person

4) Take pleasure in few if any activities

5) Lacks close friends or confidants other than 1st degree relatives

CONT-

6) Appears indifferent to the praise or criticism of other people

7) Show emotional coldness,detachment or flattened affectivity

B Do not occur exclusively during the course of schizophrenia, mood disorder,other psychotic disorder, or autistic spetrum disorder and is not due to physiological effect of another medical condition

DIAGNOSTIC FEATURES

- Individual with SPD has restricted range of expressed emotion
- Have no desire for intimacy
- Have no desire of being part of the family, or social group or for intimacy and prefer spending time by themselves
- They appear socially isolated or loners and always choose solitary activities or hobbies e.g. computer or mathematical games that do not include interaction with others
- They have no close friends or confidants and not bothered by what others may think of them

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Have difficulties in expressing anger even in response to direct provocation or responding appropriately to important life events because they lack emotion
- Due to lack of social relationship they often do not marry and their occupational functioning is impaired especially where interpersonal involvement is required
- When stressed may experience very brief psychotic episode lasting minutes to hours
- The condition may appear as the primorbid of delusinal disorder or schizophrenia

DEVELOPMENT AND COURSE

- May become apparent in childhood or adolescence with solitariness, poor peer relationship and under achievement in school which make these children or odolescence appear different and make them subject to teasing

RISK AND PROGNOSTIC ISSUES

- SPD have increased prevalence in the relatives of individual with shizophrenia or schizotypal personality disorder
- It is more common in males

DIFFERENTIAL DIAGNOSIS

- Other mental disorder with psychotic symptoms (have prolonged period of delusion and hallucination)
- Autism spectrum disorder (have more impaired social interaction and stereotyped behaviour and interest)
- Personality change due to another medical condition or substance use (physical examination, lab investigations and history confirm the diagnosis)
- Other personality disorders can be distinguished by the characteristic features

TREATMENT

- PSYCHOTHERAPY:
- Mainstay of treatment
- As trust develops they may reveal a plethora of fantacies and fear even of merging with the therapist
- They are reserved in group therapy and should be protected against aggressive patients

- PHARMACOTHERAPY:
- Small dose of antpsychotics and psychostimulants may be effective in some patients

SCHIZOTYPAL PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A) A pervasive pattern of social and interpersonal deficit marked by acute discomfort and reduced capacity for close relationship as well as cognitive and perceptual distortion and eccentricities of behaviour begin in early adulthood as indicated by 5 or more of the following

1) Ideas of reference (excluding delusion of reference)

2) Odd belief or magical thinking that influence behaviour and are incosistent with cultural norms or religious beliefs eg telepathy or sixth sense (think u know what will happen or somebody is thinking)

3) Unusual perception experience including bodily illusions

4) Odd thinking and speech (eg over elabolate or steretyed)

5) Suspiciousness or paranoid ideations

6) Behaviours or appearance that are odd,eccentric or perculiar

CONT-

7) Lack of close friends or confidants other than 1st degree relatives

8) Excessive social anxiety that does not diminish with similiarity and tends to be associated with paranoid fears rather than negative judgement about self

B Does not occur exclusively during the course of schzophrenia or mood disorder with psychotic features or autism spectrum disorder

DIAGNOSIS FEATURES

- Begins by early adulthood
- Individual often have ideas of reference (ie incorrect interpretations of casual incidents and external events as having a particular unusual meaning specifically for the person)
- They may feel that they have special power to sense events before they happen or to read others thought
- They may believe they have magical control over others which can be implemented directly eg believing that someone taking a dog for a walk is direct effect of their thinking an hour earlier or indirectly through compliance with magical rituals (eg walking past a specific object three times to avoid a certain harmful outcome)
- The social anxiety does not easily subside when they spend more time in the setting or become more familiar with other people because their anxiety tends to be associated with suspiciousness regarding others motives(eg when attending a dinner party the individual with SPD will not become more relaxed as time goes on but rather may become increasingly tense and suspicious

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individual may exprience transient psychotic episode (lasting minutes to hours which may meet criteria for brief psychotic disorder
- Over half have a history of depressive episode
- 30-50% have concurrent diagnosis of major depressive disorder
- There is considerable concurence with schiziod, paranoid, avoidant and borderline personality disorders

DEVELOPMENT AND COURSE

- Has a stable course with a propotion of individual going to develop schizophrenia or other psychotic disorder

RISK AND PROGNOSTIC FACTORS

- More common among 1st degree relatives of individual with schizophrenia
- More common in males

DIFFERENTIAL DIAGNOSIS

- Other mental disorders with psychotic symptoms (have prolonged period of delusion or hallucination) may preceed schizophrenia (premorbid)
- Neurodevelomental disorder (have language problem or stereotype behaviour)
- Personality change due to another medical condition or substance use (history, lab work and physical examination)
- Other personality disorders or traits

TREATMENT

- PSYCHOTHERAPY
- Similar to schzoid patient

- PHARCOTHERAPY:
- Neuroleptics are used for psychotic pts in dealing with ideas of reference, illusions, etc
- Antidepressants are used when depressive component of personality is present

CLUSTER B

(a) Antisocial
(b) Borderline
(c) Histrionic
(d) Narcissistic

- Individuals often appear **dramatic, emotional and erratic**

ANTISOCIAL PERSONALITY DISORDER

- DIGNOSTIC CRITERIA

A) A pervasive pattern of disregard for and violation of the right of others occuring since age 15 years as indicated by three or more of the following:

1) Failure to conform to social norms with respect to harmful behaviours as indicated by repeated performing acts that are ground for arrest
2) Deceitfulness as indicated by repeated lying or conning others for personal profit or pleasure
3) Impulsity or failure to plan ahead
4) Irritability and aggresiveness as indicated by repeated physical fights or assaults
5) Reckless disregard for safety of self or others

CONT-

6) Consistent irresponsebility as indicated by repeated failure to sustain consistent work behaviour or honour financial obligation

7) Lack of remorse as indicated by being indifferent and ratioalizing having mistreated or stolen from others

B) The individual is at least age 18

C) There is evidence of conduct disorder with onset before age 15yrs

D) The occurence of antsocial behaviour is not exclusively during the course of schizophrenia or bipolar disorder

DIAGNOSTIC FEATURES

- Characteristic feature is a pervasive pattern of disregard and violation of the rights of others that begin in childhood or early adolescence and continues into adulthood
- The pattern has also been refered to as psychopathy,sociapathy, dsysocial personality disorder
- Individual have symptoms of conduct disorder before age 15 and the diagnosis is made when the individual is at least age 18 yrs
- Individuals with APD perform acts that are ground for arrest such as destroying property, harassingg others, stealing or pursuing illegal occupation
- They disregard the rights wishes or feeling of others

CONT-

- They are deceitful and manipulative in order to gain personal profit or pleasure eg money, sex or power
- They are unable to plan ahead & decisions are made abruptly e.g. sudden change of job, residence or relationships
- These individuals display a reckless disregard for the safety of themselves or others which may be evidenced in their driving behaviours (eg reccurent overspeending, driving while intoxicated or muiliple accidents)
- They may engage in sexual behaviouh or substance use that has a high risk for harmful consequeces
- They are not remorseful of their act; may rationalize their act of having hurt mistreated or stolen from someone (eg has alot of money while we are suffering, losers have to lose, he deserved it)

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Have no regards for the rights,feelings or suffering of others
- They may have inflated, self assured and arrogant self appraisal (eg feel ordinary work is beneath them)
- They display superficial charms to impress someone who is unfamiliar with the topic
- Lack of empathy, inflated self appraisal and superficial charms are features associated with APD
- They are exploitive in their sexual relationship, they may be irresponsible as parents and may neglect their children and spouse
- Individuals are more likely than people in the general population to die prematurely by violent means (eg suicide, homicide or accidents)
- May develop other mental illiness eg depression, anxiety disorder substance use disorder, gambling disorder etc
- Those with conduct disorder before the age 10 are likely to develop APD

DEVELOPMENT AND COURSE

- Has a chronic course, become less evident or remit as individual grows older particularly by the fourth decade of life
- The condition cannot be diagnosed before the age of 18yrs

RISK AND PROGNOSTIC FACTORS

- GENETIC AND PHYSIOLOGICAL
- Common among 1st degree biological relatives
- The risk to biological relatives of females tend to be high than the risk to biological relative of males with the disorder
- Other risk includes substance use disorder and somatic symptoms disorder
- In a family that has APD, male are likely to have substance use disorder and females are likely to have somatic symptoms disorder

PREVALENCE

- DSM 5 –Between 0.2- 3.3%
- >70% among males with alcohol use disorder, and substance use clinic, prison and other forensic settings
- APD is associated with low socioeconomic status and urban setting
- More common in males than in females

DIFFERENTIAL DIAGNOSIS

- The diagnosi of APD is not given to individual less than 18yrs and is given only if there is a hx/o conduct disorder before age 15yrs
- Substance use disorder (both dignosis can be made)
- Schizophrenia and bipolar disorder
- Other personality disorders (can be diagnosed as well if the characteristic features are met)

TREATMENT

- PSYCHOTHERAPY:
- When pt with APD are immobilized (placed in hospital they become amenable to psychotherapy
- They may be engaged in group therapy
- Self help group have been more useful than jails in alleviating the disorder
- PHARCOTHERAPY:
- Used to deal with symptoms of anxiety, rage and depression

BORDERLINE PERSONALITY DISORDER

- DIGNOSTIC CRITERIA

A) A pervasive pattern of instability of interpersonal relationship, self image and affect and marked impulsivity beginning by early adulthood as indicated by four or more of the following

1) Frantic efforts to avoid real or imagined abandoment

2) A pattern of unstable and intense interpersonal relationship characterised by alternating between extremes of idealization and devalution

3) Identity disturbance and unstable self image or sense of self

4) Impusivity in at least two areas that are potentialy self damaging (eg overspending, sex, substance abuse, reckless driving or binge eating)

CONT-

5) Reccurent suicidal behaviour, gestures or threats or self mulilating behaviour

6) Affective instability due to a marked reactivity of mood (eg intense episodic dsyphoric irritability or anxiety lasting a few hours and only rarely more than a few days)

7) Chronic feeling of emptiness

8) Inappropriate intense anger or difficulty controlling anger (eg frequent display of tempers or reccurent physical fights)

DIAGNOSTIC FEATURES

- The essential features of BPD is a pervasive pattern of instability of interpersonal relationship, self image and affects and marked impulsivity that begin in early adulthood
- They make alot of effort to avoid real or imagined abandoment, the perception of impending separation causes a lot of fear and inapproprite anger (they may believe the abondonement implies they are bad. Their frantic effort to avoid abandonment may include impulsive action eg self mutilation or suicidal behaviour to elicit help from others)

CONT-

- Individuals with BPD have a pattern of unstable and intense relationship they may switch quickly from idealization (demand to spend alot of time together and share intimate details) to devaluing them (feeling that the other person does not care enough, does not give enough or is not “ there” enough)
- The individuals have indentity disturbance characterised by unstable self image or sense of self (may have sudden and dramatic shifts of goals, opinion and plans or relationships)
- Have impulsivity whereby they may spend money irresponsibly, binge eating, drive recklessly or engage in unsafe sex
- They have a high rate of suicidal attempts, self mutilation and 8-10% of them complete suicide

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individual with BPD have a tendency of undermining themselves at the moment a goal is about to be realized (eg dropping out of school just before graduation or destroying a good relationship just when it is clear that the relationship could last)
- They may develop psychotic-like symptoms (eg hallucinations) during the time of stress
- Physical handicap may arise from self inflicted abusive behaviuor or failed suicidal attempt
- Physical and sexual abuse, hostile conflict and parental loss are common histories of those with BPD

PREVALENCE

- General population about 1.6%
- 10% among individuals seen in outpatient mental clinic and about 20% among psychiatric inpatient
- BPD is commonly diagnosed in females 75%

Development and course

- Have chronic instability in early adulthood with episodes of serious mood/affective and impulsive dyscontrol
- Risk of suicide highest in young adult years and decrease with age

RISK AND PROGNOSIS

- GENETIC AND PHYSIOLOGICAL FACTORS
- BPD is about 5 times more common among 1st degree biological relatives as compared to general population
- There is also an increased risk for substance use disorders, APD and depressive or bipolar disorders

DIFFERENTIAL DIAGNOSIS

- Depressive and bipolar disorder
- Other personality disorders
- Personality change due to another medical condition or sustance use disorder

TREATMENT

- PSYCHOTHERAPY
- Is the management of choice but usually difficult for both the pt and therapist, because can regress early, show –ve and +ve transference which are difficult to analyze
- Patients do well in hospital settings in which they receive intensive individual and group therapy
- Hospital setting also limits pt who are excessively impulsive, self destructive or self mutiliting tendencies
- Under ideal circumstances pt should stay in hospital until they show marked improvement (up to a period of one year)
- Can then be discharged to special support systems such as night hospital, and half way houses

- PHARMACOTHERAPY:
- Antpsychotics used to cotrol anger and brief psychotic episode
- Antidepressant to control depressed mood
- Benzodiazepines help to control anxiety and depression

HISTRIONIC PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A) A pervasive pattern of excessive emotionality and attention seeking beginning by early adulthood as indicated by 4 or more of the following:

1) Is uncomfortable in situation in which he or she is not the center of attention

2) Interaction with others is often characterised by inappropriate sexually seductive or provocative behaviour

3) Displays rapidly shifting and shallow expression of emotions

4) Consistently uses physical cues to draw attention to self

5) Has a stye of speech that is excessively impressionastic and lacking in details

CONT-

6) Show self dramatization and exaggerated expression of emotions

7) Is suggestible (eg easily influenced by others or circumstances)

8) Consider relationship to be more intimate than they actually are

DIAGNOSTIC FEATURES

- The essential feature of HPD is a pervasive and excessive emotionality and **attention seeking** behaviour which start in early adulthood
- They demand to be the center of attention and if they are not they feel uncomfortable or unappreacited and may do something dramatic (eg make a funny story or create a scene to draw focus of attention to themselves)
- The appearance and behaviour of individual are often inappropriate, sexually provocative or seductive

CONT-

- They are overly concerned with impressing others by appearance and spend a lot of time, energy and money on clothes and grooming
- The speech lack in details and opinion are expressed dramatically
- They may embarrass friends and acquitances by an excessive public display of emotions (eg embracing them excessively or sobbing uncontrollably)
- They consider relationship more intimate than they actually are (eg describing almost all acquitances as my dear, my dear friend or refering to physician met only once or twice under professional circumstance by their 1st name)

ASSOCIATED FEATURES

- They have difficulty in achieving emotional intimacy in romatic or sexual relationships because they seek to control their partner through emotional manipulation
- These individuals are often intolerant of or frustrated by situation that involve delayed gratification and their actions are often directed at obtaining immediate satisfaction
- Long term relationship may be neglected to make way for excitement of a new relationship

CONT-

- PREVALENCE
- Approximately 1.84%
- More frequent in females

- DIFFERENTIAL DIGNOSIS
- Other personality disorders
- Personality change due to another medical condition or substance use disorder

TREATMENT

- PSYCHOTHERAPY
- Patients are usually unaware of their own real feelings; clarification of the same is important
- In psychotherapy whether group or individual is the treatment of choice
- PHARCOTHERAPY
- Useful in the treatment of depression or anxiety (antidepressant or antiaxiety)
- Ant psychotics are used for derealization and illusion

NARCISSISTIC PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A) A pervasive pattern of grandiosity, need for admiration and lack of empathy, beginning by early adulthood and present as indicated by five or more of the following

1) Has a grandiose sense of self impotance(exaggerates achievements and talents, expects to be recognised as superior without commensurate achievement)
2) Is preoccupied with fantasies of unlimited success, power briliance, beuty or ideal love)
3) Believes that he or she is special and unique and can only be understood by or should associate with other special or high status people or institution

CONT-

4) Requires excessive admiration
5) Has a sense of entiltlement (ie unreasonable expectation of favourable treatment or automatic compliance with his or her expectation)
6) Is interpersonally exploitative (ie takes advantage of others to achieve his or her own ends)
7) Lack empathy is unwilling to recognise or indentify with feeling and needs of others
8) Is often envious of others or believe that others are envious of him or her
9) Shows arrogant behaviour or attitude

Diagnostic features

- The essential features of NPD is a pervasive pattern of grandiosity, need for admiration and lack of empathy that begin in early adulthood
- They have grandiose self importance, overestimate their abilities and appears boastful
- They may get suprised when the praise they expect is not forth coming
- They may ruminate about ‘’ long overdue”admiration and privilege and compare themselves favourably with famous or privileged people
- Individuals believe that they are superior, special or unique and expect others to recognise them as such

CONT-

- They may feel that they can only be understood by and should only associate with people of high status or" top" person (doctor, lawyer, hairdresser, instructor, etc) or with the best institution
- They generally require excessive admiration and are preoccupied with how favorably they are regarded by others, they expect their arrival to be greeted with great fanfare
- They may assume that they do not have to wait in line and their priorities are so important and get irritated when others fail to assist in their very important work

CONT-

- They have lack of empathy and have difficulty recognizing the desires and feeling of others and may assume that others are totally concerned about their walfare
- They tend to discuss their own concern in inappropriate and length details while failing to recognise that others also have feeling and needs

ASSOCIATED FEATURE SUPPORTING DIAGNOSIS

- The interpersonal relationship is impaired because of problem derived from need for admiration and disregard for the feeling of others
- Performance may be disrupted because of intolence to critism or defeat
- Sustained period of grandiosity may be associated with hypomanic mood
- NPD is also associated with anorexia nervosa and substance use disorder (especially related to cocaine
- Histrionic, borderline, antsocial and paranoid personality disorders may be associated with NPD

Cont-

- PREVALENCE
- Based on DSM 1V 0-0.2% in community sample
- Common in males 50-75%
- DEVELOPMENT AND COURSE
- Narcissitic traits are common in adolescents but do not indicate the individual will develop NPD
- Individual with NPD have difficuilties adjusting to physical and occupational limitation associated with aging process
- DIFFERENTIAL DIAGNOSIS
- Other personality disorders and personality traits
- Mania or hypomania
- Substance use disorder

TREATMENT

- PSYCHOTHERAPY
- Psychotherapy is difficult as patients are unwilling to renounce nacissitic for progress to be made
- Psychoanalysis may be attempted
- Patients with mood swings and depression may benefit from mood stabilizers and antidepressants

CLUSTER C

(a) Avoidant

(b) Dependent

(c) Obsessive-compulsive

- People with this disorder are often fearful and tearful or
- Anxious and fearful

AVOIDANT PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA
- A pervasive partten of social inhibition, feeling of inadequacy and hypersitivity, to negative evalution, beginning by early adulthood as indicated by four or more of the following

1) Avoids occupational activities that involves significant interpersonal contact because of fear of critism, disapproval or rejection
2) Is unwilling to get involved with people unless certain of being liked
3) Shows restraints with intimate relationship because of fear of being shamed or ridiculed
4) Is preoccupied with being critized or rejected in social situations
5) Is inhibited in new interpersonal situation because of feeling inadequacy

CONT-

6) Views self as socially inept, personally unappealing or inferior to others

7) Is unusually reluctant to take personal risks or to engage in any new acivities that may prove embarrassing

DIAGNOSTIC FEATURES

- The essential features of APD is a pervasive pattern of social inhibition, feeling inadequacy and hypersensitivity to negative evalution that begin in early adulthood
- Offers of promotion may be rejected because of fear of critism from co-workers
- They avoid making new friends unless they are certain they will be liked and accepted without critism
- They fear to join group activities or establish intimate relationship unless there is assurance of uncritical acceptance

CONT-

- They tend to be shy, quiet inhibited and invisible because they expect that whatever they say, others will see it as wrong and so they may say nothing at all
- They have low self-esteem,doubts concerning social compentence, believe themselves to be unappealing or inferior to others

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individuals with APD are described by others as being shy, timid, lonely and isolated
- They have restricted interpersonal contact, no social support network to assist them incase of a crises and avoidant behaviour affect their occupation
- Other disorders associated with APD include depression, bipolar and anxiety disorders or other personality disorders

PREVALENCE

- Prevalence rates about 2.4%
- Equally frequent in male and female
- It starts in infancy or childhood with shyness, isolation and fear of strangers or new situations
- The individual becomes increasingly shy and avoidant during adolescence and early adulthood when social relationship with new people become especilly important
- It become less evidence or remits with age

DIFFERENTIAL DIAGNOSIS

- Anxiety disorder especially social phobia
- Other personality disorders and traits
- Personality change due to another medical condition
- Substance use disorder

TREATMENT

- PSYCHOTHERAPY
- Assertiveness training -a form of bahaviour therapy which teaches patient to express their needs openly and enlarge their self esteems
- Group therapy may help patient understand the effect of their sensitivity to rejection on themselves and others
- PHARCOTHERAPY
- Drugs used to manage anxiety and depression
- Beta-adrenergic receptors antagonist eg Atenolol may be used to control nervous system hyperactivity especially when they approach feared objects

DEPENDENT PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A) A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fear of separation beginning by early adulthood as indicated by five or more of the following

1) Has difficult making everyday decision without an excessive amout of advice and reassurance
2) Needs other to assume responsibility for most major areas of his or her life
3) Has difficulty expressing disagreement with others because of fear of loss of support or approval

CONT-

4) Has difficulty initiating project or doing things on his or her own because of lack of self confidence rather than lack of motivation or energy
5) Goes to excessive lengths to obtain narturance and support from others to the point of volunteering to do things that are unpleasant
6) Feels uncomrfortable or helpless when alone because of exaggerated fear of being unable to care for himself or herself
7) Urgently seeks another relationship as a source of care and support when a close relationship ends
8) Is unrealistically preoccupied with fears of being left to take care of himself or herself

DIAGNOSTIC FEATURES

- Have pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fear of separation (thinks they cannot function without helps of others
- Have difficulties in making everyday decision eg colour of the shirt to wear,the job to have or the people to befriend
- For adolescence may depend on their parents to decide what they should wear, with whom they should associate, how they should spend their free time and what school or college they should attend
- They don't express disagreement or anger and they agree with things which they feel are wrong rather than risk losing the help from those to whom they look for guidance

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individuals with DPD have self doubt, tend to belittle their abilities and may costantly refer to themselves as stupid
- They take critism and disapproval as prooof of their worthlessness and loss faith in themselves
- They avoid position of responsibility and social relationship is limited to those people, the individual's are dependent
- It may co-occur with other personality disorder.
- Chronic physcical illness or separation anxiety disorder in childhood or adolescence may predispose the individual to the development of the disorder

CONT-

- PREVALENCE
- Approximately 0.49%
- More frequent in famales

- DIFFERENTIAL DIAGNOSIS
- Other mental disorders eg social phobia
- Other personality disorders and traits
- Personality change due to another medical condition
- Substance use disorder

TREATMENT

- PSYCHOTHERAPY
- Insight oriented psychotherapy which enables pt to understand their behaviour and through the support of the therapist become more independent assertive and self reliant
- Behaviour therapy, assertiveness training, family therapy and group therapy can also be used
- A problem may arise when a therapist encourages a pt to change the dynamics of a pathological relationship (eg support a physically abused wife in seeking help from police)
- Therefore the therapist must show great respect for these pt feelings of attachment no mattter how pathological these feeling may seem
- PHARCOTHERAPY
- Drugs are used to deal with specific symptoms such as anxiety and depression

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

- DIAGNOSTIC CRITERIA

A) A pervasive pattern of preoccupation with orderliness, perfectinism and mental and interpersonal control at the expense of flexibility, openness and efficiency, beginning by early adulthood as indicated by four or more of the following

1) Is preoccupied with details, rules list, order, organization or schedules to the extent that the major point of the activity is lost
2) Shows perfectionism that interferes with task complection
3) Is excessively devoted to work and productivity to the exclusion of leisure activities and friendship
4) Is inflexible about matters of morality, ethics or values (not accounted for by cultural or religious identification

CONT-

5)Is unable to discard worn-out or worthless assets even when they have no sentimental value

6)Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

7) Adopts a miserly spending style toward both self and others. Money is viewed as something to be hoarded for future catastrophes

8) Show rigidity and stubborness

DIAGNOSTIC FEATURES

- The essential features OPD is preoccupation with orderliness perfectionism at the expense of flexibility,openness and efficiency it begins in early adulthood
- Individual pays strict attention to rules trivial details procedures,list, schedules to the extent that the major point of the activity is lost
- They pay extraordinaly attention to details,checking for possible mistakes and this causes delay and inconvenences other people and tasks are rarely accomplished
- Individuals displays excessive devotion to work to the exclusion of leisure activities or friendship (rarely do they take time off to go on outing or to just relax

CONT-

- They insist on perfection (eg telling a toddler to ride his or her tricycle on a straight line)
- They may be mercilessly self critical about their own mistakes and inflexible about matters of morality, ethics and values and follow authourity rules very strictly
- They have difficulties in discarding worn out or worthless objects and their spouse or roommate may complains about the amount of space taken by these objects but they regards discarding them as wasterful
- These individuals are reluctant to delegate task because they believe no one else can do it right

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- They every day relationship have a formal and serious quality they may be still in situations in which others would be smiling and happpy
- They hold themselves back until they are sure whatever they say will be perfects
- Individual are concerned about having things done in the only one “correct” way they have trouble going along with anyone else ideas (eg they often give very detailed instructions about how things should be done ie they is one and only one way to mow the lawn,to wash the dishes or clean the floor
- These individual are at risk of myocardial infaction, depressive , bipolar or eating disorder

CONT-

- PREVALENCE
- General population 2.1-7.9% it is diagnosed about twice as often among males
- DIFFERENTIAL DIAGNOSIS
- Obsessive-compulsive disorder (have true obsession and compulsion)
- Hoarding disorder (diagnosis is made when the hoarding is excessive (eg accumulated stucks of worthless objects that makes it difficult for self or others to walk through the house), both diagnosis can be made
- Other personality disorders
- Personality change due to a medical condition
- Substance use disorder

TREATMENT

- PSYCHOTHERAPY
- Unlike pt with other personality disorder those with OCPD are aware of their suffering and their seek treatment on their own
- Free association and non directive therapy are the treatment of choice
- Group therapy and individual therapy are also useful
- PHARCOTHERAPY
- Benzodiazepines reduces symptoms of OCPD
- SSRI are also effective

OTHER PERSONALITY DISORDERS

- PERSONALITY CHANGE DUE TO A MEDICAL CONDITION
- It represent a change from the individual previous characteristic personality traits
- There is evidence from the history, physical examination and laboratory finding the symptoms are due to a medical condition
- OTHER SPECIFIED PERSONALITY DISORDERS
- They are symptoms characteristic of a personality disorder but do not meet criteria for any of the personality disorder or present with mixed personality features
- UNSPECIFIED PERSONALITY DISORDER
- Where there are features of personality disorder but there is insufficient information to make a more specific diagnosis

THE END

- THANKS

NEURODEVELOPMENTAL DISORDER

- Group of conditions with onset in the developmental period characterised by:
- Impairment of
  - Personality
  - Social
  - Academic or
  - Occupational functioning
- The range of developmetal varies from mild limitation to marked impairment of social skill or intelligence
- NDD-co-occur with other conditions

CONT-

- These include:

1) Intellectual Disability (Intellectual Developmental Disorder)
2) Communication Disorder
3) Austism Spectrum Disorder
4) ADHD
5) Motor Disorder
6) Specific Leaning Disorder

INTELLECTUAL DISABILITY(IDD)

- Characterised by deficit in general mental abilities eg
  - Reasoning
  - Problem solving
  - Planning
  - Abstract thinking
  - Judgement
  - Academic learning or
  - Leaning from experience

- Also has impaired adaptive functioning eg
  - Personal independence
  - Social responsibiliy

COMMUNICATION DISORDER

- INCLUDES
- Language disorder
- Speech sound disorder
- Social communication disorder
- Childhood fluecy disorder (struttering)
- Its characterised by deficits in use of language, speech and social communication

AUTISM SPECTRUM DISORDER

- Have deficit in social communication eg social reciprocity or non verbal communication
- Have repetitive pattern of behaviour, interest and activities

ATTENTION DEFICIT HYPERATIVITY DISORDER

- CHARACTERISED BY
  - Inattention\disorganisation
  - Hyperactivity
  - Impulsivity

NEURODEVELOPMNTAL MOTOR DISORDER

- Developmental co-ordination disorder
- Stereotypic movement disorder
- Tics disorder

SPECIFIC LEARNING DISORDER

- Reading disorder
- Writing disorder
- Mathematics

INTELLECTUAL DISABILITY

DIAGNOSTIC CRITERIA

-intellectual disability (IDD) is a disorder with onset during the devepmental period that includes both intellectual and adaptive functioning deficits in conceptual,social and practical domains

Deficit in intellectual functions such as reasoning, judgement,planning, abstract thinking,academic learning and learning from experience confirmed by both clinical assessment and indvidualized stardard intellegence testing

Deficit in adaptive functioning tha t result in failure to meet developmental and sociacultural stardard for personal independence and social responsibilties.

without on going support the adaptive deficit limit functioning in one or moreactivities ofdaily life such as communication,social participation and independent living across multiple envirnments such as home.schoo.l work and community

Oset of intellectual and adpaptive deficit during the developmental period

SPECIFY current severity

Mild.moderate .severe .profound

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Associated difficuties in social judgment
- assessment of risk
- self management of behaviour or emotions
- Lack of motivation in school or work environment
- Tending to be easily lead by others
- Gullibility-lead to exploitation by others,unintentional criminal involvement or false confesion
- Risk for physical and sexual abuse

PREVALENCE

- General population1%
- Severe intellectual disability affect 6 per 1000
- Occur in all races and culture
- More common in male mild m;f 1.6;1,severe m;f 1.2.1(due to sex linked genetic factor and male vulnerability to brain insult may account for gender difference

DEVELOPMENT AND COURSE

- Onset during development period
- Age and characteristic features at onset depend on etiology and severity of brain dysfuction
- Delayed motor activities, language and social milestones may be noticeable within 2yrs of life among individual with severe interllectual disability
- Mild cases may not be noticeable until school age when difficult with academic learning become apparent
- Intellectual disability associated with genetic sydrome has characteristic physical appearance eg down sydrome or specific behaviour eg Lesch Nyhan sydrome
- Acquired form may follow illnesses eg meningitis, encephalities or head trauma

RISK FACTORS

- GENETIC AND PHYSILOGICAL
- Prenatal etiologies includes genetic sydromes (eg sequence variation or copy number varient involving one or more genes,chromosomal disorders)
- Inborn errors of metabolism
- Brain malformations
- Martenal disease(including placenta disease)
- Environmental influences (including alcohol ,other drugs,toxins,teratogens
- PERINATAL CAUSES INCLUDES

Labour and delivery events (eg trauma,fetal distress)

POSTNATAL CAUSES INCLUDES

Tramatic brain injuries

Infections

Demylinating diisorder,seizure disorder

Social deprivation

Intoxication (lead or mercury)

DIFFERENTIAL DIAGNOSIS

- Neurocognitive disorder(NCD)-characterised by loss of cognitive functions can occur at any age

(intellectual disability(ID) is a developmental disorder)

- NCD may co- occur ID (eg child with down sydrome who develops Alzhermers disease or person with ID who develops NCD following head injury(both diagnosis are made)

DIFF DIAGNOSIS CONT-

- Communication disorder or specific learning disorder

This neurodevelopmental disorder are specific to communication or specific learning domain does't affect intellectual and adaptive skills(may co-occur with intellectual disability and both diagnosis are made)

Autism spectrum disorder(ID is common in individual with ASD) NB difficulty to perform standadized test

CORMORBIDITY

- Co-occuring mental,neurodevelopmental,medical and physical conditions are frequent in intellectual developmental disorder with rates of some conditions such as epilepsy, cerebral palsy being three to four times higher than in the general population
- Mental disorder associated with intellectual disability includes ADHD,depression,bipolar disorder, anxiety disorder, stereotypic movement disorder and impulse control disorder

TREATMENT

- Intervention directed at improving adaptive functions are applied at home, in school and vocational setting
- Co-morbid psychiatric disorder eg depression, bipolar, anxiety disorder and schizophrenia are often missed and should be central focus of treatment
- mostly physical or medical condition in intellectual development disorder first present as behaviour change
- Treatment should be muiltmodel including medical, psychiatric, parental education and behaviour intervention
- This should always include long term planning

COMMUNICATION DISORDER

- Includes –dificit in language, speech and communication
- Speech-expressive production of sounds ie articulation,fluency, voice and resonance quilities
- Language-conventional use of spoken words, signs language;written works ,pictures etc
- Communication- any verbal or non verbal behaviour that influences the behaviour, ideas or attitude of another individual

DIAGNOSIS

- Diagnosis categories of communication disorder includes

-language disorder

-speech(sound) disorder

-childhood onset fluency disorder(struttering)

- social(pragmatic) communication disorder
- -other specified and unspecified communication

L ANGUAGE DISORDER

- DIAGNOSTIC CRITERIA

A)Persistant difficulties in the acquisition and use of language across modalities ie spoken, written or sign language due to

- deficit in comprehesion or production
- Reduced vocabulary(word knowledge and use)
- Limited sentence structure(inability to put word together to make sentences
- Inability to connect sentence to describe a topic or series of event or have a conversation

CONT-

B)Language abilities is below expected for age resulting in functional limitation, ineffective communication,social participation,academic achievement etc

C) Onset of symptoms in the early developmental period

D) The difficulties are not attributable to hearing or other sensory impairment,

DIAGNOSTIC FEATURES

- Difficulties in the acquisation and use of language due to reduced vacobulary,limited sentences strategy and discourse
- Language disorder is evident in spoken communication writtern communication or sign language
- NB-Language use is dependent on both receptive and expressive skills

Expressive ability-refers to the production of vocal gestural or verbal signals

-Receptive ability-refer to the process of receiving and comprehending language messsanges

Both expressive and receptive ability should be assessed they may differ in severity

ASSOCIATED FEATURES OF LANGUAGE DISORDER

- INCLUDES

Positive family history

Emerges during early developmental period

Diagnosis made by 4years tend to be stable and persist into adulthood

RISK AND PROGNOSTIC FACTORS

- Children with receptive language impaiments have a poorer prognosis than those with predominantly expressive impaiment
- they are resistant to treatment
- genetic prediposition(language disorder is highly heritable and tend to run in families)

DIFFERENTIAL DIAGNOSIS

- Normal variations in language across regions, social or cultural\ethnic variations must be considered during assessment
- Hearing or other sensory impairments(eg speech motor deficit) should be excluded)
- Intellectual disability have language delay and adaptive function impairment
- Neurological disorder can be acquired due to illness eg epilepsy meningitis or headtrauma
- Language regression-loss of speech and language in a child less than 3yrs may be a sign of autism spectrum disorder

Children older than 3yrs could be due to epilepsy etc

COMORBIDITY

- Other neurodevelopmental disorder

-learning disorder

-ADHD

Autism spectrum disorder

-developmental co-ordination disorder

-positive family history of speech or language disorder is often present

SPEECH (SOUND) DISORDER

- DIAGNOSTIC CRITERIA

-Persistant difficulty in speech,or sound production that interferes with speech intelligibility and prevent verbal communication of messanges

It causes limitation in communication leading to difficulties in social participation.academic achievement oroccupational performance

Onset in the early developmental period

difficulties are not due to congenital or acquired condition eg cerebral palsy. Cleft palate, deafness or hearing loss, traumatic brain injury or other medical or neurological conditions

DIAGNOSTIC FEATURES

- Speech sound production requires phonological knowledge of speech sounds and the ability to coordinate the movements of articulation(ie the jaw, tongue and lips with breathing and vocalizing for speech
- speech sound disorder may include phonological disorder and articulation disorder
- Diagnosis made when a child speech production is not what would be expected for the child age, developmental stage and the deficit is not due to physical .structual,neurological or hearing impairment
- In most children at age 4 overall speech should be intellegible wheras at 2yrs only 50% may be understandable

ASSOCIATED FEATURES AND COURSE OF SSD

- Positive family history of language or speech disorder is common
- could have diffulties in coordinating the articulation in other acquired skills that includes chewing,maintaining mouth closure and blowing the nose
- Speech sound disorder improves on treatment or with time (the disorder may not be life long)
- When language disorder is also present the speech disorder has a poorer prognosis and may be asssociated with learning disorder

DIFFERENTIAL DIAGNOSIS

- Normal variation in speech across regional,social or cultural\ethnic variation of speech should be considered before making the diagnosis
- Hearing or other sensory impairment should be ruled out(deafnes result in speech impairment)
- Structural impairment eg cleft palate
- dysrthria-speech impairment is due to a motor disorder eg cerebral palsy
- Selective mutism(anxiety disorder-lack of speech in one or more contexts or settings-talk appropriately in safe setting such as at home or with close friends

CHILDHOOD ONSET FLUECY DISORDER

- Diagnostic criteria

A) Disturbance in the normal fluency characterised by

a) Sound and syllable repeatition

b) sound prolongation for consonants as well as vowels

c) brokenwords eg pauses within a word

d) Audible or silent blocking filled or unfillled pauses in speech)

e) circumlocutions(word sustititions)

f) Word s produced with an excess of physical tension

g) Mono syllabic whole word repetition eg i-i-i-i-see him

B The diagnosis cause anxiety about speaking or limitation in efffective communication,social participation or academic or occupational perfomance

C) Onset in early developmental period(late onset cases are diagnosed as adult onset fluecy disorder

D) The diagnosis is not attributable to a speech-motor or sensory deficit or due to a neurological deficit eg stroke, tumuor,traumar or another medical condition or mental disorder

ASSOCIATED FEATURES AND COURSE

- Stress and anxiety exacebate dysfluency it is more severe when there is pressure to communicate eg giving reports at school,or interviewing for a job,It is often absent during oral reading ,singing or talking to inanimate objects or to pets
- Childhood onset fluecy disorder may be accom panied by motor movement eg eye blinking,tics, tremas of the lips or face, jerking of the head or fist clenching
- Age of onset 2-7 yrs(80-90%occur by age 6
- Children with fluency disorder may develop mechanism of avoiding it eg avoiding public speaking and use of short and simple utterances
- 65-85% recover
- It tends to run in families

DIFFERENTIAL DIAGNOSIS

- Sensory deficit eg hearing impairment or other sensory deficit or speechmotor deficit
- Normal speech dysfluences common in young children which includes whole words or phrase repetitions eg i want ,iwant ice cream
- Medication side effect
- Adult dsyfluencies –it start during or after adolescence-associated with specific neorological insults, variety of medical condition or mental disorder
- Tourette’’s disorder vocal tics and repetitive vocalization of tourette’s disorder should be distinguished from repetitive sounds of childhood onset fluency disorder by their nature and timing

SOCIAL (PRAGMATIC) COMMUNICATION DISORDER

- DIAGNOSTIC CRITERIA

A) Persistant difficulty in the social use of verbal and non verbal communication manifested by

a)Deficit in communication for social purposes eg greeting or sharing information

b)Difficulties in changing communication to match situation or needs of the listerner eg speaking differently in a classroom than on a play ground,talking differently to a child than to an adult

C)Difficulties in following rules for conversation and storytelling eg taking turns in coversation,rephrasing when misunderstood and knowing how to use verbal and non verbal signs to regulate interation

d)Difficulties in understanding what is not explictly stated eg proverbs ,humours etc

B)The dificit results in functional limitation in effective communication,social participation,social relationships and academic achievements or occupational performance

C) Onset of symptom in the early developmental period

d) Symptoms are not attributable to another medical, neurological or austism spectrum disease or mental disorder

DEVELOPMENT AND COURSE

- Rare in children < 4yrs
- Mild deficit manifest in adolescence when language and communication become more complex
- Outcome varies some children improves with time other have difficulties even in adulthood

RISK AND PROGNOSTIC FACTORS

- Family history of autism spectrum disorder,communication disorder or specific learning disorder increases risk for social(pragmatic) communication disorder

DIFFERENTIAL DIAGNOSIS

- Autism spectrum disorder

-have restricted/repetitive pattern of behaviour interest or activities

ADHD

-Have difficulties in social communication, social participation or academic functioning

SOCIAL PHOBIA

-Have well developed communication skills which are not utilized because of anxiety,fear or distress about social interation

AUTISM SPECTRUM DISORDER

- DIAGNOSTIC CRITERIA

A)Persistant deficit in social communication and social interation as manifested by

-la ck of social-emotional reciprocity eg lack of back and forth coversation,reduced sharing of interest emotions or affect, failure to intiate or respond to social interaction

-lack of non verbal communication eg eye contact, no use of gestures,lack of facial expression

-difficuilties in developing relationship eg difficuilties adjusting behaviour to suit varies social situations,difficuilties in sharing imaginative play or in making friends, to absence of interest in peers

CONT-

- B)Restricted repetitive pattern of behaviour, interest or activities as manifested by

-stere typed or repetitive motor movements, use of objects or speech eg lining up toys or echolalia

-insistance on sameness,inflexible adherence to routines or ritualized pattern of verbal or non verbal behaviour eg distress on small changes, rigid thinking pattern, greeting rituals, need to take same route or eat some food every day

-restricted fixated interest eg preoccupation with unusual object,toys or part of object

Hyper or hypoactivity to sensory inputs or unusual interest in sensory aspect of the envirnment eg apparent indifference to pain ,temperatures or excessive smellingor touching of objects

Or visual fascination with lights or movements

CONT-

- C) Symptoms must be present in the early development period
- D) symptoms causes clinically significant impaiment in social, occupational and other important areasof functioning
- These disturbances are not better explained by intelluctual disability(IDD)although both frequently co-occur
- SPECIFY-with or without accampanying intellectual or language impairment or associated with known medical or genetic condition or envirnmental factors
- NB-DSM IV diagnosis of autistic disorder Asperger's disorder or pervasive developmental disorder not otherwise spicified should be given the diagnosis of autism spectrum disorder

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individual with autism spectrum disorder also have intellectual impairment and /or language impairment
- Motor deficit is also common including odd gait clumsiness and other abnormal motor signs eg walking on tiptoes; self injury eg head banging or biting the wrist
- Adolescent and adult with autism spectrum disorder are prone to anxiety and depression
- some individual develop catatonic like motor behaviour eg slowing and freezing mid action ,mutism grimacing or waxy flexibility especially during adolescence years

PREVALENCE

- Affect 1% of population
- Sex- four times more common in male than females

DEVELOPMENT AND COURSE

- Symptoms are recognised during the 2nd year of life but may appear<12 months if ymptoms are severe or> 24 months if symptoms are mild
- 1st symptom of ASD frequently involve delayed language accompanied by lack of social interaction(eg avoiding eye contact),odd play pattern(eg carrying toys around but never playing with them)or unusual communication(not responding to their name(deafness may be suspected but should be ruled out
- During the 2nd year odd and repetitive behaviour eg eating the same food or watching the same video multiple times
- Symptom are most marked in childhood and early school years and some developmental gain may be achieved in later childhood in some areas eg increased interest in social interactions
- Some may deteriorate behaviorally during adolescence but most other improves
- only a minority of individual with ASD live and work independently in adulthood

RISK AND PROGNOSTIC FACTORS

- ENVINMENTAL FACTORS

-Non specific factors includes

a) Advanced parental age

b) Low birth weight

c) Fetal exposure to valproate

GENETIC

Heritability ranges from37% to higher than 90% based on twins concordance rates

DIFFERENTIAL DIAGNOSIS

Retts sydrome

Disruption of social interaction is observed during regressive phase between 1-4years of age,after this period most individual with Rett's sydrome improves they social communication skills and autistic features disappears

SELECTIVE MUTISM

Have appropriate communication skills in certain context and setting

No restricted or repetitive pattern of behaviour

ADHD

Inattention and hyperactivity are common in children with ASD''But diagnosis of ADHD is made when attentional difficulties or hyperactivity excceds that seen in individual of comperable mental age

SCHIZOPHRENIA

Childhood onset schizophrenia develops after a period of normal development

Such children has hallucination and delusion which are not features of ASD

comorbidity

- ASD is associated with

-intellectual impaiment

-Structural language disorder(inability to comprehend or constract sentences with proper grammar

-70%of individual have one comorbid mental disorder

-40% may have two or more comorbid mental disorder

This may include-

Developmental coordination disorder

Anxiety disorder

Depression disorder

-Medical condition associated with ASD includes

Epilepsy

Sleep problem

Constipation

avoidant-restritive food intake disorder(is a frequent feature of ASD and extreme and narrow food preferences may persist)

TREATMENT

- Behaviuor therapy to increase skill as well as reducing the severity and frequency of disruptive behaviour
- Education programmes which expand their capacity to learn,communicate and relate to others
- Medication can be used to help alleviate certain symptoms
- Family education and support is essential
- Dietly approaches

ATTENTION-DEFICIT HYPERACTIVITY DISORDER

- DIAGNOSTIC CRITERIA

A) Persistant pattern of inattention and or hyperactivity- impulsivity that interferes with functioning or development

i. INATTENTION

- Six or more symptoms has persisted for 6 months and impairs social, academic or occupational activities
- a) Often fails to give close attention to details or makes careless mistakes in school, at work or during other activities (misses details)
- b) Often has difficulty sustaining attention in tasks or play activities (eg has difficuilties remaining focused during lectures, coversation or lengthy reading
- c) Often does not seem to listern when spoken to directly (eg mind else where even in the absence of any obvious distraction)
- d) Often does not follow through on instructions and fails to finish school work or duties in the work place
- e) Often has difficulty organizing tasks and activities (eg poor time management, fails to meet deadlines or disorganised work)

CONT-

- f) Oftens avoids, deslikes or is reluctant to engage in tasks that requires sustained mental effort (eg school work or home work for adolescence and adult preparing reports or completing forms)
- g) Often **loses things** necessary for task or activities eg school material, pencils, books, wallets, keys, eye glasses, mobile phone, etc
- h) Is often easily **distracted** by extraneous stimuli (for older adolescence and adult includes unrelated thoughts)
- i) Is often **forgetful** in daily activities (eg home work for adolescence/adult returning calls ,paying bills or keeping appointment

ii) HYPER ACTIVITY AND IMPULSIVITY

- DIAGNOSTIC CRITERIA
- Six or more symptoms for > 6months and impair social, academic or occupational acivities
- Age 17 and above 5 symptoms

a) Often fidgets with or taps hands or feet or squims in seat

b) Often leaves seat in situation where remaining seated is expected (eg in classroom or office)

c) Oftens runs about or climbs in situation where it is inapproprite (or restless in adult)

d) Often unable to play or engage in leisure activities quietly

e) Is often on the 'go' acting as if driven by a motor; unable to be still in restaurants or, meeting

f) Often talks excessively

g) Often blurts out an answer before a question has been completed (eg complete people's sentences and cannot wait for turn in conversation

h) often has difficulty waiting his or her turn while waiting in line

i) Oftens interrups or intrudes on others eg conversation, games or activities or takes over what others are doing

CONT-

- B) Several inattention or hyperactivity-impulsive symptoms were present bofore the age of 12 yrs
- C) Several inattention or hyperactivity-impulsivesymptoms are present in two or more settings eg at home or in school, at work, with friends or relatives
- D) the symptoms inteferes with or ruduce the quality of social, academic or occupational functioning
- E) The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and not better explained by another mental illness eg mood, anxiety, personality or a substance use disorder
- SPECIFY
- Combined presentation
- Predominatly inattention; or predominatly hyperactivity-impulsivity
- SPECIFY
- Severity eg mild, Moderate or severe

DIAGNOSTIC FEATURES

- INATTENTION MANIFEST AS
  - Wondering off tasks
  - Lacking persistence
  - Having difficulty sustaining focus
  - Being disorganised
- HYPERACTIVITYMANIFEST AS
- Excessive motor activity eg running about, fidgeting, tapping (in adult manifest as restlessness)
- IMPULSIVITY MANIFEST AS
- Hasty actions that occur in the moment without fore thought and have high pontential for harm to the individual (darting into the street without looking or social intrussiveness eg interrupting others excessively)

PREVALENCE

- Most culture affect 5% of children and 2.5% adult
- Sex –more common in boys; male:female ratio childhood 2:1, adult 1.6.1

DEVELOPMENT AND COURSE

- A stable diagnosis
- ADHD is mostly indentified during elementary school year
- symptom of motoric hyperactivity become less in adolescence and adulthood but restlessness, inattention, poor planning and impulsivity persist
- A big propotion of children with ADHD remain impaired in adulthood

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL
- Low birth weight <1.5kg (2-3times chance of developing ADHD)
- Smoking in pregnacy
- History of child abuse, neglect or neurotoxin exposure
- Infection eg encephalities
- Alcohol exposure in utero

- GENETIC AND PHYSILOGICAL
- Common in 1st degree relatives
- Metabolic abnormalities
- Sleep disorder
- Nutritional deficiences
- Epilepsy

DIFFERENTIAL DIAGNOSIS

- Oppositional defient disorder-resist conforming to others demand
- Intermittent explosive disorder-show serious aggression toward others, no inattention
- Specific learning disorder- may appear inattentive because of frustration, lack of interest or limited ability
- Anxiety disorder- may be inattentive associated with worry
- Bipolar disorder- may have impulsivity but features are episodic

COMORBIDITY

- Most have Oppositional defiant disorder in about 5% of children
- Conduct disorder 25% of children
- Disruptive mood disrequlation disorder most children meet criteria for ADHD
- Specific learning disorder
- Anxiety disorder /mood disorder, substance use disorder, antisocial personality disorder, obsessive-compulsive disorder, tics disorder, and austism spetrum disorder (higher than in the general population

TREATMENT

- TREATMENT APPROACHES
- Muiltmodel produces best results
- A chronic disorder and treatment planning must reflect this reality
- In adolescence 70-80% have symptoms and in aduilthood 50-60% have symptoms
- Educational approaches
- Breaking instructions into small steps
- Provide structured learning environment
- Prescibing more immediate cosequences for action in the classroom
- Use of cues to remind child of homework

TREATMENT CONT-

- PSYCHOLOGICAL AND BEHAVIOUR APPROCHES

i. Parent and teachers should use same behaviour modification
ii. Parent support group are highly efffective
iii. Social skill training may be helpful
iv. Behaviour based family therapy is recommended

- PSYCHOPMACOLOGICAL APPROACHES

i. Psychostimulants such as methylphenidate (ritalin) 70-80% response, dextramphetamine is also effective
ii. Tricyclic antdepressants –imipramine 60 -70% response
iii. Atomoxetine (strattera) norepinephrine re-uptake inhibitor is also effective

SPECIFIC LEARNING DISORDER

- DIAGNOSTIC CRITERIA

Difficulties learning and using academic skill as indicated by the presence of at least one of the following symptom that have persisted for at least 6 months despite the provision of intervention that target those difficulties

1) Inaccurate or slow and effortful word reading(eg difficulty sounding out words)
2) Difficulties in understanding the meaning of what is read
3) difficulties in spelling eg may omit or substitute vowels or consonants
4) Difficulties with written expression(make multiple grammatical errors within sentences
5) Difficulties mastering number sense,number facts or calculation eg has poor understanding of numbers their magnitude and relationship,count on fingers to add single digit numbers insteady of recalling the maths facts as peers do,get lost in the midst of arthrimetic
6) Difficulties with mathematical reasoning eg has severe difficulty applying mathematical cocepts,facts or procedures to solve quantitative problems

CONT-

- B) The academic skills are markedly below the expected for the child age
- C)The learning difficulties begin during school-age years but manifest when academic demands exceeds the individual's limited capacities
- D)The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory aculty,other mental or neurological disorder or inadquate educational instructions
- Nb coding note-specify academic domain impaired

a)With impairment in reading-

Reading rate or fluecy

word reading accuracy

readinng comprehesoin

DYSLEXIA –is an alternative term used to refer to a pattern of learning difficulties characterised by problem with accurate or fluent,word recognition,and poor spelling abilities

CONT-

- b) with impaiment in writtern expression
- Spelling accuracy
- grammer and punctuation accuracy
- clarity and orgnization of writtern expession

c) With impairment inmathematics

-number sense

Memorization of arithmetic facts

accurate or fluent calculation

Accurate mathematics reasoning

DYSCACULIA- a term used to refer to a pattern of difficulties characterised by problem processing numerical information,learning arithmetic facts and performing accurate or fluent calculation

CONT-

- SPECIFY SEVERITY

MILD –The individual may be able to compensate or function well when provided with appropriate supports in school

Moderate – marked difficulties and requires intensive and specilized teaching in school ,work place or at home

SEVERE – severe difficulties in various domain and requires individualized and specialized teaching during school years

PREVALENCE

- Affect 5-15% school age children
- Male ;female ratio 3;1
- Approximately 4% in adults
- accurs across all cultures races and sociaeconomic group

RISK AND PROGNOSTIC FEATURES

- ENVIRONMENTAL

-Low birth weight or prenatal exposure to nicotine

GENETIC AND PHYSOLOGICAL

Runs in families

4-8 times high in 1st degree relatives as compared to the general population

There is high heritability for both reading ability and reading disability

DIFFENTIAL DIAGNOSIS

- Normal variation in academic attainment

Diagnosis made if learning difficulties persist despite adquate educational oppotunities and exposureto the same instructions as the peer group and compentency inthe language of instruction

Intellectual disability (IDD)

Learning disorder occur in the presence of a normal level of intellectual functioning ie IQ score of at least 70

Learning difficulties due to neurological or sesory disorder eg peadiatric stroke traumatic brain injury etc

ADHD

Has inattention and hyperactivity which makes learning difficulty,Both condition may co-occur

CORMODIBITY

- ADHD, communication disorder,other developmental disorder, other mental disorder eg anxiety disorder, depressive or bipolar disorder

TREATMENT

- Treatment of choice in learning disorder is remedial education approahes
- Teacher should devote as much as 2hours a day to such reading,writing or mathematics instructions
- Co-existing emotionaland behavioral problem should be treated by approprite psychotherapeutics
- Parental counseling is essential

MOTOR DISORDER

- DIAGNOSIS CRITERIA

A) The acquisition and execution of coordination of motor skill is substantially below that expectd of individual age and learned skill(eg clumsiness-dropping or bumping into objects or slowness or inaccuracy of perfomance of motor skill eg catching an object using scissors or cutley, hand writing, riding a bike or participating in sports

B) The deficit significantly affect academic, social productivity, leisure and play and vocational activies

C) Onset of symptoms in the early developmental period

D) the motor skill deficit are not better explained by intellectual disability or visual impairment and not due to a neurological disorder eg cerebral palsy or muscular dystrophy or degenerative disorder

PREVALENCE

- Children aged 5-11yrs is 5-6%
- Male-female ratio 2;1 and 7;1
- Across all cultures races and socioeconomic condition

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL FACTORS
- Prenatal exposure to alcohol
- Preterm babies
- low birth weight children

GENETIC AND PHYSIOLOGICAL

Genetic predsposition

Co-occurance in twins especially for severe cases

DIFFENTIAL DIAGNOSIS

- Motor impairment due to another medical condition eg visual impaiment ,cerebral palsy(other neurological deficit on examination)
- Intellectual disability(IDD) motor activities may be impaired and also intellectual deficit
- ADHD

Children with ADHD may fall bump into object or knock things over but motor incoordination in this case is attributable to distractibility and impulsiveness rather than co-ordination disorder(both diagnosis can co-occur)

COMORBIDITY

- Speech and language disorder
- specific learning disorder
- ADHD
- Autism spectrum disorder

STEREOTYPIC MOVEMENT DISORDER

- DIAGNOSTIC CRITERIA

a) Repetitive seemingly driven and apparently purposeless motor behaviour eg hand shaking or waving,body rocking head banging , or self biting

b) the repetitive motor behaviour interferes with social, academic or other activities and may result in self injury

c) Onset is in early developmental period

d) The repetitive motor behaviour is not attributable to the physiological effect of substance or neurological condition and is not better explained by another neurodevelopmetal or mental disorder eg trichotillomania or obssessive compulsive disorder

CONT-

- SPECIFY SEVERITY

MILD-symptoms are easily suppressed by sensory stimuli or distractions

MODERATE-symptoms requires protective measures and behaviour modification

SEVERE- continuous monitoring measures are required to prevent serious injury

NB – injuries ranges from bruising or swelling from hitting hand against the body to amputation of digit or retinal detachment from head banging

PREVALENCE

- Common in children with intellectual disability 10-15 % may have stereotypic movement disorder with with self injury tendencies
- Occur in all cultures, races and sociaeconomic group

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL

Social isolation is a risk factor for self stimulation that may progress to stereotypic movement with repetitive self injury

Environmental stress may also trigger stereotypic behaviour eg fear

GENETIC AND PHYSILOGICAL

Low cognitive functioning is associated with risk of steretypic behaviour

Intellectual disability

Retts sydrome

Lesch Nyan ydrome

DIFFERENTIAL DIAGNOSIS

- A) Normal development

simple stereotypic movement occur in infancy and early child hood

Rocking may occur in the transition from sleep to awake which resolve with age

b) Autism spectrum disorder

stereotypic repetitive occur but also have deficit in social communication and social reciprocity

c)Tic disorder

Stereotypies have ealier onset< 3yrs and are fixed inpattern tics age of onset 5-7 yrs and are variable

Stereotypies may involve arms hands or the entire body while tics commonly involve eyes, face, head and shoulder

Stereotypies are more fixed rhythymic and prolonged in duration than tics which are generally brief,rapid randon and fluctuating

d)obssessive-compulsive

In stereotypies movement disorder no obssession behavour and are apparently purposeless

OCD the individual feels driven to perform repetitive behaviour in response to an obssession or according to rules that must be applied rigidly

e) Other neulogical, medical, drug induced eg akathisia tardive dyskinesiaor chorea

TIC DISORDER

- DIAGNOSTIC CRITERIA

DEF –Tic is a sudden,rapid reccurent non rhythmic motor movement or vocalization

TYPES

A) Tourettes disorder

B) persistent (chronic) or vocal tics disorder

C) Provisional tics disorder

TOURETTES DISORDER

- A) Both multiple motor and one or more vocal tics have been present during the cause of illness although not necessary at the same time
- the tics have persisted for one year
- Onset before age of 18yrs
- The distubance is not due to effect of a substance eg cocaine or medical condition eg Huntingtons disease

PERSISTANT (CHRONIC) MOTOR DISORDER OR VOCAL TIC DISORDER

- A) Single or muiltiple motor or vocal tics have been present during the illness but not both motor and vocal
- B(the tics may wax and wane in frequency but have persisted for >1yr since 1st tic episode
- C) onset is before age 18yrs
- D) the disturbance is not attributable to the physiological effect of a substance eg cocane or medical condition eg Huntington's disease
- E) criteria have not been meet for Tourette's disorder
- NB Specify –with motor tic or vocal tics

PROVISIONAL TIC DISORDER

- A)Single or muiltiple motor and/or vocal tics
- B)the tics have been present for less than 1yr since 1st tic onset
- C) onset before age 18 yrs
- D) the disturbance is not attributable to the physi ological effects of a substance eg cocaine or medical condition eg Huntington disease or post viral encephalities
- NB-criteria have never been met for Tourette'S disorder or chronic tics disorder

DIGNOSTIC FEATURES

Tics disorder comprise four diagnostc categories

- Tourrete's disorder
- persistant motor or vocal tics
- provisional tics disorder
- other specified and nonspecified tic disorders

NB Tic disorder are hierarchial in order as above such that once a tic disorder at one level of hierarchy is diagnosed a lower hierachy dignosis can not be made

Tics can be simple or complex

-simple motor tics- are of short duration(millisecond) may include eye blinking,shoulder shrugging and extension of the of the extremities

-simple vocal tics include- throat clearing,sniffing or grunting often caused by contractions of the diaphragm or muscles of the oropharynx

CONT-

- Complex motor tics

-are of longer duration(seconds) and often includes combination simple tics such as simultaneous head turning and shouder shrugging

They can appear purposeful such as a tic like sexual or obscene gesture(copropraxia)

or a tic like imitation of someone else movement(echopraxia)

Or repeating one own sound or words(palilalia)

Or repeating last word or phrase(echolalia)

Or uttering socially unacceptable words including obscenities or ethnic racial or rreligious slurs(coprolalia)

PREVALENCE

- Tics are common in childhood but transient in most cases

Tourette’s disorder ranges from3-8 per1000 in school age children

Males are more commonly affected than females2;1to4’;1

Affect all races ethnicity and cultures

RISK AND PROGNOSTIC FACTORS

- Temperamental –tics are worsened by anxiety,excitement and exhaustion improve when one is calm or involved in focused activities eg school work
- Environmental-observing a gesture or sound in another person may result in an indvidual with tic disorder making a similar gesture or sound which may be incorrectly perceived by others as purposeful

-This can be a particular problem when the individual is interating with authority figures eg teachers,supervisors or police

Obstetrical complication-eg older parenal age, low birth weight and martenal smoking during pregnacy

DIFFERENTIAL DIAGNOSIS

- MOTOR stereotypies
- OCD
- Impulsive control problem

COMORBIDITY

- ADHD
- OCD
- MENTAL DISORDER eg depresive disorder ,bipolar or substance use disorder

OTHER TIC DISORDER

SPECIFIED TIC DISORDER

- Do not meet criteria for tic disorder but cause clinically significant distress or impairment in social,occupation or other impotant areas of functioning or onset after age 18yrs

UNSPECIFIED TIC DISORDER- cause clinically significant impairment in social ,occupational and other important areas of functioning but does not meet criteria for neurodevelopmental disorder

- No sufficient information to make a more specific diagnosis

TREATMENT

- Neuroleptics medication are effective against motor disorder
- Haloperidol reduces tics by80%
- Risperidone also effective with benign side effect profile
- Behaviour therapy which includes habbit reversal or relaxation techniques may reduce tics frequency

THE END

- THANK

TRAUMA AND STRESS RELATED DISORDERS

- They are associated with exposure to traumatic or stressful event
- This includes

1) Reactive attachment disorder
2) Disinhibited social engagement disorder
3) Post traumatic stress disorder
4)Acute stress disorder and
5) Adjustment disorder

REACTIVE ATTACHMENT DISORDER

- DIAGNOSTIC CRITERIA

A) A consistent pattern of inhibited, and emotionally withdrawn behaviour toward adult caregivers as manifested by both of the following

1) The child rarely or minimally seeks comfort when distressed
2) The child rarely or minimally responds to comfort when distressed

CONT-

B) A persistent social and emotional disturbance charecterised by at least two of the following

1) Minimal social and emotional responsiveness to others
2) Limited positive affect
3) Episodes of unexplained irritability,sadness or fearfulness when interacting with adults caregivers

CONT-

C) The child has experieced a pattern of extreme of insuffficient care as evidenced by at least one of the following

1)Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort,stimulation and affection met by caregiving adults

2) Repeated change of primary caregiver that limit opportunity to form stable attachment (eg frquent changes in foster care)

3) Rearing in unusual settings that severely limit opportunities to form selective attachments(eg institution with high child to caregiver ratios)

CONT-

D) The care in criteria C is presumed to be responsible for the disturbed bahaviour in criteria A(eg the disturbance in criteria A began following the lack of adequate care in criteria C

E) The criteria are not met for autism spectrum disorder

F) The disturbance is evident before age 5 years

G) The child has a developmental age of at least 9 months

Specify if

Persistent if the disorder has been present for more than 12 months

DIAGNOSTIC FEATURES

- Have a pattern of markedly disturbed and developmentally inappropriate attachment behaviuor in which the child rarely turns to an attachment figure for comfort, support, proctection or nurturance
- They is no attachment between the child and care giver adults but can form selective attachment
- This children when distressed show no consistent effort to obtain comfort, support, nurturance or proctection from caregivers
- The diagnosis is not made in children who are unable to form selective attachment and for this reason the child must have a developmental age of at least 9 months

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Because of the shared etiological association with social neglect the condition co-occur with developmental delays especially delay in language and cognition
- Other associated features includes steretypies and other signs of severe neglect (eg malnutrition and signs of poor care)

PREVALENCE

- The prevalence rate is unknown
- The disorder has been found in young children exposed to severe neglect before being placed in foster care or raised in institution
- But even in population of severely neglected children the disorder is uncommon occuring in less than 10% of such children

DEVELOPMENT AND COURSE

- Condition of social neglect are present within the 1st month of life in children diagnosed with this disorder
- The signs of absent to minimal attachment behaviours and emotional detachment manifest in a similar way between the age of 9months to 5years
- The signs without remediation and recovery through normative care giving environment may persist for several years
- The dignosis is rarely made in children old than 5 years

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL

Serious social neglect is a diagnostic requirement of reactive attachment disorder and is the only known risk factor for the disorder

Prognosis depend on the quality of the caregiving environment following serious neglect

DIFFERENTIAL DIGNOSIS

- Autism spectrum disorder

Have restricted interest and ritualized behaviour(no history of neglect)

Intellectual disability

No demostratable reduction in positive affect and emotion(developmental delay is common in both conditions)

Depressive disorder

In young children is associated with reduction in positive affect and emotions(may respond to comforting effort by caregiver

COMORBIDITY

- Condition associated with neglect such as cognitive delay, language delay,stereotypies etc
- Medical condition includes severe malnutrition
- Mental condition includes depressive symptoms

DISINHIBITED SOCIAL ENGAGEMENT DISORDER

- DIAGNOSTIC CRITERIA

A) A pattern of behaviour in which a child actively approaches and interacts with unfamiliar adults and exhibit at least two of the following

1) Reduction or absent fear in approaching and interacting with unfamiliar adults
2) overly familiar verbal or physical behaviour(not consistent with cultural or age appropriate social boundaries
3) Dimi nished or absent checking back with adult caregiver after venturing away even in unfamiliar settings
4) Willingness to go off with an unfamiliar adult with minimal or no hesitation

CONT-

- B) The behaviour in criteria A are not limited to impulsity (as in ADHD) but include socially disinhibited behaviour

C) The child has experieced a pattern of extremes of insuffient care as evidenced by at least one of the following

1) Social neglects or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation and affection met by caregiving adults
2) Repeated changes of primary caregivers that limit opportunities to form stable attachments (eg frequent changes in foster care)
3) rearing in unusual settings that severely limit opporunities to form selective attachment(eg institution with high child to caregiver ratio

D) The care in criteria C is presumed to be responsible for the disturbed behaviour in criteria A

E) The child has a developmental age of at least 9 months

DIAGNOSTIC FEATURES

- The essential features of this disorder is a pattern of behaviour that involves culturally inappropriate overly familiar behaviour with relative strangers
- This overly familiar behaviour violates the social boundaries of the culture
- The diagnosis is made when a child developmental age of at least 9 months

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Because of shared etiological association with social neglect disinhibited social engagement disorder may co-occur with developmental delays especially language delays, steretypies and other signs of severe neglect such as malnutrition or poor care
- Sign of disorder often persists even after other signs of neglect are no longer present

PREVALENCE

- Prevalence unknown
- The disorder is rare occuring in minority of children even in those who are severely neglected (it affect only about 20%)

DEVELOPMENT AND COURSE

- Condition of neglect are present in the 1st month of life
- No evidence that neglect beginning after age 2 years is associated with the disorder
- The disorder has been described from the 2nd year of life through adolescence
- It is rare in adult

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL

Serious social neglect is a diagnostic requirment for this disorder and is the only known risk factor for the disorder

However the majority of severely neglected children do not develop the disorder

Prognosis depends on quality of the caregiving environment following serious neglect

In many cases the disorder may persist even in children who caregiving environment become markedly improved

DIFFERENTIAL DIAGNOSIS

- ADHD

Both have social impulsivity

But children with social disinhibition social engagement disorder have no difficulties with attention or hyperactivity disorder

COMORBIDITY

- Condition associated with neglect including cognitive delays ,language delay and steretypies may co-occur with disinhibition social engagement disorder
- Children may be diagnosed with ADHD and disinhibitionsocial engagement disorder

POST TRAUMATIC STRESS DISORDER

- DIAGNOSTIC CRITERIA

The criteria applies to adult ,adolescents and children> 6yrs

A Exposure to actual or threatened death,seroius injury or sexual violence in one or more of the following ways

1)Directly experiecing the traumatic event/s

2) witnessing, in person the event(s) as it occurred to others

3) Learning that the traumatic event(s) occured to a close family member or a friend, the event must have been violent or accidental

4)Experiencing repeated or extreme exposure to aversive details of the traumatic events(eg 1st responders collecting human remains,)

NB Criteria A 4 does not apply to exposure through electronic media, television, movies or pictures unless this exposure is work related

CONT-

B Presence of one or more of the following intrusion symptoms associated with traumatic event , begginning after the traumatic event

1)reccurrent, involuntary,and intrusive distressing memories ofthe traumatic event(in children repetitive play may occur in which themes or aspects of the traumatic event are expressed)

2) Reccurrent distressing dreams in which the content and affect of the dream are related to the traumatic events(in children there may be frightening dreams without recognizable content)

3) Dissociative reactions such as flashbacks in which the individual feels or act as if the traumatic event were recurring(in children trauma specific reenactment may occur in play)

4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

CONT-

C) P ersistent avoidance of stimuli associated with the traumatic event beginning after the traumatic event as evidenced by one or both of the following

1) Avoidance of or effort to avoid distressing memories thoughts or feelings about or closely associated with the traumatic event

1) Avoidance of or effort to avoid external reminders eg people,places, coversations, activities, object or situations that arose the distressing memories thought or feelings about or closely asociated with the traumatic events

CONT-

D) Negative alteration in cognition and mood associated with the traumatic event as evideced by 2 or more of the following

1) Inability to remember or an important a spect of the traumatic event due to dissociative amnesia and not due t other factors eg head injury ,alcohol or drugs
2) Persistent and exaggerated negative beliefs about oneself others or the world(eg i am bad,no one can trusted,the world is completely dangerous,my whole nervous system is premanently ruined)
3) Persistent,distorted cognition about the cause or cosequences of the traumatic event that lead the individual to blame himself/ herself or others
4) persistent negative emotional state(eg fear, horror ,anger, guilt or shame
5) markedly diminished interest or particiption in significant activities
6) feeling of detachment estrangement from others
7) Persistent inability to experience positive emotions(eg inability to experience happiness,satisfaction or loving feelings

CONT-

E) Marked alteration in arousal and reactivity associated with the traumatic event ,beginning or worsening after the traumatic event occured as evidenced by two or more of the following

1) Irritable behaviour and angry outburst(with little or no provocation) typically expressed as verbal or physical agression torward people or objects
2) Reckless or self destructive behaviour
3) Hypervigilance
4) exaggerated startle response
5) Problem with concentration
6) sleep disturbance(eg difficulty falling or staying asleep or restless sleep

CONT-

F) Durationof the disturbance in criteria B,C,Dand E is more than one month

G) The disturbance causes clinically significant distress or impairment in social, occupational or other important areasof functioning

H) The disturbance is not attributableto the physiological effects of a substance or a medical condition

CONT-

- Specify wheather

With dissociative symtoms where individual has the symptom of either of the following

1)depersonalization- persistent or reccurent experience of feeling detached from, and/or as one were an outside observer of, one's mental processes or body(eg feeling as though one were in dream,feelinga sense of unreality of self or body or time moving slowly

2)derealization-persistent or reccurent experience of unreality of the surrounding(eg the world around the individual is experienced as unreal dreamlike distant or distorted)

SPECFY IF

Wit delayed expression- if the full diagnostic criteria are not met until at least 6 months after the event(although the onset and expression of some symptoms may be immediate)

DIAGNOSTIC FEATURES

The essential features of PTSD is the development of chacteristic symptoms following exposure to one or more traumatic events

This traumatic events includes

-exposure to war

Physical assault(mugging or robbery with violence)

-sexual assault/forced sex eg rape

-being kidnapped

Terrorist attack

Ethnic clashes

Road traffic accidents

Witnessed events includes-

Domestic violence

War or disasters

CONT-

- The traumatic event can be re-experieced in varius ways eg reccurent involuntary and intrusive recollection of the events or distressing dreams that replay the events
- The individual makes deliberate efforts to avoid stimuli thoughts memories, feeling or talking about the traumatic event
- They also avoid activies,objects situation or people who arouse recollection of the event
- Negative alteration in cognition or mood worsen with time and it takes varius forms
- 1) amnesia-inability to remember an important aspect of the traumatic event
- 2) exaggerated negative expectation regarding important aspect on ones life ,others or future eg i cant trust anyone ever again OR
- Negative emotions eg its all my fault that i was assaulted ,robbed or kidnapped or raped

CONT-

- Loss of interest in previously enjoyed activities
- May be quick tempered with aggressiveness with little or no provocation eg yelling at people,getting into fights or destroying objects
- May develop reckless behaviour such as dangerous driving excessive alcohol or drug use or self injurious or suicidal behaviour
- They tend to display heightened startle response to a round noise or unexpected movements
- May have difficulty in concentration or attending to focused tasks eg lenthy coversation
- Sleep disturbance is common associated with nightmares which inteferes with adquate sleep

ASSOCIATED FACTORS SUPPORTING DIAGNOSIS

- In young children may experience developmental regress eg loss of language,enuresis
- Pseudo –hallucination such as having the sensory experiece of hearing ones thought spoken in one or more different voices and also paranoid ideation
- Individual may also experience difficuilties regulating emotion or maintaining stable interpersonal relationship

PREVALENCE

- Twelve months prevalence rate among adult 3.5%
- Prevalece rate is higher in individual whose occupation exposes them to traumatic events eg police, firefighters military or emergency medical personal
- Highest rate is found among survivors of rape military combat, ethnically or politically clashes and genocide

DEVELOPMENT AND COURSE

- Can occur at any age beginning after 1st year of life
- Symptoms usually begins within the 1st 3 month after the trauma(although there could be delay for months or years before the criteria for the diagnosis are met)
- In DSMIV called late onset as delayed onset but is now called delayed expression due to the fact that typically some symptoms appears immediately but the delay is in meeting the full criteria
- Symptom of PTSD varies with time and also duration of symptoms eg
- a ½ recover within 3 months
- Some individual has symptoms for more than 12 months and sometimes for more than 50yrs
- Symptoms reccurence may occur in response to reminders of the original trauma, ongoing life stressor or newly experieced traumatic events

RISK AND PROGNOSTIC FACTORS

- risk and prognostic factors are divided into

1) Pre traumatic
2) -temperamental –this includes childhood emotional problems by age 6yrs, prior tramatic exposures,anxiety problems or prior mental disorder eg panic attacks or depressive disorder
3) Environmental –these includes lower socioeconomic status, lower education ,exposure to prior trauma(especially during childhood) childhood adversity (eg family dysfunction, parental separation or death)
4) Cultural characteristics-eg self blaming or lack of social support systems
5) Genetic and physiological-this includes female gender and younger age at the time of trauma exposure(for adults)

CONT-

- PERITRAMATIC FACTORS

Environmental- this includes severity(dose) of the trauma ,the greater the magnitude of the trauma ,the greater the likelihood of PTSD ie perceived life threat, personal injury etc

POST TRAUMATIC FACTORS

These includes –ve appraisal , inappropriate coping strategies and development of acute stress disorder

Environmental-these includes sebsequent exposure to upsetting reminders,sebsequent adverse life events and financial or other trauma related losses,social support (including family stability in children is a proctective factor for PTSD)

CONT-

- GENDER-RELATED DIAGNOSTIC ISSUES

PTSD is more prevalent in females they also experience symptoms for a long duration than do males

They have greater likelihood of expose to traumatic events eg domestic violence, rape etc

SUICIDE RISK

Traumatic events such as childhood abuse increases risk of suicide

PTSD is associated with suicidal ideation and suicide attempt

FUNCTIONAL CONSEQUENCES OF PTSD

It is associated with high level of social, occupational and educational impairments

It is also associated with impaired physical health, considerable economic cost, high level of medical utilization,poor social and family relationship

DIFFERENTIAL DIAGNOSIS

- Other posttraumatic disorder and conditions(eg panic disorder dissociative amnesia,adjustment disorder)
- Acute stress disorder-duration of symptoms restricted to between 3 days to 1month following exposure to traumatic events
- Anxiety disorders and obsessine complusive disorders-the intrusive thoughts are not related to traumatic event,compulsinon are present and other symptoms of PTSD are absent
- Major depressive disorder-(symptom of depression are present)
- Personality disorder- have interpersonal difficulties but symptom appears independent of traumatic event
- Dissociative disorders- dissociative amnesia,dissociative identity disorder and depersonalization and dealization disorder do not necessarily occur after a traumatic event
- Psychotic disorder flashbacks in PTSD must be distinguished from illusion or hallucination and other perceptual disturbances that may occur in schizophrenia or in mood disorder with psychotic features

COMORBIDITY

- Individual withPTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental (eg depression,bipolar. Anxiety or substance use disorder)

TREATMENT

Major aproaches are support, encouragement to discuss the event and education regarding a variety of co ping mechanism(eg relaxation)

Use of sedative and hypnotics is helpful

TCA- are effective and adqaute trial should be 6-8 weeks

Treatment should continue for 1yr before the drugs are withdrawn

Other effective drugs includes SSRI,MAOI and anticonvulsant,carbamazepine

PSYCHOTHERAPY

- PSYCHODYNAMIC PSYCHOTHERAPY

Reconstruction of the tramatic events with associated abreaction(verbalizing suppressed feeling) and cathexis(investing psychic energy into a particular event) may be therapeutic

other therapies includes behaviour therapies- eg systemic desensitization and relaxation method

cognitive therapy- to help in coping with stress

Group therapy-share multiple trauma experience and support from other group members

Family therapy- help sustain marriage through period of exacerbation of symptoms

ACUTE STRESS DISORDER

- DIAGNOSTIC CRETERIA

A Exposure to actual or threatened death, serious injury,or sexual violation in one or more of the following ways

1) Directly experiecing the traumatic event
2) witnessing in person the event as it occured to others
3) Learning that the event occured to a close family member or a close friend (in this case the event must have been violent or accidental)
4) Experiencing repeated or extreme exposure to aversive details of the traumatic event (eg 1st responders collecting human remains)

NB this does not apply to exposure through media televion movies or pictures,unless this exposure is work related

CONT-

B Presence of nine or more of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance and arousal beginning or worsening after the traumatic event

INTRUSION SYMPTOMS

1) reccurent, involutary and intrusive distressing memories of the traumatic event NB- in children repetitive play may occur in which themes or aspects of the traumatic events are expressed
2) Reccurent distressing dreams in which the content and/or affect ofthe dream are related to the event NB in children,there may be frightening dreams without recognizable content
3) Dissociative reactions(eg flashbacks) in which the individual feels or acts as if the traumatic event were recurring NB in children,trauma specific reenactment may occur in play
4) Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event

CONT-

- NEGATIVE MOOD

5)Persistent inability to experiece positive emotions(eg inability to experience happiness, sastifaction or loving feelings

DISSOCIATIVE SYMPTOMS

6) An altered sense of the reality of one's surrounding or oneself(eg seeing oneself from anothers perspective being in a daze, time slowing)

7) Inability to remember an important aspect of the traumatic event due to dissociative amnesia and not due to othe factors such as head injury, alcohol or drugs

CONT-

- AVOIDANCE SYMPTOMS

8) Effort to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event

9) Effort to avoid external reminders(people, places, conversations activities or situation) that arouse distressing memories,thoughts or feelings about or closely associated with the traumatic event

AROUSAL SYMPTOMS

Sleep disturbance(eg difficulty falling or staying asleep)

11) Irritable behaviour and angry outburst(with little or no provocation)typically expressed as verbal or physical agression toward other people or objects

12) Hypervigilance

13) Problems with concentration

14) Exaggerated startle response

CONT-

C Duration of the disturbance(symptom in criteria B) is 3 days to 1 month after trauma exposure

D The disturbance causes clinically significant distress or impairment in social, occupationa or other important areas of fuctioning

E The distubance is not attributable to the physiological effects of a substance (eg medication or alcohol or another medical condition (eg mild traumatic brain injury and is not better explained by brief psychotic disorder)

DIAGNOSTIC FEATURES

- The essential feature of ASD is the development of characteristic symptoms lasting 3 days to 1 month following exposure to traumatic event
- The traumatic event that are experieced directly includes sexual violence, physical attacks, robbery with violence, mugging,active combart, terrorist attacks kidnapped, torture, RTA etc
- NB A life threatening illness or debilitating medical condition is not cosidered as atraumatic event but catastropic medical incident eg waking during surgery, anaphylatic shock may qualify as traumatic event

CONT-

- Witnessed events includes observing thretened or serious injury, unnatural death,severe domestic violence, war or disaster
- Medical catastrophe include life threatening hermorrhage involving ones child or spouse
- Events experinced indirectly through hearing are limited to close relative or close friends which must be violent or accidental eg violent personal assault,suicide serious accident or serious injury

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

- Individual engage in catastrphic extremely negative thoughts about their role in the traumatic events,their response to the traumatic event and/or the likelihood of future harm eg individual may feels excessively guilty about not having prevented the traumatic event or about not adapting to the experiece more successfully
- May develop panic attacks triggered by truama reminders
- May display choatic or impulsive behaviour eg driving recklessly ,gambling excessively or abuse substance
- for young children re-enactiment of event appear in play and include dissociative movement(eg a child who survives a motor vehi cle accident may repeatedly crash toy cars during play in a focused and distressing manner

PREVALENCE

- The prevalence of ASD varies accordingto the nature of trauma and the context in which it is assesed
- ASD tend to be identified in less than 20% of cases following traumatic events that does not involve interpersonal assult
- 13- 21% of RTA
- 19% of assault
- 14% of mld traumatic brain injury
- 10% of severe burns
- 6-12% of industrial accidents
- High rates (ie 20-50% are reported following interpersonal traumatic event including assault ,rape terrorist attacks or witnessing mass shooting

DEVELOPMENT AND COURSE

- ASD can’t be dignosed until 3 days after the event
- It may progress to PTSD after 1 month or remit withiin one month after exposure
- ½ of individual who develops PTSD intially present with ASD

RISK AND PROGNOSTIC FEATURES

- TEMPERAMENTAL

Risk factor includes prior mental disorder, high levels of negative affectivity(neurotism),greater perceived severity of the traumatic event and avoidance coping style

Exaggerated appraisal of future harms, feeling guilty or hopelessness are strongly preditive of ASD

ENVIRONMENTAL

History of prior trauma

GENETIC AND PHYSIOLOGICAL

Females are at higher risk of developing ASD

GENDER-RELATED DIAGNOSTIC ISSUES

- ASD is more prevalent among females
- Sex linked neurobiological difference in stress response may contrbute to females increased risk ofASD
- Females have greater likelihood of exposure to traumatic event eg rape interpersonal violence(domestic etc)

FUNCTIONAL COSEQUENCES OF ASD

- Impaired functioning in social ,interpersonal or occupational domains has been shown across survivor of accident,assault and who develops ASD
- Avoidance in ASD-may lead to generilized withdrawal from many important activities eg avoidance of driving absentism from work

DIFFERENTIAL DIAGNOSIS

- Adjustment disorder-diagnosis is made when acute stress symptom do meet diagnostic criteria for ASD
- Panic disorder- spontaneous panic attacks are common in ASD. But panic disorder is diagnosed only when/ if panic attacks are unexpected and there is anxiety about future attacks
- PTSD-symptoms in ASD must occur within 1 month and resolve within that one month period .if symtoms persist beyond one month a diagnosis of PTSD is made
- Absessive compulsive disorder- intrusive thoughts are not related to a traumatic event
- psychotic disorder- flashbacks experieced in ASD must be distinguished from perceptual distubance that may occur in psychotic disordersuch illusion or hallucination

TREATMENT

- Major approaches are support, encouragement to discuss the event and education regarding a variety of coping mechanism(eg relaxation methods)
- Use of sedative and hypnotics are helpful
- TCA,SSRI and MAOIs are helpful

CONT-

- PSYCHOTHERAPY

Psychodynamic psychotherapy

Recontruction of the traumatic events with the associated abreaction and cathersis may be therapeutic

Behaviour therapies eg systemic desensitization and relaxation mathod

Cognitive therapy-to help in coping with stress

Group therapy- share multiple trauma experience and support from other group members

ADJUSTMENT DISORDER

- DIAGNOSTIC CRITERIA

A) The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occuring within 3 months of the onset of the stressor/s

B) These symptoms or behaviour are clinically significant as evidenced by one or both of the following

1) Marked distress that is out of proportion to the severity or intensity of the stress or taking into account the external context and the cultural factors that might influence symptoms severety and presentation

2) Significant impairment in social,occupational or other important areas of functioning

CONT-

C) The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder

D) The symptom do not represent normal bereavement

E) Once the stressor or its consequences have terminated the symptom do not persist for more than an additional 6 months

CONT-

- Specify wheather

with depressed mood; low mood ,tearfulness or feeling of hopelessness are predominent

With anxiety; Nervousness, worry ,jitteriness, or separation anxiety is predominant

With mixed anxiety and depressed mood;A combination of depressed and anxiety is predominent

With disturbance of conduct; disturbance of conduct is predominant

With mixed disturbance of conduct and emotions; both emotinal symptoms (eg depression,anxiety) and a disturbance of conduct is predominant

Unspecified'; for maladaptive reactions that are not classifiable as one of the subtypes of adjustment disorder

DIAGNOSTIC FEATURES

The essential features of adjustment disorder is the presence of emotional or behavioural symptoms in response to an identifiable stressor may be single(eg termination of a romantic relationship)or there may be multiple (eg marked business difficulties and marital problems)

The stressor may be reccurent(eg seasonal business crises or continuous(eg a persistent painful illness)

Stressor may affect a single individual or entire family or a large group or community (eg natural disaster)

CONT-

- Stressor may accompany specific developmental events (eg going to school, leaving parental home, getting married, becoming a parent, falling to atain occupatinal goals ,retirement etc
- Adjustment disorder may be diagnosed following the death of a loved one when grief reaction exceeds what mourning might be expected when cultural,religious or appropriate norm are taken into account
- Adjustment disorder are associated with increased risk of suicide attempt and completed suicide

PREVALENCE

- AD Prevalence vary widely depending on population studied and assessement method used
- In outpatient mental health treatment the prevalence is approximately 5-20%
- In hospital psychiatric consultation it is often the most common diagnosis frequency nearly 50%

DEVELOPMENT AND COURSE

- By difinition the disturbance in adjustment disorder begins within 3 months of onset of a stressor and last longer than 6 months after the stressor
- If the stressor is acute (eg being fired from job) the onset of the disturbance is usually imediate ie within a few days and the duration is brief not more than a few months
- If the stressor and its cosequences persist the adjustment disorder may also continue to be present and become the persist form

RISK AND PROGNOSTIC FACTORS

- ENVIRONMENTAL

individual from disadvataged life circumstances experience a high rate of stressor and may be at increased risk for AD

FUNCTIONAL CONSEQUENCES OF AD

- The subjective distress or impairment in functioning associated with AD may manifest as decreased performance at work or school and temparory change in relationship
- AD may change the course of an illness in a patient who have a general medical condition(eg decrease compliance with the recommended medical regimen, increased lenth of hospital stay

DIFFERENTIAL DIAGNOSIS

- Major depressive disorder

Individaul may develop MDD following trauma

PTSD and ASD

In AD the stressor can be of any severity rather than of the of severity and type required by criteria A of PTSD and ASD

Timing and symptoms profile distinguishes these condition

AD symptoms may appear immediately after trauma and persist for 6 months

ASD->Imonth

PTSD- after 1 month

Personality disorder-have a long standing distressing behaviour

Normative stress reaction- when bad thing happen most people get upset(this is not AD).

The diagnosis should only be made when the magnitude of the distress exceed what would normally be expected(which varry in different cultures

COMORBIDITY

- AD can accompany most mental disorders and any medical condition eg an individual may develop adjustment disorder with depressed mood after lossing a job or
- an individual may have a depressive or bipolar disorder and an adjustment disorder as long as the criteria for both diagnosis are met

OTHER SPECIFIED TRAUMA AND STRESSOR RELATED DISORDER

The category applies to presentation in which symptoms characteristics of a trauma and stressor related disorder are present and it cause significant distress and impairment in social, occupational or other important areas of fuctioning but do not meet the criteria for any of the disorders in the trauma and stress related disorders eg

Adjustment like disorder with dalayed onset of symptoms that occur> 3months after the stresor

Adjustment like disorder with prolonged duration of >6 months without prolonged duration of stressor

Persistent complex bereavement disorder-this disorder is characterised by severe and persitent grief and mourning reaction

UNSPECIFIED TRAUMA AND STRESSOR RELATED DISORDER

- The diagnosis is made when there are symptoms characteristic of trauma and stressor
- or related disorder which cause clinically significant distress or impairment in important areas of fuctioning but there is insufficient information to make a more specific diagnosis(eg in emergency room settings)

THE END

- THANKS

ALTERNATIVE(COMPLEMENTARY) MODE OF TREATMENT

- Complementary or altenative medicines is widely used especially for treating chronic illinesses
- Traditional medicine includes diverse health practices, beliefs and cultural knowledges
- This may incorporate the use of plant, animals and mineral based medicines
- Others includes:
  - Spiritual therapies
  - Manual techniques in various combination

ALTERNATIVE MEDICINE CONT-

- The role of traditional practitioners has been recognised but their inco-operation into modern mental health care has not been put in practice
- Traditional practictioners manage upto 80% of health care needs in rural setting of developing countries
- 40% of clients of traditional practictioners have mental health problems

ALTENATIVE MEDICINE CONT-

GLOBAL OVERVIEW OF PRACTICE OF TRADITIONAL MEDICINE

- Population throughout Africa, Asia and Latin America use traditional medicine to help meet their primary health care needs
- It is commonly used because it is accessible and affordable and it is often part of the wider cultural belief system
- Others are concerned about adverse effect of modern medicine
- A desire for a more personalised health care
- The rise in advetisement has increased the use of traditional medicine
- In Africa the indigenous beliefs in supernatural causes of illness especially mental illness promote the use of traditional medicine

CHALLENGES IN DEVELOPING CAM POTENTIAL

- The challenges relates to:
  - Policy
  - Safety
  - Efficiacy
  - Rational use
- No policy that provides a sound basis for defining the role of CAM in national health care delivery
- No policy to ensure that the necessary regulatory and legal mechanisms are created for promoting and maintaining good practices that assures safety and efficiency of therapies
- Other challenges is that CAM has developed within different cultures in different regions
- There has been no parallel development of standards and methods either national or international for evaluating them

CONT-

- Evalution of CAM products is also problematics e.g. herbal remedies, because their effectiveness and quality can be influenced by numerous factors such as:
  - When they were picked
  - What parts are used eg leaves ,flowers, stems barks or roots
  - Their dosage regiments and directions of treatment/use

CAM CONT-

- TYPES OF CAM
- The terms Complementary and alternative medicine and sometimes non-conventional or parallel are used to refer to this mode of treatment (traditional medicine) especially where it is incorporated into the health care systems
- According to the WHO there are 3 systems to describe the degree to which traditional medicine or complementary or alternative medicines is officially recognised as element of health care.

These include:

(1) Integrative system

(2) Inclusive system

(3) Tolerant system

CONT-

- **INTERGRATIVE SYSTEM**
- This system is officially recognised and incorporated into all areas of health care provision
- This means that CAM is included in the relevant country's national drug policy, products and providers are registered and regulated
- CAM therapies are then available in hospitals and clinics, relevant research is undertaken and education in CAM is available

CAM CONT-

- **INCLUSIVE SYSTEM**
- This recognises CAM but has not yet fully integrated it into all aspects of health care either in health care delivery, education and training or regulation
- CAM might not be available at all health levels

- **TOLERANT SYSTEM**
- In this system the national health care system is based entirely on conventional medicines but some CAM practices are tolerated by law

THE END

THANKS

DEFENCE MECHANISM

- The dynamics of personality involve a continuos conflict between the ID and the counter forces of the EGO and SUPEREGO
- When dangerous ID impulses threaten to get out of control or when danger from the environment theatens the result is anxiety
- To deal with the threat the EGO may develop defence mechanism which are used to ward off anxiety and permit some gratifications in disguised form

CONT-

Defence mechanism deny or distort reality

- Used to defend oneself when hurt
- Methods of protecting oneself against further pains
- Helps one get through difficulties and handle painful situations
- Defence mechanism is necessary for survival
- BUT when defence mechanism is used to often to

hide your true feelings it stops being helpful

NB-Feeling must run their natural course no matter how painful it is

MAJOR DEFENCE MECHANISM

- RATIONALIZATION –This is making excuse for a mistake or failure

An attempt to preserve self esteem and to avoid feeling of guilty

-Ratianal explanation are offered by a person in an attempt to justify a behaviour that may be unacceptable

People are rationalizing when they make up a reason for something when the real reason is too painful to face eg somebody has not done a homework and is afraid to go to school but say he does't want to go because he is sick

CONT-

- COMPENSATION

Covering up faults by trying to excel in other areas

It is helpful because it helps one to achieve their full pontential or attain their best abilities eg a academically poor student may excel in sports

CONT-

- PROJECTION

Seeing your own faults in other people even when they don't have them

People accuse others because of having their own characteristics

Used when people do not like what they see in themselves

CONT-

- IDENTIFICATION

Feeling connected and similar to someone

Identify withh some one you admire it allow you to image you have the style or talent of that person

It is a health feeling if one try to develop qulities you respect in them but it can be a problem if you neglects your own personality growth

CONT-

- REACTION FORMATION

Reaction formation is the expression of an emotion that is opposite of what you truely feel inside

Example when somebody steal something feels, guilty about it, but does't want to face this reality, so one brags to friend about the stolen object pretending to be happy about it

CONT-

- REGRESSION

Regression means to act in an immature way

People are regressing when they throw tantrum instead of expressing dissappoitments in a mature way

Other express anger by biting or destroying items

CONT-

- DENIAL
- Denial is the refusal to accept reality
- People are in denial when they behave as if something which is true is not true and vice versa
- It helps people to tame a painful fact that you cannot accept immediately
- Denial is the first stage in the grief process
- A person denials that he has been sacked or some body has passed on
- If denial takes too long it can prevent one from accepting the reality or seeking help for a problem or moving on with life

CONT-

- DISPLACEMENT
- Repressing an undesirable impulse and directing it to a safer substitute object
- People take out their emotions of anger to an innocent person
- It usually accurs when they feel unable to face the person who brought the emotions in them
- EG- If you are angry with your parent but end up shouting or beating your younger brother

CONT-

- SUBLIMATION

Releasing a repressed impulse in a socially acceptable behaviour

Replacement of an undesirable outlet of energy by a desirable one

People sublimate when they use their strong or angry feeling to do something insteady of hurting others

CONT-

- NEGATIVISM
- Always refusing to do what others suggests or ask or doing opposite of what others expects
- A defence mechanism used as a way of avoiding failure

Awalys saying no because you dont want to try something and fail

It is not helpful because it keep you away from trying and thus you don’t experiece failure but you miss the opportunity to do well and increase your self confidence

CONT-

- DAYDREAMINGS
- Day dreaming is creation of a situation or issues that seem pleasant or exciting than the real world
- Living out in you mind of things you wish would happen
- This are obstacles when they serve as substitute for reality

THE END

PHYSICAL TREATMENT IN PSYCHIATRY

Electro convulsive therapy (ECT)

An effective treatment for patient with major depressive illness and other serious mental illness

Physical rx con-

- History-1934 Von Medura a psychitrist used seizures treatment based on two observations

  (a)Schizophrenic symptoms decreased after a seizure

  (b) Schizophrenia and epilepsy it was incorrently believed cannot coexist inthe same patient- induction of seizure would cure schizoprenia

- In April 1938 the 1st Ect, refered to as electroshock was done in Rome by Lucio Bini

MECHANISM OF ACTION

- Mechanism of action unknown but there are several theories

  (a) Neurophysiological theory-during the seizure there is increase in blood flow, use of glucose and oxygen in the brain and also permeability of blood brain barrier. After the seizure there is decrease in glucose, oxygen and permeability and this decrease is associated with a therapeutic effect.

  (b) Neurochemical theory-after several session of ECT there is down regulation of neurotrasmitter recepters (post synaptic beta adrenergic receptor

  (c) It affects the coupling of G protein to receptor, affects activity of adenylyl cycliase and phospholipase C' and the regulation of calcium entry into neurons

INDICATIONS

- 3 MAJOR CONDITIONS
  - (A) Major depressive disorder
  - (B) Manc episode
  - (C) Schizophrenia

INDICATION CONT-

- Major depression
  - -failed medication trial
  - -have not tolerated medications
  - -have severe psychotic symptoms
  - -acutely suicidal or homicidal
- Manic episode- quite effective especially bilateral placement of electrodes
- Schizoprenia- effective in treatment of acute schizophrenia and not for symptoms of chronic schizoprenia

OTHER INDICATIONS

- Delirium
- Catatonia
- Obsessive –compulsive disorder
- Pregnancy those who can not take drugs
- Geriatric and medically ill pt who cannot take antidepressants drug safely
- Neuroleptic malignant syndrome (a severe medical condition associated with neuroleptics side effect)

PREPARATION FOR ECT

- Informed consent (beneficial and possible side effect)
- Baseline routine investigations Hb, U/E,
- Starvations for 6hrs
- Administer muscurinic antcholinergic 1/2hr before procedure (atropine) to minimize oral and respiratory secretions and to block bradycardias and asystole

GENERAL ANAETHESIA

- Methohexital
- Thiopentone sodium 2-3mg per kg
- Etomidate
- Ketamine but is associated with psychotic features
- Muscles relaxant -to minimize risk of STI or bone fractures (succinylcholine 0.5-1mg per kg)

TYPES OF ECT

- 2 TYPES-Bilateral and unilateral, depending on electrodes placements
- Bilateral –electrodes placed on the bitemporal region (one inch above a line drawn from the lateral canthus of the eye to trigus of the ear)

  -It is associated with a higher therapeutic effect but more cognitive impairment
- Unilateral-less therapeutic effect and less cognitive impairment (electrode placed on the non dorminant hemisphere)

NUMBER AND SPACING

- Major depression 6-12 sessions
- Mania 8-20 session
- Schizoprenia >15 sessions
- Delirium and catatonia 1-4 sessions
- Pt should receive maximam therapeutic response; when a patient fails to improve further after 2 consecutive sessions
- Multiple ECT are given in a single session in severely sick pt or in those unable to withstand GA
- ECT maintanance treatment can be given weekly/biweekly or monthly to prevent relapse
- Spacing 2-3 sessions per wk, 2wkly is associated with less memory impairment
- Locally, 6 are done

CONTRAINDICATIONS

- ECT has no absolute contraindications
- Close monitoring required in those at risk

(a) Pt with space ocupying lesion in the brain (are at risk of developing brain oedema and brain herniation after Ect) .If lesion is small pretreatment with dexamethasone is given

(b) Hypertensive pts (control Bp before ECT) or give propanolol

(c) Cerebralvascular disease are at risk of bleeding eg (aneurysm, epidural, subdural or intracerebral hge)

(d)Myocardial infarctions pt are at high risk (risk <2wks after MI risk diminished further 3 mons after MI)

(e) Monitor fetal heart in high risk pregnancy

SIDE EFFECTS

- CNS-confusion and delirium after ECT and during recovery from GA (treated by use of barbiturates or benzodiazepines)
- Delirium commonly occur in pt with co-existing neurological disorder or those who receive bilateral ECT, but it clears within days or weeks
- Memory-commonest cognitive side effect recovery is obvious by 6months,worse in pt who exprience little improvement with ECT
- No evidence of brain damage due to ECT

SIDE EFFECT CONT-

- SYSTEMIC EFFECT-Transient cardiac arrhythmias occur during ECT especially in pt with cardiac disease(can be prevented by increasing the dose of antcholinergic premedication
- Toxic or allergic reaction to the pharmacological agent used in ECT (rarely reported)
- Fractures of bones, soreness of muscles, biting of tongue, teeth breakages can be reduced by administration of muscles relaxant

MISSED SEIZURES (FAILURE OF ECT)

- If no seizure 4 attempts should be made
- Check contact between the skin and electrode
- Increase intensity of stimuli by 25-100%
- Hyperventilation lower the seizure threshhold
- Change anaethetic drug to minimize increase in seizure threshold
- In case of a prolonged seizure >180 sec or status epilepticus increase the dose of barbiturates anaethesia or give intrvenous diazepam

  -Intubation is necessary

OTHER BIOLOGICAL THERAPIES

- Light therapy is indicated in treatment of major depressive disorder with seasonal pattern
- In light theraphy or phototheraphy pt is exposed to a bright artificial light on daily basis during the treatment
- Sleep deprivation is indicated for short term treatment of depressive disorder together with antidepressant

OTHER BIOLOGICAL THERAPIES CONT-

- Psychosurgery-indicated in pt with epilepsy and in pain control

  -chronic unresponsive depressive disorder

  - obsessive compulsive disorder
- Acupuncture –is the stimulation of specific points of the body with electrical stimulation
- Acupressure-is the stimulation of specific point with pressure

OTHER BIOLOICAL THERAPIES CONT-

- Subcoma insulin therapy- small dose of insulin is injected to induce hypoglycemia and resultant sedative effect used to treat mania (now have effective sedatives this has been abandoned)
- Coma therapy-insulin was used to induce comatose state lasting 15-60mins -schizophrenia pt improves following coma (antipsychotic drugs led to abandonement of above treatment
- Atropine can also induce coma

THE END

THANKS

PSYCHOPHARMACOTHERAPY

- Traditionally pharmacological agents used to treat psychiatric disorder are refered to as:

- Psychotropic drugs
- Psychoactive drugs
- Psychotherapeutic drugs

- The main categories of these drugs are:

i. Antpsychotics or neuroleptics
ii. Antidepressants
iii. Antianxiety (anxiolytics)
iv. Mood stabilisers -Used in maniac- hyper (Bipolar I), Hypo (Bipolar II)
v. Anticonvulsants
vi. Psychostimulants – used in ADHD
vii. Others

THE BASIC OF PSYCHOPHARMACOLOGY

- Pharmacokinetics- simply the study of the body's effects on drugs
- Pharmacodynamics- study of the effect of drug on the body
- PHARMACOKINETICS

- It involves obsorption,distribution, metabolism and excretion of drugs
- Bioavailability- is the fraction of the total amount of drug taken that reaches the blood concentration
- Elimination half life refers- to the time it takes for the plasma concentration to fall by half

CONT-

- The route of administration has a direct effect on pharmacokinetics
- Oral route is associated with erratic obsorption and drugs are subject to first pass effect i.e they are metabolised by the liver soon after obsorption
- Intravenous route ensure most rapid obsorption followed by intramuscular route
- The distribution of drug in the brain depends on the drug's affinity to its brain receptors and it's concentration in the brain depends on its solubility through the blood brain barrier

PHARMACODYNAMICS

- Most psychotropic drugs influences the functions of specific neurotransmitters
- The functions that are affected may be the:

- Synthesis of neurotransmitter
- Storage
- Release
- Re-uptake
- Degradation
- Receptor site or other post synaptic mechanism
- Drugs effects can be classified as agonist or antagonists

CONT-

- AGONIST -Mimic endogenous neurotransmitters
- ANTAGONIST- Bind to receptors without causing an effect and they block the effect of agonist
- TOLERANCE -diminished response to a drug after repeated exposures this may be due to increased metabolism, reduced receptor sensitivity or an effect called down regulation

GENERAL PRESCRIBING PRINCIPLES

- There are some guidelines for selecting psychotropic drugs
- Complete through medical evalution r/o CVS disease and determine Thyroid status
- NB: Hyperthyroidism can cause maniac while hypo depression
- Select drugs on basis of side effects or history of previous response
- Inform the patient of anticipated side effects and possible delay in therapeutic response
- Intiate and increase dose of pharmacological drugs slowly
- If there is no significant therapeutic effect after one week, increase dosage to maximum recommended dose over the next six weeks
- Children should be given smaller doses based on weight
- Geriatric patients should receive smaller doses and look out for side effects such as cardiac side effects

CONT-

- For pregnant and nursing women, drugs should be avoided unless the mother life is at risk
- Educate patient on the:
- Diagnosis
- Duration of treatment (effects after about 3-6 mo)
- Side effects to expect
- Obtain informed consent after the patient has been educated and agreed to treatment

MAINTANANCE THERAPY

- Drugs therapy should not be withdrawn before 4 to 5 symptoms-free months
- After this period the psychotropic drugs are then tapered and treatment discontinued while monitoring the patient’s sleep, energy and mental state

DRUGS CATEGORIES

I) ANTIPSYCHOTICS

- These drugs are indicated for treatment of psychosis as in:

i. Schizophrenia
ii. Mania
iii. Psychosis associated with other psychiatric or organic disorder
iv. Psychosis associated with organic disorder also responds well
v. Non psychiatric indication includes Tourrrettes disorder

CLASSIFICATION

- 2 Classes
- TYPICAL OR
- ATYPICAL

A) TYPICAL (TRADITIONAL)

They are subdivided on the basis of their chemical structures

a) Phenothiazines

These include:

(1) Chlorpromazine -administered orally or intramuscularly, (very rarely a small amount of it may be given IV in cases of acute disturbance)

(2)Thioridazine (Mellaril) causes prolongation of QT interval, it is inappropriate for patient with heart problems, causes fewer extrapyramidal side effects

(3) Others include: fluphenazine (Modecate) as along acting preparation (fluphenazine decanoate)

b) Butyrophenones

- The phototype of this group of drugs is **haloperidol**
- Haloperidol is a low dose high potency antipsychotic medication (5mg of haloperidol are equivalent to 100mg of chlorpromazine)
- It has high tendency to cause extrapyramidal side effects
- Causes less drowsiness
- Can be used orally or long acting injectable form which is useful in long term maintance

c) Thioxanthenes

i. The phototype is flupenthixol (fluanxol)

- -Exist in orall form but the most common form in which it is used is as a long acting injection (flupenthixol decanoate).

ii. Zuclopenthixol (clopixol)is also commonly used as a long acting injection (clopixol depot 200-400mg monthly) and as rapidly acting injection (clopixol acuphase 50-150mg every 2-3days) which is used for intiating treatment in acutely disturbed patients.

- Also exist in oral form

d) Diphenylbutylpiperidine

- Structurally similar to butyrophenones
- The prototype of this group is **pimozide** which is approved for treatment of **Tourette's** disorder
- It is also thought to be effective in reducing negative effects of schizophrenia

e) Benzamide

- Sulpiride and Raclopride are effective antipsychotics drugs
- They are associated with fewer neurological side effects than other antipsychotics

f) Dibenzo-xazepine

- **Loxapine** which is similar in structure to clozapine

g) Dihydro-indole

- An example is **molindone** which has unusual clinical properties such as not inducing weight gain and perhaps being less epileptogenic than are the other dopamine receptor antagonist antipsychotics

B) ATYPICAL ANTIPSYCHOTICS

- These drugs have low risk of extrapyramidal side effects
- Do not cause significant drowsiness
- Are effective against +VE and –VE symptoms of schizophrenia

1) Clozapine

- Treatment of choice for resistant schizophrenia
- It has a rare tendency to cause blood dyscrasias especially agranulocyctosis
- Therefore a baseline full blood count is indicated on initiation of treatment and a repeat test is required regularly at least once every month
- This adds to the cost of treatment
- Repeated blood testing puts a strain on the facilities available

2) Olanzapine

- A widely used drug for treatment of active psychosis and prevention of relapse
- It causes weight gain and drowsiness
- In some people it causes disturbances of sugar metabolism and a tendency to develop diabetes. Thus, avoid in DM
- Its average drug dose is 5-20 mg/day
- It is a relatively expensive drug; the cost is a limiting factor to widespread use

3) Risperidone

- Used for treatment of acute and chronic psychotic illnesses
- Some patients complain of drowiness and very rarely there are extrapyramidal symptoms
- May also cause menstrual irregularities due to hyperprolactinaemia
- Usual dose for acute episode is 2-6mg/day

4) Quetiapine

  - Used for treatment of acute and chronic schizophrenia
- A minority of patient may experience extrapyramidal side effects
- Treatment is iniatiated in graduated way with an average maintanance dosage of 300-450mg/day
- Other atypical antipsychotics includes

ZIPRASIDONE, ZOTEPINE, ARIPIPRAZOLE, AND SERTINDOLE

MODE OF ACTION OF ANTIPSYCHOTICS

- Both typical and atypical antipsychotics share the property of blocking the dopamine D2 receptors subtype
- There are also other dopamine receptors eg D3 and D4 whose activity is also affected by these drugs
- Some atypical antipsychotics achieve their effect without high D2 receptor but with 5HT serotonin receptor occupancy
- It is important to understand that nearly all antipsychotic drugs are multi-receptor antagonists contributing to both their therapeutic efficancy and side effect profile

SIDE AFFECTS

- There are 4 neurological side effects associated with atypical/ conventional antipsychotics medications

i. Drug induced parkinsonism

ii. Dystonia

iii. Akathisia

iv. Tardive dyskinesia

- These are due to blockade of dopamine receptors at the striatal level
- The above are extra pyramidal symptoms (EPS) or side effects (EPSE). EPS include various movement disorders such as dystonia, parkinsonism, akathasia, or tardive dyskinesia. EPSE are akinesia (inability to initiate movement) or akathisia (inability to remain motionless). They are due to dopamine blockade.

i. Drug Induced Parkinsonism

- A common side effect of treatment with traditional antpsychotics especially the high potency one like haloperidol
- It consist of:

- A slow “zombie like’’ movement with broad based gait,
- A mask-like expressionless face, and
- An intentional tremor of the hands and other parts of the body
- It is reversible by lowering the dose of medication or taking antiparkinsonian drugs such as benzehexol (artane) 5-15mg, benztropine 1-6mg daily and biperiden 2-8mg daily

ii. Dystonia

It is a sudden muscular spasm usually affecting the muscles of the face and neck

It may manifest as

-A sudden turning of the neck

-Rolling up of the eye ball

-Stiffness and protrusion of the tongue

The experiece can be quite distressing and painful for the patient

It is upsetting and alarming to relatives

It is a common cause of non compliance with medication

The symptoms respond to treatment with antiparkinsonism

Immediate relieve is achieved by slow intravenous injection of 5-10mg of diazepam

iii. Akathisia

- **Akathisia**, or **acathisia** (Gr. *kathízein* – "to sit", *a-* indicating negation or absence, lit. "inability to sit").
- It is sometimes described as the restless feet syndrome
- The patient experiences an overpowering urge to move up and down
- It occurs within a week or two of commencing antipsychotics drugs
- It improves by taking anticholinergic drugs or lowering the dose of the antipsychotics medication or both

iv) Tardive Dyskinesia

- This is observed after a person has been on antipsychotics drugs for many months or years
- It often manifests as:
  - Thrushing movements of the tongue or chewing or flicking
  - Twisting movements of the neck and trank
  - Or pursing movement of the lips
- It can improve by stopping or changing the antipsychotics drugs
- It does not respond to anticholinergic medications

OTHER SIDE EFFECTS

- ENDOCRINE DYSFUNCTION
- Blockade of the pituitary dopamine receptors by antipsychotics lead to hyperprolactinaemia which may cause:

(1) Breast enlargement and lactation
(2) Irregular menstrual cycle
(3) Reversible cessation of menstruation

- ANTICHOLINERGIC EFFECTS

-Dryness of the mouth
-Constipation
-Urinary retention
-Blurred vision
-Erectile dsyfunctions

SIDE EFFECTS CONT-

- ANTIHISTAMINERGIC EFFECTS

-Sedation

-Weight gains

- ANTIADRENERGIC EFFECTS

-Dizziness

-Postural hypotension

-Reflex tachycardia

SIDE EFFECTS CONT-

- NEUROLEPTIC MALIGNANT SYDROME
- -A rare side effect characterised by

(1) Extreme rigidity of the body especially over the abdomen
(2) Extremely high body temperatures
(3) Lowered sensorium
(4) It is rapindly progressive and may lead to death wihin 24hrs
(5) The common cause of the death is cardiovascular collapse
(6) Irreversible brain damage may be sustained by those who survive
(7) The condition is treated by general supportive measures and by administration of bromocriptine (a central dopamine agonist) and dantrolene (a peripheral muscles relaxant)

II) ANTIDEPRESSANTS

- This class includes a wide range of drugs with different structures and mechanism of actions
- There common property is that they improve the mood and other symptoms of depression
- All antidepressants essentialy work by facilitating norepinephrine and /or serotonin neurotransmission
- This occurs by

(1) Increasing the amount of these substances at the synaptic space
(2) Reducing or slowing down their degradation or
(3) Reducing their re-uptake into the neurons

CLASSIFICATION OF ANTIDEPRESSANT

a) Heterocyclic (tricyclic and tetracyclic)
b) Monoamine oxide inhibitors (MAOI)
c) Selective serotonin re-uptake inhibitors (SSRI)
d) Selective nor-epinephrine re-uptake inhibitors (SNRI)
e) Serotonin and nor-epinephrine re-uptake inhibitors
f) Nor-epinephrine and dopamine re-uptake inhihitors eg bupropion

a) TRICYCLIC ANTIDEPRESSANT

- Named depending on the number of rings in the nucleus
- All tricyclics have a three ring nucleus in the molecular structures
- Tetracyclics have 4 rings
- Monocyclic have one ring
- Dicyclic have 2 rings
- In general called heterocyclics

CLASSIFICATION OF TCA

(1)Tertiary amines includes
Imipramine
Amitriptyline
Trimipramine
Clomipramine
Doxepin
All have a 2 methyl group on the nitrogen atom of the side chain
(2) Secondary Amines includes
Despramine
Nortriptyline
Protriptyline
(3)Tetracyclics drugs
Maprotiline
Amoxapine

TRICYCLICS ANTDEPRESSNT CONT-

- Among the oldest effective medication for depression
- Most effective where the symptoms of depression:
  - Are episodic
  - Has a clear onset
  - Preceded by a period of normal mood
- Less effetive in patient with vegetative symptoms of depression such as:
  - Hypersomnia (disorder of excessive daytime sleeping)
  - Increased appetite
  - Weight gain or
  - Patient with chronic neurotic (dysthymic) symptoms are less likely to benefit substantially

TRICYCLIC ANTIDEPRESSANT CONT-

i. Amitriptyline is an effective/cheap antidepressant which leads to improvement in 3 out of 4 depressed patients

- Effective dosage 25-150mg/day
- Dosage is built gradually usually starting from 25mg daily and increase by 25mg until the full effective dose is achieved
- It takes 7-14 days for the antidepressant effect to become noticeable
- The drug has additional effect of improving sleep

CONT-

ii. IMIPRAMINE -Has same level of effectiveness as amitriptyline but has less sedative effects

iii. NORTRIPTYLINE – Is the demethylated form of amitriptyline and has fewer side effects

iv. DESIPRAMINE -Is the demethylated form of imipramine; has better side effects profile

v. CLOMIPRAMINE- Has 2 important properties:

- It is effective in obsessive-compulsive disorder
- It is available in injectable form (it comes in hardy in cases where patient is unable or unwilling to take oral medication

MODE OF ACTION

i. Reducing reuptake of norepinephrine
ii. Reducing re-uptake of serotonin
iii. Blocking muscurinic acetylcholine receptors
iv. Blocking histamine receptors

INDICATIONS

- The main indications are in the treatment of:
  - -Major depressive disorders
  - -Panic disorder with agoraphobia
  - -Generilized anxiety disorders
- Others indications include:
  - Obsessive compulsive disoder
  - Eating disorder
  - Pain disorder
  - Enuresis
  - Narcolepsy
  - Posttraumatic stress disorder
  - Migrane headache

SIDE EFFECTS

- Side effects include:

i. Antihistaminic effects –sedation/weight gain

ii. Anticholinergic effects:

-Dryness of the mouth
-Urinary retention
-Blurring of near vision
-Erectile dysfunction
-Excessive sweating and
-constipation

iii. Electrocardiographic (ECG)

-Causes prolonged conduction time
-Thus ECG is necessary before commencement of treatment

b) SELECTIVE SEROTONIN RE-UPTAKE INHIBITORS (SSRI)

- SSRI have become the drugs of choice for treatment of depression
- SSRI selectively block re-uptake of seronin at synaptic junction
- They are structurally different
- They also differ in their half life
- Fluoxetine has the highest half life
- All of them are metabolized through cytochrome P450 in the liver
- Has minimal secretion in the breast milk
- They are useful in erderly patient; unlike TCA they course fewer side effects
- SSRI discontinution should be gradual to prevent discontinution sydrome characterised by dizziness, somatics symptoms, mood changes and paraesthesia

SSRI CONT-

- These drugs and dosages include:

1) Fluoxetine -20-60mg/day
2) Sertraline -50-200mg/day
3) Citalopram-20 -6mg/day
4) Escitalopram-20-40mg/day
5) Paroxetine-20-60mg/day
6) Fluvoxamine-50-300mg/day

- The use of SSRI in pt receiving other drugs for medical illness requires exercising care due to drug –drug interation during metabolism through cytochrome P450
- This may lead to altered metabolism leading to non efficiecy, side effects, or toxicity

c) SEROTONIN AND NOREPINEPHRINE RE-UPTAKE INHIBITORS (SNRI)

- Effectively act by inhibiting the re-uptake of the two neurotransmitters hence elevating their levels
- SNRI's are also called duel action re-uptake inhibition
- An example is Venlafaxine given in the dose 37.5-225mg/day

d) NOR EPINEPHRINE RE-UPTAKE INHIBITORS (SNRI)

- Inhibition results in elevated levels of nor epinephrine at the synaptic junction
- These drugs include Reboxetine and duloxetine
- SNRI are useful in preventing recurrent attacks of panic and in the treatment of obsessions

e) MONOAMINE OXIDASE INHIBITORS (MAOI)

- MAOI's are a group of antidepressants which are useful in treatment of:

➢ Atypical depression or

➢ Chronic depression where other antidepressants have failed

- MECHANISM OF ACTION
  - Block the breakdown of serotonin and nor-epinephrine
  - They do this by combining irreversibly with the enzyme monoamine oxidase

MAOI CONT-

- The enzyme Monoamine oxidase (MAO) occurs in 2 forms, A and B
- MAO (A) acts selectively on nor-epinephrine and serotonin while MAO (B) acts on phenylethylamine
- Both MAO (A) and (B) act on dopamine and tyramine
- MAO (A) inhibition confers antidepressant effect

MAOI CONT-

- Clinical use of MAOI requires that the patient avoid foods containing tyramine eg milk and its products
- Inhibition of monoamine oxidase impairs metabolism of tyramine and this leads to excessive release of norepinephrine from presynaptic storage granules
- This norepinephrine cause profound alpa-adrenergic activity which lead to elevated blood pressure (a state refered to as hypertensive crises or cheese reaction)
- This condition is life threatening and can be fatal
- Another precaution is to avoid combining MAOI and SSRI; this can result in SEROTONIN SYDROME a condition characterised by hypermetabolic reaction seen as:

➢ Tremors
➢ Lethargy
➢ Restlessness
➢ Myoclonus jerk's

And finally there is:

➢ Cognitive impairment
➢ Hyperthermia and
➢ Lead to death

MAOI CONT-

- MAOI and TRICYCLIC antidepressants are refered to as typical antidepressants, whereas others are refered to as new generation antidepressant

III) MOOD STABILIZERS

- Indicated in the treatment of Bipolar disorder (typically the manic phase)
- These drugs include:

a) Lithium (gold standard) drug of choice

b) Anticonvulsant drugs:

- Sodium valproate
- Carbamazepine
- Lamotrigine
- Gabapentin

a) LITHIUM

- Lithium is the highest of all solids in the periodic table
- It was discovered in 1817
- It has a wide range of use in commercial application

➢ Rubber processings
➢ Manufacture of long life batteries
➢ Construction of nuclear weapons
➢ Strengthening of glass and ceramic

Used for the first time in medicine in 1840 for management of

➢ Gout
➢ Bladder stones
➢ Anxiety and
➢ Poor sleep

LITHIUM CONT-

- PHARMACOKINETICS

Has a narrow therapeutic index

It is readly obsorbed in the gastroinstestinal tract (20% in the stomach and 70% in the small intestine)

Serum level peaks in 60-90 minutes

Lithium is almost entirely eliminated in the kidneys

It is also secreted in all body fluids including sweat, tears, saliva, ejaculate, and breast milk

LITHIUM CONT-

- CLINICAL INDICATIONS

(1) Bipolar 1 disorder

It is used for prophylaxis and short term treatment

It has delayed response and neuroleptics and benzodiazepines may be used in the first 3 weeks of treatment for a manic episode

(2) Major depressive illness

Can be used in patient who have failed to respond to antidepressant alone

(3) Schizo affective disorders

Lithium is more likely to benefit those patients whose symptoms clinically resembles bipolar mood disorder more than schizophrenia

LITHIUM CONT-

- BASIC PRICIPLES IN LITHIUM USE

Due to narrow therapeutic range, baseline parameters should be established before start of treatment. These include:

- A complete blood count (full heamogram)
- Thyroid function test
- Renal functions test including creatinine clearance
- Baseline ECG
- Pregnacy test in all women of child bearing age

All these tests should be repeated twice a year

LITHIUM CONT-

- DOSAGES

Dose range between 400-1000mg given in divided doses
Therapeutic serum level is 0.6-1.2mmol/l
Serum level should be monitored every 3 months
While at 6 months the other test should be repeated

ADVERSE EFFECTS

The most common side effects of lithium are:

- Polyuria
- Polydypsia
- Gastric irritation
- Tremors
- Weight gain

Lithium is teratogenic & should be avoided in pragnancy

b) ANTICONVULSANTS

1) SODIUM VAPROATE

An anticovulsant traditionally used for treatment of petit mal epilepsy

It has antimanic and mood stabilising effects

Other indications includes:

-Impulse control disorder

-Alcohol withdrawal

-Non acute aggressive behavior

-Schizoaffective behavior

Usual dose is 500 -2000mg /day

SIDE EFFECTS

-Gastroinstestinal upsets

-Drowsiness and tremors

Petit mal epilepsy –a staring spell or an absence seizure. It's a brief (us. <15 sec) disturbance of brain function due abnormal electrical activity in the brain

-Rarely causes hepatotoxicity and pancreatitis

2) Carbamazepine

- An anticonvulsant effective in treatment of temporal lobe epilepsy
- It is effective in treatment of mania and prevention of recurrence of bipolar disorder
- Usual dose 600-1200mg/day
- The most serious side effects associated with this drug are:

-Aplastic anaemia

-Agranulocytosis

-Exfoliative dermatitis

Other newer antiepileptic agents include:

i. Lamotrigine

ii. Gabapentin

iii. Topiramide

All are effective in treatment of bipolar disorder

IV) ANXIOLYTICS SEDATIVES AND HYPNOTICS

- This consist of benzodiazepines and non benzodiazepines

a) BENZODIAZEPINES

-Also called antianxiety, anxiolytics or minor tranguillisers

-They act as anxiolytics, sedatives or hypnotics depending on the dosage used in that order

Anxiolytics -decrease anxiety and restlessness

Sedatives -reduce hyperactivity, reduce tempers, excitement and generally calm the patient

Hypnotics -increase drowsiness and facilitate onset and maintenace of sleep

Benzodiazepines are also useful in other psychiatric condition eg panic attacks, phobias, agitation in bipolar disorder/schizophrenia

Also used as anticonvulsants and muscle relaxants

TYPES OF BENZODIAZEPINES

- Diazepam, clonazepam, oxazepam, lorazepam tenazepam, lprazopam, chlordiazepoxide, triazolam,
- Others include prazepam, clorazepate, midazolam,quazepam, midazolam, loprazolam

BENZODIAZEPINES CONT-

- MODE OF ACTION

They work by augmenting Gamma-amino-butyric acid (GABA) an inhibitory neurotransmitter present in many areas of the brain

Diazepam- is used for treatment of acute or chronic anxiety disorders eg situational or social phobia, neurotic disorder such as hysteria

It is also used in relief of panic states, alcohol and other drugs withdrawal conditions

Usual dose 2-5mg 2-3times daily

Higher dose is occasionally used

DIAZEPAM CONT-

- SIDE EFFECTS

Tiredness, excessive drowsiness, morning hangover, dizziness, and ataxia

In children causes paradoxical effect characterised by restlessness, anxiety, and aggressive behavior

Drug dependence may develop in prolonged use especially in higher doses

Sudden withdrawal may lead to restlessness discomfort and fits

BENZODIAZEPINES CONT-

- NITRAZEPAM -has a shorter period of action than diazepam and is less likely to cause morning hangover
- It is useful in treatment of insomnia
- Doses 2.5-10mg
- CLONAZEPAM -is useful as an anticonvulsant and a mood stabilizer in addition to its anxiolytic functions

V) OTHER DRUGS USED IN PSYCHIATRY

a) Anticholinergics

Are used to treat side effect of antipsychotic drugs

These specifically include:

- extrapyramidal symptoms
- pseudo-parkinsonism
- Akathisia
- acute dystonic reactions (but may require injectable form of the drugs)

• These drugs are:

- Trihexyphenidyl hydrochloride (Benzhexol or Artane)
- Benztropine
- Biperiden
- Procyclidine and
- Orphenadrine citrate

CONT-

- SIDE EFFECTS –
  - Intoxication
  - Delirium
  - Coma
  - Seizures
  - Extreme agitation
  - Hallucinations
  - Severe hypotension
  - Supraventrcular tachycardia

Others include-

- Decreased bowel motility
- Dry skin
- Hyperthermia

OTHER DRUGS CONT-

- b) **Antihistamines** -Has anticholinergic effects.

i. Indicated for treatment of extrapyramidal side effects eg diphenhydramine or promethazine –
ii. Hydroxyzine hydrochloride (atarax) is given for its sedating effect and treatment of generalised anxiety disorder
iii. Cyproheptadine is indicated for delayed male or female orgasm caused by serotonergic agents
iv. Other indications includes drug induced akathisia or lithium induced tremors

CONT-

- SIDE EFFECTS INCLUDE:

-Weight gain

-Sedation

-Poor motor co-ordination

-Dizziness and

-Hypotension

c) **Sympathomimetics (Psychostimuants)**

Includes

Methylphenidate -is used for treatment of attention deficit hyperactivity disorder(ADHD)

THE END

SOCIAL APPROACHES

- The social approaches attempt to modify attitudes and behavior by altering the environmental factors contributing to the patient's maladaptation
- In constrast to psychological techniques which deals with intrapsychic phenomena and interpersonal problems

SOCIAL APPROACHES CONT-

(1)Part time hospitalization

-Where patient participate in hospital activities during the day(day hospital) going home at night

or stays the night(night hospital) going to work or school during the day

Or spends several hours a day in the hospital for up to 5or 6 hours a week

This is cost effective alternative to full hospitalization

SELF HELP COMMUNITIES

- This are usually sponsored by non-governmental agencies for the purpose of helping people with particular type of difficulties eg half way houses or residences for alcoholic
- They act as bridge between hospilization and independent

SUBSTITUTE HOMES

- Substitute homes provide shelter and treatment program for longer period of times eg foster houses (orphanage)or shelter for young people –often in the process of withdrawing from drugs (rehabilitation centers)

NON RESIDENTIAL SELF HELP ORGANIZATION

- This are organized to help people deal with practical and psychological problems
- Usually administered by people who have survived similar problems and helps other cope with similar problems eg

-Alcoholic anonymous

-Schizophrenic anonymous

-Overeaters anonymous

-Epilepsy society

-Mastectomy clubs

SPECIAL PROFESSIONAL AND PARA PROFESSIONAL ORGANIZATION

- Such as medical camps in which physician, nurses, pharmacists provide education regarding drugs and help patient to accept the need for long term medication
- Religious group and churches also play major role in psychosocial adjustments eg marriage counselling and family problems.

STRESS REDUCTION TECHNIQUES

- Social and environmental factors are major aids in lowering stress
- This includes active recreation eg sports and physical exercise
- Others includes reading, musics and painting are all necessary for a balanced life and alleviation of stress
- Thus children play ground and libraries should be provided

THE END

- THANKS

THEORIES OF PERSONALITY GROWTH

- Three best known theories of personality growth were developed by-

(1)Sigmund Fred– identified five stages from birth to middle adolescence

(2)Eric Erikson- identified eight stages from birth to late adulthood

(3)Jean Piaget- identified four stages of development

FREUD'S THEORIES

- Psychoanalytic theory

According to him the personality is divided into three structures

(a)The ID

(b)The EGO

(c)The SUPER EGO

THE ID

- The ID exist within the unconscious mind.
- It is the innermost core of personality and the only structure present at birth
- It has no direct contact with reality and functions in a totally irrational manner
- It operates according to the pleasure principal (seeks immediate gratification or release regardless of rational consideration and environment)
- It has no contact with the outer world
- Shared with the animals

THE EGO

The Ego functions primarily at a conscious level

-It operates in the reality principal, by testing reality to decide when and under what condition the ID can safely discharge its impulses and satisfy its needs eg sexual gratification within a consenting relations rather than allowing the pleasure principle to dictate an impulsive sexual assault

THE SUPEREGO

- It is the moral arm of personality and contains traditional values and ideals of society
- Ideals are internalised by the child through idetification with parents who also use reinforcement and punishment to teach the child what is ‘’right’’ and what is ‘’ wrong’’
- Like the Ego the Superego strives to control the instincts of the ID (especially sexual and aggresive impulses that are condemned by society)

FREUD'S PSYCHOSEXUAL THEORY OF PERSONALITY DEVELOPMENT

- It states that personality is powerfully moulded by experiences in the 1st yrs oflife
- Children pass through a series of psychosexual stages during which the ID's pleasure seeking tendencies are focused on specific pleasure sensitive areas of the body (erogenous zone)
- Potential deprivations or over indulgences can arise during any of these stages resulting in fixation (a state of arrested psychosexual development)

PSYCHOSEXUAL THEORY CONT-

- THE ORAL STAGE: birth-18months
- The infants needs are centred in the mouth
- Infants gain primary satisfaction from taking in food and from sucking on the breast, thumb, some other objects
- Excesssive gratification or frustration of oral needs can results in fixation on oral themes of self indulgence or dependency as an adult
- Successful resolution of the oral phase lead to individuals who have capacities to give to and receive from others without excessful dependence
- To rely on others with a sense of trust as well as with a sense of self reliance

PSY THEORY CONT-

- THE ANAL STAGE: 2ND-3RD YRS OF LIFE
- Pleasure become focused on the process of elimination
- The child is faced with society's first attempt to control a biological urge (during toilet training)
- Harsh toilet training can produce compulsion or overemphasis on cleanliness and insistance on rigid rules and rituals
- Extremely lax toilet training results in messy negative and dorminant adult
- Successful resolution of this stage lead to individual with personal autonomy
- Individual with capacity for indepence and personal intiative without guilt
- A capacity for self determing behavior without a sense of shame or self doubt

PSYCH THEORIES CONT-

- THE PHALLIC STAGE: 3-5yrs

-At this stage, children begin to drive pleasure from their sexual organs

-The male child experiences erotic feelings towards his mother

-He experiences desire to possess her sexually and views the father as a rival

-These feelings arouse strong guilt and a fear that the father might castrate him (castration anxiety)

This conflicting situation is the Oedipus complex

PSYCHO THEORIES CONT-

- The girls discover that they lack a penis and blame the mother for the lack of the more desirable sex organ (penis envy)
- The female version of the Oedipus complex is the Electra complex
- Phallic stage is a major milestone in the development of gender indentity where children resolve this conflict and identify themselves with the same sex parent
- Boys taking on the traits of the father and girls those of their mother

PSYCHO THEORIES CONT-

- THE LATENCY STAGE: 5-6 to 11-13yrs

A period of development of important skills

A period of exploring the environment and becoming more proficient in dealing with the world and persons around them

Too much regulation often give rise to pattern of behavior that is obsessive and hypercontrolling

PSYCHO THERORIES CONT-

- THE GENITAL STAGE:11-13 to young adulthood

There is separation from dependence on parent.

Achievement of a mature sense of personal identity;

Successful resolution of this stage lead to a mature personality who participate in the areas of work and love and has meaningful goals and values in life

PSY THEORIES CONT-

Jean Piaget-(stages of cognitive development)

Born 1896-1980

He focused on how children and adolescence grow and acquire knowledge

He described 4 major stages

(1)Sensorimotor stage: Birth -2yrs

(2)Stage of preoperational thought: 2-7yrs

(3)Stage of concrete operations: 7-11yrs

(4)Stage of formal operation: 11yrs through the end of adolescence

JEAN PIAGET CONT-

- SENSORIMOTOR STAGE: Birth- 2 yrs

Piaget used this term sensorimotor because children learn through sensory observation and they gain control of their motor function through activities

The achievement during this stage is object permanence (schema of the permanent object)

The child ability to understand that object have an existance independent of the child involvement with them

At 18 months, develop SYMBLIZATION- ie, they learn to maintain a mental image of an object even though it is not present and visible

A child can creat a visual image of a ball or symbol of the ball

PIAGET CONT-

- PREOPERATIONAL THOUGHT: 2-7 YRS

During this stage child use symbols and language more extensively

The child learn but is not able to reason

Children are unable to think logically and have primitive concepts.

They can name objects but not classes of object

Events are not linked by logic (eg if a child drops a glass and it breaks, the child may believe that the glass was ready to break and not that they broke the glass .Because they have no concept of cause and effect

CONT-

- They are unable to grasp the sameness of object in different circumstances
- They have egocentric thoughts they are unable to modify their behavior for somebody else (eg when told to keep quiet because their brother is studying may not do it because they cannot understand their brother's point of view
- They have atypical thinking called phenomenalistic casuality in which they believe that events that occur together cause one another (eg lightining cause thunder)
- Children also use animistic thinking ie they think physical event and objects have life like psychological attributes such as feeling or intentions

CONT-

- Stage of concrete operation: 7-11yrs

Egocentric thought is replaced by operational thought

The child can now see things from someone else point of view.

During this stage children use logic, they can group things in classes on the basis of common characteristics.

Logical conclusion can be formed from two premises during this stage, eg, all horses are mammals (premise), all mammals are warm blooded (premise), all horses are warm blooded (conclusion)

This is refered to as “syllogistic reasoning’’

CONT-

- Children are able to reason and follow rules, develop moral sense and code of values.
- But children who become overly invested in rules may show obsessive compulsive behavior
- CONSERVATION- develop ability to recognise that even though a shape or form of an object may change it may contain the same amount of material eg if clay is made into a ball or a thin sausage shape, it still contains the same amount of clay
- REVERSIBILITY- a capacity to understand that one thing can change into another and back again eg ice and water
- The most important sign that children are still in the preoperative stage is that they have not achieved conservation and reversibility

CONT-

- STAGE OF FORMAL OPERATION: 11yrs throughout the end of adolescence
- Characterised by the young preson's ability to think abstractively, to reason deductively and to define concepts
- The person's thinking operate in a formal highly logical, systematic and symbolic manner
- During this stage, language use is complex and follow formal rules of logic and is grammatically correct

CONT-

- Application to psychiatry and education

(a) Hospitalised children who are in sensorimotor stage have not achieved object permanence and they suffer from separation anxiety; such children are best if their mother are allowed to stay with them

(b) Pre-operational children who are unable to deal with concepts benefit more from role playing

(c) Adults under stress can regress cognitively as well as emotionally their thinking can become pre-operational ,egocentric and sometimes animistic

(d) Education- used to assess intelluctual development or grade placemement

ERIC ERIKSON

- Born in1902-1994
- His theories formulations were based on epigenetic principal which holds that develpment occurs in sequential clearly defined stages, and that each stage must be satifactorily resolved for development to proceed smoothly
- According to epigenetic model, failure to successfully resolve a particular stage would result in physical, social, or emotional maladjustment

ERIC ERIKSON CONT-

- STAGE 1: Basic trust versus basic mistrust

Birth-18months of life

Through interaction with the mother, the infants develops the feeling of trust that their needs will be sastified and develops a positive expectation of the world

If the mother is not attentive the infant develops mistrust sense that their needs will not be met

STAGE 1 CONT-

- In the 2nd half of 1st yr the child teeth develops and drive to bite occurs
- The child discovers whevever it bites the nipple is withdrawn
- The child learn that it must control the urge to bite
- Infant also learn that they can influence the environment
- The infant progresses from being passive to becoming active
- They also develops a sense of themselves as different from the environment
- NB If oral needs are not sastified in infancy may lead to oral dependence personality where they use chemicals to sastify unmet needs such as alcohol, cigarrettes etc

STAGE 2

- STAGE 2: (18months-3yrs): Autonomy versus shame and doubt
- Autonomy concerns children's sense of mastery over themselves and their drives and impulses
- Toddlers gain a sense of their separateness from others (" I, you, me, mine are common words used by children during this period)
- It is the time for the child either to retain feces (holding in) or to eliminate feces (letting go), both behaviors has an effect on the mother

CONT-

- Children in the 2nd and 3rd yr of life learn to walk alone, to feed for themselves, to control their anal sphincter, and to talk
- If the parent permit the toddlers to function with some autonomy and are supportive without being overproctective they gain self –confidence and feel that they can control themselves and their world
- If toddlers are punished for being autonomous or are over controlled they feel angry and ashamed
- If parent show approval when the child shows self control the child's self esteem is enhanced and a sense of pride develops
- Parental overcontrol or the childs loss of self control (also called muscular and anal impotence by Erickson) produces a sense of doubt and shame

CONT-

- Shame implies that one is looked down on by the outside world and the child is easily shamed by poor parenting experiences

CONT-

- PSYCHOPATHOLOGY
- Rigorous toilet training- compulsive/anal personality that is meticulous, very punctual, perfetionistic, and selfish

CONT-

- STAGE 3 INITIATIVE VERSUS GUILT 3-5YRS

The stage corresponds to Freuds phallic Oedipal phase

-The child grows a sense of sexual curiosity at this stage manifested by engaging in group sex play, by touching ones own genitalia, or those of a peer

-If parent do not make an issue, these impulses are repressed and emerge later at puberty

-If parent makes too much of these impulses, child may become sexually inhibited, eg if you touch it the doctor will cut it off

-At the end of 3rd yr, the children are able to intiate both motor and intellectual activities

CONT-

- Whether intiative is reinforced depends on how much physical freedom children are given and on how well their intellectual curiosity is sastisfied
- If toddler are made to feel inadquate about their behaviour or interest they may emerge from this stage with a sense of guilt about self intiated activity
- Conflicts over initiative can prevent children from developing their full pontential and can interfere with their sense of ambition which develops during this starge
- By playing with peers the child learn how to interact with others and the child learn there are limit to their behavior and aggressive impulses can be expressed in a construactive ways such as health competitons, playing games and using toys

CONT-

- Excessive punishment however can restrict the child's imaginations
- If the crisis of intiative is successfully resolved a sense of responsibility, dependability and self discipline develops
- PSYCHOPATHOLOGY- severe prohibitions lead to sexual inhibtions (persons feel guilt because of normal impulses with resulting symptoms formations eg psychosomatic disorder, coversion disorder, hysteria and sexual related disorder

CONT-

- STAGE 4 INDUSTRY VS INFERIORITY(6-11yrs)
- The school age period during which the child participate in an organized school programme of learning
- It is equivalent to Freuds latency period when biological drives are dormant and peer interations prevails
- Industry – is the ability to work and acquire adult skills. It is the key note of this stage
- If too much emphasis is placed on rules and regulations, child may develop a sense of duty at the expense of natural desire to work and the pride of doing something well
- A sense of inadequacy and inferiority may develop if a child is discriminated agaist in school, is overprocteted at home or excessively dependent on the emotional support of their family.
- OR if the children compares themselves unfavorably with the same sex parent

CONT-

- PSY CHOPATHOLOGY-when a child effort is curtailed they are made to feel personal goals cannot be accomplished or are not worthwhile
- In adulthood severe work inhibition and a character marked with feeling of inadquancy,in some person the feeling may result in compensatory drive for money, power and prestige

CONT-

- STAGE 5 IDENTITY VS ROLE CONFUSION(11yrs-through end of adolescence)

Developing a sense of identity is the main task of this period which concides with purbety and adolescence

Identity is defined as the characteristic that establish who the person are and where they are going

Health identity is built on their success in passing through the earlier stages

How successful they have been in attaining trust autonomy intiative and industry has much to do with developing a sense of identity

CONT-

- Identity implies a sense of inner solidarity with the ideas and the values of a social group
- NB –The adolescence may make sevaral false start before deciding on an occupation or may drop out of school only to return at a later date to complete a course of study
- Failure to negotiate this stage leaves the adolescence without solid identity and the persons suffers from identity diffusion or role confusion

This is characterised by not having a sense of self and by confusion about one's place in the world

CONT-

- Role confusion may manifest itself in such behaviour abnormalities as running away from home,criminality and overt psychosis
- Problem in gender identity and sexual role confusion may become manifest at this time
- The adolescence may defend against role diffusion by joining a cult or by indetifying with folk heroes
- PSYCHOPATHOLOGY includes many of the adolescence disorder eg gender identity disorder, conducts disorder, disruptive behaviour disorder or inability to leave home or separate from parents which lead to prolonged dependent (30-40yrs stays with parents)

CONT-

- STAGE 6 INTIMACY VS ISOLATION 21-40YRS

This period extend from late adolenscence to middle age

It depends on how successful one has negotiated earlier stages of develop ment

A person with resolved identity crisis is not frightened of intamacy of sexual relationship, friendship or all deep associations

A person with role confusion is unable to become involved in intense and longterm relationship and without a friend or a partner in marriage, a person may become self obsorbed and a sense of isolation may grow to a dengerous propotion

CONT-

- If as a child had achieved intiative in genitality this merges with the ideas off genital orgasm and the young adult is able to make and have love with another person
- Successful formation of a stable marriage and a family depend on capacity to become intimate

CONT-

- STAGE 7 GENERATIVITY VS STAGNATION(40-65yrs)
- During this middle yrs of life the person chooses between generativity and stagnation
- Generativity- concern not only a person having and raising children but also includes interest outside the home;guarding the oncoming generation or improving the society
- Parents need to have achieved successful identities themselves to be truely generative
- Stagnation is barren state characterised by lack of productivity or creativity, and this is dengerous because the person is not able to accept the ideas that death is inescapable part of life and time is running out

CONT-

- PSYCHOPATHOLOGY-Higher incidence of depression due to disappointment and failed expectations
- There could be increased use of alcohol and other substances (middle life crisis)

CONT-

STAGE8 –INTEGRITY VS DESPAIR(OVER 65YRS)

The stage is described as the conflict between integrity and despair

INTEGRITY- The sense of satisfaction that one feels in reflecting on a life productively lived

DESPAIR- The sense that life has had little purpose or meaning

Late adulthood can be a period of contentment, a time to enjoy grandchildren, to contemplate one's major efforts and perhaps to see the fruits of one's labour being put in good use by younger generation

CONT-

- INTEGRITY- Allows an acceptance of one's place in the life cycle and the knowledge that one's life is one's own responsibility
- Those without conviction that one's life has been meaningful and that one has made a contribution either by producing happy chilldren or by giving to the next generation, the elderly person fears death and has a sense of despair or disgust
- Everyone must recognise that growing old requires active preparations which must begin at an ealier stage of life
- Because society is not yet prepared to meet the demands of the old a great responsility remains with individuals

THE END

PSYCHOTHERAPY AND COUNSELLING

- PSYCHOTHERAPY: Def- a way of helping people understand their thoughts, feelings, and actions
- It is used in treatment of mental, emotional, and nervous disorder
- It is based on communication between a person and a therapist
- A therapist –is a person who has been trained to treat an illness eg psychologist, psychiatrist

TYPES OF PSYCHOTHERAPY

- **PSYCHOANALYSIS-** Derived from Freuds theoretical formulations
- Pt lies on a couch to enable maximum relaxation
- The analyst sits outside the client field of vision''
- The clients talks whatever thought that come to mind in whatever form or order they occur taking care not to censor them either in logic or appropriateness
- This process tries to reveal the person unresolved conflicts
- According to Freud' unresolved conflicts are the source of some mental disorder

Cont-

- Many of the unresolved conflicts may lie in the persons unconscious mind that is the part which is hidden from our awareness
- When such conflicts become clear the analyst point them out
- This Process is **Called Free Association**

Dream Interpretation

- Another important tunnel to the unconsciousness is dreams interpretation
- Freud believed that in sleep the Ego's defences were lowered allowing the unconscious material to surface
- After a dream is reported, the analyst asks the pt to freely associate to its content and the resulting association are taken as clues to the meaning of the dream

Challenges in Psychoanalysis

- **Resistance-** Freud believed that some unconscious ideas or impulses are repressed and prevented from reaching awareness because they are unacceptable or painful
- He refered to this phenomenon as **Resistance**
- Resistance is unconscious process of withholding informations manifested as- remaining silent over a long period; being late or beginning to miss appointments or picking a fight with the therapist
- For Psychoanalysis to be successful, must overcome this resistance

Transference-

- Refers to the patient feelings and behaviour towards the therapist and these are usually the pt's childhood feelings torwards important people and above all their feelings towards their parents
- The transference can be +ve or -ve depending on the quality of the expressed feelings towards a therapist
- The client can admire, express sexual attraction or perceive a therapist as a good parent or a friendly figure (+ve transference)
- He can criticise the therapist, compete with him or demostrate anger and hostility (-ve transference)

Countertransference-

- Just as client develops transference feeling towards the therapist the same is possible with the therapist
- He can express jealousy, anger, attraction excessive concern or boredom towards the client
- The counter –transference in psychoanalysis is considered a therapeutic error since the therapist is no longer in control of the therapeutic situation

CONT-

- One way of reducing the disruptive effects of countertrasference is by the therapist undergoing personal analysis during his training
- This may help him to become aware of his personal strength and weakness which in turn enables the therapist to handle the therapeutic situation more objectively

Cont-

- Indications for tretment:

➢ Long standing psychological conflict

➢ Psychoanalysis is effective in treament of certain anxiety disorder such as phobias and obsessive-compulsive disorder, mild depressive disorder, some personality disorder, and sexual disorder

CONT-

- CONTRAINDICATIONS
- AGE- Children are unable to follow the rule of free association
- Age above 40yrs lack flexibility for major personality changes
- Intelligence -pt should be intelligence enough to follow the procedure and cooperate in the process
- Antisocial personality disorder -they cannot develop therapeutic relationship
- Time constraints -it takes 3-4 times a wk for several yrs
- Nature of relationship -the analysis of friends, relatives and acquaintances is contraindicated because it distorts the transference and the analyst objectivity

THE END

PSYCHOTHERAPY AND COUNSELLING 2

- PSYCHOANALYTIC PSYCHOTHERAPY -A modified psychoanalysis
- It focuses on the pt's current conflicts and dynamics
- Interviewing and discussion techniques are used -(analysis of transference and free association is not necessary)
- No use of a couch and the client and therapist are usually in full view of each other
- It can be used in combination with psychotropic drugs

Psychoanalytic psy

- TYPES

1) Expressive psychotherapy (Insight-oriented psychotherapy)
2) Supportive psychotherapy (Relationship – oriented psychotherapy)

a) Insight Oriented Psy-

- It helps pt regain insight, ie understand their psychological functioning and personalities
- In the Insight oriented psychotherapy the therapist emphasis is on the value to pt gaining new insight into current dynamics of their feelngs, their response to issues, their behaviour in different situations and also their relationship with other persons

b) Supportive Psychotherapy

- The therapist offers patient support during period of illness turmoil or temporary decompensation
- It also has the goal of restoring and strengthening the pt defences
- It provides a period of dependence for a pt who is in need of help in dealing with guilt, shame anxiety and in meeting frustrations or extenal pressure that may be too great to handle
- One danger lies in the possibility of a client regression and becoming too dependent

CONT-

- The therapist should strive to make the client assume independence and he should also encourage the expression of emotions which is an important part of supportive psychology
- The verbalization of unexpressed strong emotions may bring considerable relief
- It also leads to reduction of inner tension and anxiety

a) GROUP PSYCHOTHERAPY

- GP- A treatment in which carefully selected pts are placed into a group guided by a trained therapist to help one another effect personality change
- Inclusion Criteria:

  -Ability to perform group task

  -Should have similar problem

  -Motivated to change

CONT-

Exclusion Criteria:

- Inability to tolerate group setting
- Severe incompatibility with one or more of the members
- Tendency to assume deviant role

Structural Organisation of GP

- Size 3-15 members
- Ideal 8-10 optimal size
- <8 interaction may not be enough
- >10 members the interaction may be too great for the member or therapist to follow
- Frequency of Sessions -most groups meet once or twice a week once with the therapist and once without therapist

Length Of Sessions

- 1-2hrs (time limit set should be constant
- Time extended therapy (marathon grp therapy) where the grp meets continuosly for 12-72hrs
- Sleep deprivation breaks down certain EGO defences and promote open communication
- Group can be homogeneous or heterogeneous
- Some therapists believe that the gp should be as heterogeneous as possible to ensure maximum interactions
- The gp should be composed of members from different diagnostic categories, from all races, social level, varying ages, education background, and both sexes

Open Vs Closed GP

- Some grps have set members and composition (if a member leaves no new members are taken in) -closed grp
- An open grp is one in which there is more fluidity of membership (new members are taken on whenever old member leaves)

b) FAMILY THERAPY

- Therapy where all or some family members may take part in treatment
- Aims of FT -improves communication in the family and reduce conflicts
- Indications Of FT
- When a family is experiencing major stressful life events eg accidental or suicidal death, financial crisis, loss of job, illness or when there are communications problems or separation difficulties, etc

CONT-

- Contraindication of FT

✓ Family members are unmotivated

✓ When the level of disturbance is so severe or long standing or both, that family therapy may prove futile

c) MARITAL THERAPY

- **Indications:**

✓ Alcoholism in one or both partners

✓ Unsatisfactory sexual relationship

✓ Money management issues

✓ Fidelity/unfaithfulness

✓ Responsibility over child rearing

- NB –Attention is paid to issues partaining to the relationship eg, sharing of values, tolerance of differences, and agreed level of dorminance and decision making

d) BEHAVIOUR THERAPY

- It helps individuals change their personal behavior
- Behaviour therapy uses a system of rewards and punishments to encourage healthy changes in behaviour
- Behaviour therapist try to change problem behavior rather than focus on reasons for the problem
- Bahaviour modification rewards good actions and punishes bad actions
- Praise or treat may be given to the person when the problem has ended
- Behaviour therapy relies heavily on the principles of learning theory –in particular **Operant** (by B.F. Skinner) and **Classical** conditioning (by Ivan Pavlov)
- Operant –deals with rewards and punishments to behaviors

i) Classical Conditioning

- A neutral stimulus comes right before another stimulus that causes reflexive response. With time the neutral stimulus will produce the reflex even without the othwer stimulus
- For example, experimental bell was sounded whenever food was presented to a dog
- The response of salivation become conditioned to the sound of the bell

ii) Systematic Desensitization

- This was developed by Joseph Wolpe based on behaviour principals of counter conditioning
- In SD the pt is encouraged to relax and is then exposed to feared situation
- The negative effect of anxiety is inhibited by a relaxed state
- The SD consist of three steps

➢ Relaxation training

➢ Hierarchy constructions

➢ Desensitization of the stimulus

➢ Relaxation Training

- Relaxation produces physilogical effects that are opposite of those of anxiety, ie slow heart rate, reduce sweating, increases peripheral blood flow, etc
- Relaxation methods include: meditations, imagery, hypnosis, or progressive muscular relaxations

➢Hierarchy Constructions

- The client and therapist prepare a graded list or hierarchy of anxiety provoking scenes or situations
- When the list is complete the client is asked to relax while being exposed to the items in the hierachy starting from the least anxiety provoking situation
- Once the client is relaxed in the presence of the situation which had previosly elicited anxiety, he progresses to the next item
- The client is gradually desensitised and is able to reach the top of the hierachy without any anxiety
- Desensitization can be done in real life setting or in the therapist's office
- Sometimes, drugs can be used to hasten desensitization

CONT-

- Desensitization is indicated when there is a clearly indentifiable anxiety provoking stimulus eg phobia, obsessions, compulsions, and certain sexual disorder

iii) Graded Exposure

- Graded exposure is similar to systematic desensitization except that relaxation training is not involved and treatment is usually carried out in a real life situation

iv) Flooding

- Flooding is based on the premise that escaping from an anxiety provoking experience reinforces the anxiety through conditioning
- The client confront the feared situation directly without systematic densentization or graded exposure
- The client should remain in fear generating situation until they are calm and feeling a sense of mastery
- Prematuly withdrawing from the situation, conditioned anxiety and avoidance behavior are reinforced the opposite of what was intended

v) Implosion

- Similar to flooding but feared object or situation is confronted only in the imagination rather than in real life

vi) Participant Modeling

- Patient learn by imitation
- Patient learn a new behaviour by observing other fearless model confronting the feared object (eg phobic children are placed with other children of same age who approach the feared object or situation)

vi) Aversion Therapy

- When punishment (noxious stimulus) is presented immediately after a specific behaviour response
- Theoretically the response is eventually inhibited and extinguished
- Many types of noxius stimulus are used, eg electric shock, substance that induce vomiting, corporal punishment, and social disapproval

COUNSELLING

- Counselling is the process of assisting and guiding clients to resolve personal, social, and psychological problems
- It involves two people, a counsellor and the client
- Client problems should be clearly identified and shared with the counsellor

QUALITIES OF A COUNSELLOR

1) Personal warmth- one should be approachable and open to patient or colleagues
2) Empathy- ability to understand what the other person is going through (ability to perceive accurately the feeling of another person and to communicate this understanding to him)
3) Caring- this is a process that offer people opportunities for personal growth
4) Hope- a counsellor should give hope
5) Honesty- this involves the counsellor sharing with the client information without giving false hope or impossible promises

CONT-

6) Patience- acounsellor should take time with patient without rushing them through the sessions
7) Sense of humour- humour breaks tension and bring relaxation to the counselling relatioship
8) Knowledge- a counsellor must know about their client and also have the knowledge to use and give their client
9) Humility- acounsellor needs to be humble and recognise his own limitation
10) Unconditional positive regard- the client is viewed with the diginity and valued as a worthwhile human being

THE END

MENTAL HEALTH TEAM

- MHT- Consist of a psychiatrist, a psychologist, a psychiatric nurse, a pychiatric social worker and occupational therapist
- PSTCHITRIST (role)–A medical; doctor who specializes in diagnosis and treatment of mental disorder

- Leader of the team
- He prescribes psychoactive drugs, monitors pt progress and preventS and manages any adverse side effects
- Order for appropriate investigations to arrive to a diagnosis
- Teaches other members and students on promotion, prevention , treatment and rehabilitation of mentally sick patients
- He conducts research on mental illnesses and on new treatments modalities

Psychiatric social worker

- A trained social worker with special course and training in psychological counselling
- They provide family support and family therapy
- Often calm family members during hospitalization
- Help them to accept mental illness and reduce stigma associated with mental disorders
- They report pt progress to the family while hospitalized
- Visit patient at home after discharge
- They may help to mobilise resources to assist pt family meet medical expenses

PSYCHITRIC NURSE

- A nurse trained in mental health
- Gives pt emotional supports
- They administers the medication prescribed by doctors / psychiatrist
- Observe pt symptoms over time and report the same to other members
- Prevent self injury and harm to others
- Promote adquate hydration and nutritions
- Alleviate disorientation and promote optimal perception
- Provide health education on the causes and prevetion of the disorder
- Facilitate social re-integration in the family and community (community nurse)

OCCUPATIONAL THERAPIST

- Helps patient to involve themselves in pleasurable activities such as sports, crafts, art, drawing etc
- This helps patient express their emotions
- Helps patient to learn practical skills such as carpentry, painting, tailoring ,typing, cooking, washing etc especially patient on long term admission
- Also helps patient to re-learn the forgotten skills, perfect in poorly used skills or learn new skills
- All this helps in restoring self confidence and a sense of responsibility

CLINICAL PSYCHOLOGIST

- Helps in collection, organizations and interpretation of information about the patient and his or her condition
- He is involved in psychological assesment of the patient
- Helps in planning the therapeutic intervention of the patient
- He provides psychotherapy to patients and relatives
- He also conducts research on the patient condition and on new treatment modalities

THE END

- THANKS

FORENSIC PSYCHIATRY

- Forensic psychiatry- the branch of medicine that deals with disorder of the mind and their relationship to legal principles
- A health practitioner may be requested to evaluate the mental state of a person in relationship to legal investigations
- Mentally ill or mentally handicapped person may break the law because of

- Lack of understanding
- Disturbed perception of the world
- Abnormal emotional state
- Abnormal thoughts
- Defects in cognition (such as impaired judgement or intellect)
- Alcohol or substance abuse

PREPATION OF COURT REPORT

- Doctors once in a while are required to prepare and present medical reports relating to the mental status of a person before court
- Such report may be requested by the defence, prosecution or the magistrate or the judge

TYPES OF REPORTS: (1)CIVIL (2)CRIMINAL

- Reports could relate to civil or criminal matter
- It can be an enguiry about past or present status or even on how the expert believes the person could behave in future
- The author of a report must ensure that:
- He has received all available information from relatives, teachers, police, etc
- State clearly the source of the referal (eg police,court) and the purpose of report (eg criminal or civil case)
- Write the report in simple and clear language
- Make sure to retain a copy of the report (it takes long for some cases to be concluded)
- State clearly the limitation of your opinion eg inadquate information (patient unable to express themselves, no available relatives to give corroborative information)

APPEARANCE IN COURT

- Having prepared a medical report you may be summoned to appear and present it. Some basic principles are essential:

(1)Before going to court familiarise yourself with all aspect of the case and establish to your satisfaction what the real or true issues are (if murder what lead to the murder eg issues of land, relationship, substance use)

(2)Come to court with all your documents relating to the case eg past report , case note, lab report

(3)Determine in advance the right term to addres the court; judges are addressed as my lord/lady, magistrates are addressed as your honour. Always address the judge.

(4)Dress appropriaterly

(5) Remember to always tell the truth- if you don't know do not guess, if you don't get the question ask for a repeat

CONT-

- NB –The lawyer on the other side earns his money by discreding you as an expert witness, he can go to all length to redicule you.
- He can keep asking you the same question again and again trying to get you to contradict yourself. The judge may come to your defence, if not you will have to answer.
- It is only by remaining truthful that you will avoid embarrassment
- Remain polite and firm at all times

LEGAL AND ETHICAL ISSUES IN THE MENTAL HEALTH CARE PROCESSES

- CIVIL COMMITMENT

(a) Invonluntary Hospitalisation

- Done when a patient is a danger to self (such as suicidal patient) or to others (such as violent or homicidal patients)
- When pt do not recognise the need for hospital care, so application for admission is made by a relative, a friend, an administrator or police
- Two physician have to examine the pt and concur that hospitalisation is indicated
- Next of kin must be notified
- Pt should have access to legal counsel who can bring the case before a judge, if a judge does not think that hospitalisation is indicated the pt release can be ordered
- Involuntary admission allow the pt to be hospitalised for 60 days
- After that time if the pt is to remain hospitalised, the case must be reviewed periodically by a board consisting of psychiatrist, non psychiatrist physician and a lawyer/s.

CIVIL COMMITMENT CONT-

(b) Out Patient Commitment

- Patient can be spared hospilization if close monitoring and commitment to take medication can be ordered by a court after full hearing of medical evidence
- This may cause many challenges unless the patient poses minimal danger to self and others
- Examples is refusal to take anti TB drugs

SECLUSION AND RESTRAINT

- Aim at preventing a person from causing harm to self or to others
- Seclusion- is placement and retention of an impatient in a bare room for the purpose of preventing a person from causing harm to self or to others
- Restraints – measures to prevent patient bodily movements by use of leather cuffs, ropes, etc. Release carefully e.g. after sedation.
- Once the person regain control release should be immediate
- It should be instituted only under review and supervision of a trained practitioner
- Observation of the person should be frequent with attention paid to the person's personal and medical needs
- NB-It should not be used as a punishment for bad behaviours or when other less restritive alternative are available

HEALTH CARE DECISION MAKING

- INFORMED CONSENT
- Refers to a person's voluntary agreement to a specific treatment based on his assessment of the risk and benefit to be realised
- NB-It is a matter of a persons assessment not the practitioner's-sufficient information should be provided and a person should have capacity to make decisions free from coercion
- In general informed consent require:

(a) An understanding of the nature and foreseeable risks and benefits of a procedure

(b) A knowledge of alternative procedures

(c) Awareness of the consequences of withholding consent

(d) The recognition that the consent is voluntary

- NB-The physician must be ready to listern, to discuss anything the pt may fear as risk, side effect or concern about the proposed treatment before he or she sign the consent form

CIVIL PROCEEDING

(a) TESTAMENTARY CAPACITY

- This is the ability to make a will
- Medical practitioners may be asked to evaluate pt testamentary capacity
- 3 psychological abilities are necessary to prove that compentence.
- Patient must know:

i. The nature and the **extent** of their bounty (**property**)

ii. Pt has presence of the mind to reasonably know the **implication** of the will directives

iii. Who their **natural beneficiaries** are eg their spouse/s, their children and other relatives

CONT-

- Compentence is determined on the basis of a person's ability to make a sound judgement, that is to weigh, to reason and to make a reasonable decision
- Compentent or incompetent is determined by the court
- Witnesses at the signing of a will may prove that the person (testator) was rational at the time of making a will (witness may include a psychiatrist, a lawyer who may videotape the proceedings)
- This is important especially for persons who believe that question may be raised about their testamentary compentence

b) CONTRACTUAL CAPACITY

- Compentence is also essential in contracts as contract is an agreement between parties to do some specific act
- A contract is considered invalid if:
  - When it was signed one of the parties was unable to comprehend the nature and the effect of his or her act
  - Marriage contract is subject to the same standard and thus can be voided if either party did not understand the nature, duties, obligations to be able to function as a wife or a husband

c) MANAGEMENT OF ESTATE

- A person may lack capacity in making rational decisions regarding property management
- Thus it may be necessary to recommend the appointment of a guardian (substitute decision maker)
- He can be appointed informally by the family or can be appointed formally through a court or a person is also permitted to make provision for their own anticipated loss of decision making capacity
- This is called durable POWER OF ATTORNEY
- This allow advance selection of a substitute decision maker who can act without necessity of court proceeding when the signitory become incompetent through illness eg progressive dementia

CRIMINAL LAW

- CRIME- Is an act which at the time it is performed is prosecutable by common law or by specific stature
- In English law before a person is convicted of any crime the prosecution must prove that an illegal act or omission was caused by the person voluntary conduct (actus reus)
- Certain crimes such as murder, the prosecution must prove specific intent or criminal mind or evil intent (mens rea)
- The medical practitioner may be asked to give an opinion on the mental state of the accussed person
- This could help the court to decide on:
  - (a) criminal responsibililty (insanity defence, or some automatism)
  - (b) competence to stand trial or
  - (c) the most reasonable disposal like commitment to a mental hospital for treatment or commitment to out patient treatment etc

CRIMINAL RESPONSIBILITY

- A crime has two components voluntary conduct (actus reus) and evil intent (mens rea)
- There cannot be an evil intent if the offender's mental status is so abnormal that the patient does't know the difference between right and wrong or does't know the nature and consequences of their act
- In all societies it is accepted that children and mentally retarded person are less responsible than others
- M,NAGHTEN RULE- is where persons are found not guilty by reason of insanity. It was established in 1843 & it derives from the famous M'NAGHTEN case

CONT-

- DANIEL M'NAGHTEN –Was a young man who was suffering from delusion of persecution for several years
- He believed that the LABOUR PARTY PRIME MINISTER at the time had hired some people to kill him
- He complained to many people about his persecution but nobody took him seriously including his father and police
- He decided to correct the situation by killing the prime minister ROBERT PEEL
- He went to the prime minister home with a gun and when EDWARD DRUMMOND (who was the private secretary to prime minister) come out of prime minister home he shot him dead mistaking him for MR PEEL
- The jury and the judge found him not guilty by reason of insanity
- M'NAGHTEN was later committed to a hospital for the insane

COMPETENCE TO STAND TRIAL

- In civil societies it is considered inhumane to subject to trial someone unable to defend himself or herself
- Compentence to stand trial is determined by:

(a) An accused person must be able to understand the nature of the charge he/she is facing

(b) He should know the difference between pleading guilty and not guilty

(c) The person should be able to follow the court proceedings

(d) The person should also be able to work/ instruct his lawyer

(e) The person should have capacity to challenge prosecution witnesses realistically

COMPETENCE TO BE EXECUTED

- Punishment are held as meaningless unless the person is aware of what it is and why it is given
- A person who does't understand why he should be executed is not competent
- A competent person about to be executed are thought to be in the best position to make whatever peace with their religious beliefs including confession
- Competent person about to be executed preserves (until the end) a possibility of being abandoned or committed to life imprisonment
- Medical practitioners are called upon to determine competence for execution but most medical bodies consider this unethical for a clinician to participate
- If a clinician find somebody incompetence due to a mental illness he is under obligation to recommend treatment plan
- If implemented it will ensure person fitness to be executed

MALPRACTICE

- The term refers to professional negligence
- Negligence is defined by what a reasonable person would do or would not do in the same or similar circumstances
- Malpractice actions includes

(1) Negligent treatment

(a) After diagnosis one give an overdose, underdose, or wrong drugs

(b) Failure to respond to side effect appropriately

(c) Development of addiction

(d) Informed consent is important before initiating procedures eg surgical or ECT

(2) Misdiagnosis

(a) Failure to discover a patient's suicidal or homicidal intent

(b) Failure to discover concomitant or underlying medical condition

THE END

- THANKS

LIASON PSYCHIATRY

- A sub-speciality of psychiatry that caters for the provision of psychiatric care in a general hospital or community setting alongside other medical services
- WHY LIASON PSYCHIATRY
- 40% of patients in hospital have diagnosable mental illness eg depression, anxiety or organic brain sydrome
- I f the condition are untreated would lead to increased

  -Morbidity

  -Length of stay in hospital

  -Cost of care

LIASON PSYCHIATRY

- AIM OF LIASON PSYCHIATRY

(1) To provide psychiatric treatment to patients with medical or surgical illnesses who may develop psychiatric complications eg
  -HIV delirium
  -Substance induced psychosis
  -Post operative delirium

(2) Patients who have psychiatric illnesses and have developed a medical complication eg
  -Depressed patient who take suicidal overdose of a drug
  -Schizophrenic patient who injure/cut himself due to bizarre delusional beliefs

(3) To clarify diagnosis in a difficult differential diagnosis eg
  -Depression stupor versus stroke
  -Conversion disorder versus loss of limb function

(4) To teach staff about treatment terms and also teach all candres of students regarding psychiatric illness

LIASON CONT-

- AIMS OF LIASON CONT-

  (5) To evaluate a patient's ability to make decision about medical care eg

  -Patient who refuse to cosent to a procedure

- A psychiatrist may be called to determine wheather the patient can understand and appreciate the diagnosis, the prognosis and the risks and benefits of accepting or rejecting the offered treatment
- If the patient can do so, the patient has the right to refuse treatment

PSYCHIATRY

- PSYCHIATRY-Is the medical study, treatment and prevention of mental illness
- PSYCHIATRIST-Medical doctor who specialize in psychiatry
- There are two classification of mental disorder

  -American psychiatric association(Diagnostic and statistical manual of mental disorder) DSM IV /5

  -WHO International classification of disease ICD-10/11

PSYCHIATRY HISTORY

- More elabolate, involves a person's entire life
- Relationship with other people
- Patient should give history in their own words and in their own order
- Corroborative information is important

IDENTIFYING DATA

- Name, age, sex, marital status, religion, source of information, occupation and where the patient come from eg home or refered
- Chief complaints-in patient own wards, no matter how bizarre
- History of present illness-in chronological order, onset of current episode, precipitating factors/ triggers, how it has affected his occupation/ relationship
- Get more information from informants

PREVIOUS ILLNESS

- Past psychiatric history- treatment received, compliances with treatment and clinic follow up
- Past medical/surgical history- head injuries/ surgeries, HIV infection/ syphyllis, history of fits, episode of confusions, loss of consciousness or prolonged headache

PERSONAL HISTORY

- Divided into 5 major developmental periods
- Prenatal and perinatal
- Early childhood-birth to 3yrs
- Middle childhood 3-11yrs
- Late childhood
- Adulthood

PRENATAL AND PERINATAL

- Problems during pregnancy diabetes/ hypertension/ infections
- Wheather the child was planned and wanted
- Use of alcohol and other substances during pregnancy
- Home situation eg poverty -malnutrition

EARLY CHILDHOOD(birth-3yrs)

- Feeding-bottle or breast feed/weaning
- Milestones –delayed eg mental retardation /autism
- Toilet training age it was achieved
- Personality as a child eg shy, restless, overactive, friendly, withdrawn, pattern of play
- Symptoms of behavior problem eg thumb sucking, bedwetting, nail bitings, headbanging etc
- Excess stranger anxiety or separation anxiety
- Mode of play –alone or with others, favorities toys etc

MIDDLE CHILDHOOD(3-11yrs)

- Gender identification
- Punishment at home
- School experiences and reaction after separation with the mother
- Relation with other children, a leader or a follower, group activities eg antisocial behaviour, aggressiveness, impusilveness etc
- Presence of night mares, firesetting, bed wetting, cruelty to animals and excessive mustubation should be explored

LATE CHILDHOOD (Puberty/Adolescence)

- People child associate with
- Relationship with teachers and other pupils
- Favorite studies and sports
- Sexual relationship with opposite sex, ie sexual orientation, gender indentity issues, homosexuality, self esteem etc
- Use of substances eg alcohol, smoking etc
- Onset of puberty and feeling about it

ADULTHOOD

- Accupational history-training achieved, choice of accupation, feeling about the current job relationship at work with collegues and bosses, job history eg job held reason of change from one to another

ADULTHOOD CONT

- Marital and relationship history-Relationship with partner/s eg how long,areas of disagrement financial issues, sexual relationship (sastifactory/unsatifactory)
- Education history –indication of intelligence/motivation, compare level of education with that of other siblings
- Religion-a religious person or not, altitude torwards religion
- Forensic history-has the person ever been arrested, reason of arrest, how many times
- Family history-history of mental illness, substance abuse accupation of other members of the family, patient should mention all members by name

MENTAL STATUS EXAMINATION

- MSE/A-Clinical assessment that combine observation and impression made of a psychiatric patient during the time of interview (it can change from day to day or hour to hour)
- Appearance-grooming kempt/unkempt, posture, gait restless/calm, altitude torward examiner (co-operative, friendly, hostile, playful, evasive) etc
- Mood-pervasive and sustained emotion that colour the person's perception of the world. It is described as low, irritable anxious, expansive, high, euphoric, angry, empty or labile.
- Affect –outward expression of emotion ie what is observable(may or may not be congruent with mood). It is described as,
  - Normal range-variation in facial expression, use of hands and body movements
  - Constricted-reduction in intensity of above.
  - Blunted-further reduction.
  - Flat-no sign of affective expression (face immobile, voice monotonous),

MSE CONT-

- SPEECH-Describe physical characteristic of speech eg rate of production, quanitity etc. Described as talkative (pressure of speech) or unspontenous-mute, poverty of speech
- Perception disturbances –Hallucination “’perception without an external stimuli’’. ILLusions misinterpretation of an external stimuli. Can affect any of the sensory systems eg auditory. visual. olfactory. tactile or gustutory. OTHER perception problem include:
- (a) Depersonalization-feeling of detachment from self (feeling unreal)
- (b) Derealization-feeling of detachment from the enviroment (unreal environment)
- (c) Formication-feeling of bugs crawling on or under the skin seen in cocainsm

MSE CONT-

- THOUGHT divided into (a)process or form

  (b)content

- Process-The way in which a person put together ideas or associtions or the form in which a person think. The process of thought can be coherent and logical or incoherent and illogical
- Content- Refer to what aperson is thinking about
- Ideas, beliefs, delusions, obsessions, preoccpation etc

MSE CONT-

- Thought proces (form of thinking)
- Disorders includes:

(a) Overabundance or poverty of ideas

(b) Rapid thinking, flight of ideas

(c) Loose association-ideas expressed appear unrelated

(d) Blocking-interruption of the train of thought before idea is fully explained

(e) Circumstantiality-loss of capacity of goal directed thinking in the process of explaining an idea pt bring in many irrelevent details but eventually come back to the original point

(f) Tangentiality-the pt loses the thread of conversation and pursues other irrelevant idea and never return to the original point

(g) Word salad-incomprehesive connection of word

(h) Neologism –new words created by the patient through the combination or condensation of words

MSE CONT-

- CONTENT OF THOUGHT

Distubances include

(a)delusions-fixed false belief out of keeping with pt level of education or cultural background

(b)pre-occupations with an idea eg pt illness,suicidal or homicidal ideation

(c)obsession-ideas which are intrusive and repetitive

(d)compulsions-doing thing over and over again in a repetitive manner

(e)Ideas of reference-where somebody belief the people,TV or Radio is speaking to or about one

(f)Ideas of influence-belief that another person or force is controlling some aspect of one behaviour

MSE CONT-

- ORIENTATION-time,place and person

MEMORY-(a)immediate-repeat digit to test for rentention and recall

(b)recent memory-events within the last 24hrs

(c)recent past memory-events within the last few months

(d)remote(long term)memory-historical events

CONCENTRATION –mental sum eg substrating serial 7 from 100 or serial 3 from 20 depending on level of education (impaired in depression,cognitive disorder,anxiety or hallucination

ATTENTION-tested by calculation or by asking a pt to spell a word backward egworld or count backward 17-0 or months Dec-Jan

ABSTRACT THINKING –Ability of a patient to deal with concepts eg explain meaning of proverbs or similarities

INTERLLIGENCE-current affairs ,simple calculation

JUDGEMENT-what to do in case of emengency eg if you smell smoke in a crowded theater what would you do

INSIGHT-PT degree of awareness and understanding that they are sick

PSYCHIATRIC REPORT(FORMULATION)

- After a comprehensive psychiatric history and mental status examination

  (a)other diagnostic examination(physical examination/ test that must be performed

  (b)summary of positive and negative finding

  (c)make a diagnosis as per DSM 5 (muilt axial not applied in DSM5)

  (d)give prognosis

  (e)give psychodynamic formulation

  (f)management and recomendations

DIAGNOSTIC STUDIES

- -General physical examination

  -Neurological examination

  -Additional psychiatric diagnostic interview from relative and important others

  -Psychological,neurological or laboratory test or other test as indicated eg EEG ,CT scan and MRI

SUMMARY OF POSITIVE/NEGATIVE FINDING

- History data eg family hx of mental illness

-Mental symptoms

-lab findings

-psychological and neurological findings.

DIAGNOSIS

- Diagnosis is made according to the 5th edition of the American Psychiatric Association “Diagnostic Statistical Manual of Mental disorder(DSM5)
- No multiaxial diagnosis(eg schizophrenia with personality disorder and aneamia)

PROGNOSIS

- An opinion about probable immediate and future course and outcome of disorder.The good and bad prognostic factor as known are listed

PSYCHODYNAMIC FORMULATION

- This is a summary of psychological influences or causes of the patient problem ie problem in pt life eg separation,environmental issues eg loss of a loved one

RECOMMENDATION

- Determine wheather pt require psychiatric treatment at that time
- Type of treatment eg inpatient or outpatient
- Outpatient how often should the pt be seen, length of treatment
- Inpatient-length of stay in the hospital etc
- If the relative decline the mode of treament as recommended they should sign a statement the treatment recommended is refused

LABORATORY TESTS IN PSYCHIATRY

- Psychiatrist are more dependent than other field on history ,signs and symptoms than lab test .No test can confirm or rule out schizophrenia or mood disorder
- Basic sreening test are done before initiating psychiatric treatment to rule out concurrent disease and establish baseline values.This test includes –complete blood count,hemoglobin level ,U/E ,LFT, Thyroid function,Blood sugar

THYROID FUNCTION TESTS

- Hypothyroidism is associated with depression,it present with body weakness, poor appetite ,slowed speech ,impaired memory, apathy hallucination and delusion-symptoms found in depressed patient
- Lithium used to treat bipolar disorder causes hypothyroidism
- Neonatal hypothyroidism result in mental retardation and is preventable if the diagnosis is made at birth

DEXAMETHASONE SUPPRESSION TEST

- Dexamethasone is a long acting synthetic glucocorticoid with a long half life
- The test is used to confirm a diagnosis of major depressive disorder or endogenous depression .About 1mg of dexamethasone which is equivalent to 25mg of cortisol is given by mouth at 11pm and plasma cortisol is measured at 8am,4pm and 11pm.plasma cortisol of above 5ug/dl is positive
- DST is used to follow the response of depressed pt to treatment
- Patient with a +ve DST respond better to physical treatment such as ECT

CATECHOLAMINES

- This includes serotonin,norepinephrine and epinephrine
- The amount of serotonin metabolite(5-hydroxyindole acetic acid) is low in CSF in person with suicidal depression or those who commit suicide in a violent way
- Low 5-HIAA is associated with violence in general
- Patient with anxiety or PTSD have elevated level of nor epinephrine and epinephrine

OTHER TEST

- Renal function test-important in pt taking Lithium which is excreted in urine(creatinine clearance is important)
- Liver function test need to be taken routinely in pt taking – tegretal and sodium valproate
- Liver disease or damage may present with signs and symptoms of cognitive disorder such as disorientation and delirium

OTHER TEST CONT-

- Blood test for sexually transmitted diseases
  -syphilis may present with psychotic symtoms
  -HIV-has psychiatric manifestations

Urine testing for substance abuse-a number of sub stance can be detected in urine within a specific time after ingestion eg

-Alcohol 7-12hrs
-Cannabis 3days-4weeks
-Cocaine 6-8hrs
-Benzodiazapines 3days

AMOBARBITAL INTERVIEW

- Amobarbital(amytal) has a diagnostic and therapeutic indications

  Diagnosis -diffentiate organic/non organic cause in pt who present with catatonia,stupor and muteness

  Organic condition tend to get worse with admistration of amobarbital

  -Non organic get better on admistration of amobarbital because of disinhibition,decreased anxiety and increased relaxation

  Therapeutically-it is indicated in recovery of memory in amnestic disorder,recovery of functions in conversions(hysteria) disorder and in facilitation of emotional expression in PTSD

THE END

- THANKS

COMMUNITY (PUBLIC) PSYCHIATRY

- Includes all mental health services sponsored and funded by goverment
- BASIC CONCEPT IN COMMUNITY MENTAL HEALTH

(1) Identify all the mental health needs in the population

(2) Organise resources available

(3) Involve all citizen including minority gp, elderly, children and those who are marginalized.

(4) Intergrate services such that patient are discharged home as soon as they get better and others are admitted promptly as need arise

COMMUNITY HEALTH TEAM

- Community health team includes
- ➢ psychiatrist, clinical psychologist, psychiatric social work, psychiatric nurse occupational/recreational therapist and administrative/clerical officers
- They should link with welfare workers, the clergy, family agencies and social group

PREVENTION OF MENTAL ILLNESS

- PRIMARY PREVENTION

-The goal is to prevent onset of a disease or disorder through

(a) Eliminating causative agent

(b) Reducing risk factors eg helping person cope with life through mental health education

(c) Alcohol and drugs prevention programmes

(d) Crisis intervention after stressful life events

(e) Parental advice about improved nutrition and avoidance of alcohol and other substances during pregnacy to reduce incidence of mental retardation and other cognitive disorder

PREVETION CONT-

- Debriefing programmes effective in preventing PTSD
  - Modification of divorce,adoption and child abuse law to provide a healthy environment for child development
  - Genetic counseling for parents at high risk for chromosomal abnormalities to prevent birth of compromised infants
  - Effort to reduce spread of certain sexually transmitted diseases e.g., HIV and syphilis that can lead to mental disorder

PREVENTION CONT-

- SECONDARY PREVENTION
- -Defined as early identification and prompt treatment of an illness or disorder with the goal of reducing the prevalence (the propotion of existing cases in the population at a specified time
- Crisis intervention and public education are component of secondary prevention
- Secondary prevention is embodied in the work of most health workers who try to intiate treatment and alleviate suffering at the earliest possible time
- Effort to educate the public and reduce stigma to allow people to seek treatment earlier is also secondary prevention

PREVENTION CONT-

- TERTIARY PREVENTION (REHABILITATION)
- The goal of tertiary prevention is to reduce the the presence of the residual defects and disabilities caused by an illness or a disorder
- Enables those with chronic mental illness reach the highest possible level of functioning
- Tertiary prevention targets patient suffering from the severe debilitating illnesses such as schizophrenia, severe affective disorder and most disabling personality disorder
- All these diseases especially schizophenia tend to strike in the late aldolences or early adulthood consequently these indivuduals are removed from the society at a time when most person are in college, or completing their education, learning new trade, establishing a career, beginning families or developing social support systems in the community

PREVENTION CONT-

- Tertiary prevention con-
  - Modern community psychiatry attempt to limit the length of hospitalization by rapid intervention and to maintain social support system even when the patient are acutely ill
  - Rehabilitation is a life long program because of the chronic relapsing nature of many types of mental illness especially schizophrenia

DEINSTITUTIONALIZATION

- Deinstitutionalization is the process by which large number of patient are discharged from public psychiatric hospital back to the community to receive outpatient care
- A revolving door policy should be developed where patient are hospitalized as need arise
- Deinstitutionalization in most developing countries is a failed public policy due to underfunding, patients are dumped in the hospital, no social support systems in the communities and outpatient care is wanting

TRANS-INSTITUTIONALIZATION

- Transfer of state hospital patient to other facilities
- Essentially one set of problem is exchanged for another
- For example many mentally ill patients receive psychiatric services as prison inmates
- Severe mental illness is 2-3 times more prevalent in prison population than among the general public
- Many homeless mentally ill person are arrested for minor crimes that are survival strategies (eg trespassing in building or cars as a means of obtaining shelter) or due to behavior directly produced by psychosis

THE END

CRISIS INTERVENTION.

- CRISIS-
- (1) A state of emotional upset
- (2) A state of desequilibrium and disorganisation
- A crisis situation is overwhelming may involve danger to the individual’s personal security

PERSONS RESPONSE TO CRISES

- Affected person may become disorganised, intially may feels powerful and mobilise energy to fight the stressful event-whereby
  - Muscles become tense
  - The heart beat faster and work extra hard to pump blood to the muscles
  - Become mentally alert and their pupil dilate
  - Extra heat generated by increased muscles activity is lost through sweating

CONT-

- When the threat or personal danger is over
  - Muscles relax
  - The heart rate drops
  - Sweating stops
  - Mental alertness drops and
  - The pupils assume their usual size
- If threat persists, stress related state of fatigue result and this may lead into a crisis

COPING WITH STRESS

- Indiviaduals go through many stressful situations and learn to make necessary adjustments to cope with stress through making changes(e.g. if a course stresses, you can change to another course)
- Controlling the situation-
  - Learn how to say no,
  - Know your limits and stick to them
  - Refuse to accept added responsibilities

CONT-

- Avoid stressful situation eg avoid people who stresses you, avoid topic that stresses you
- Changing the way one thinks eg if you can’t change the stressor change self by changing your attitude and expectation
- Don’t try to control the uncontrollable especially the bahavior of other people (you can ignore or avoid them)

TYPES OF CRISIS

- Two types-

  (a) Maturational or transitional crisis

  (b)Situational crisis

MUTURATIONAL CRISES

- This is part of growing up & occurs as a result of human development from one stage to another
- This crisis includes crucial stages in life such as:
  -Beggining of school
  -Leaving home
  -Beginning first employment
  -Getting married
  -Retirement
- At each stage one is forced to make adjustments, resolve anxiety and conflicts neccessitated by the transition

Maturational cont-

- Successful resolution of a maturational crisis normally lead to personal growth, emotional stability and good mental health
- Unsuccessful resolution may result in unresolved anxiety and internal conflicts which may lead to unstable emotional state, depression, maladaptive behavior or personality disorder

SITUATIONAL CRISIS

- Result from specific and intense environmental stressor or threat to one ‘s life
- These include:

(a) Suicidal behaviour-

- Suicide; def- human act of self infliction. Self intentional cessation which is due to the following factors:

(1) Biological factors eg depressive illness

(2) Psychological factors eg failure in exams, job loss, rejection, marital problems, etc

(3) Interpersonal difficulties eg feeling of inferiority

(4) Family history of suicide which can cloud the life of a person who may later commit suicide.

CONT-

(b) Attempted suicide/ parasuicide

- During suicidal acts death is not always the objective
- The goal may be to attract attention (attempted suicide should not be taken lightly and the survivor should be assessed for suicide intent).
- This helps the assessor predict occurence of future suicide eg:
  - Suicidal note
  - Means of suicide (violence means -such as use of knife or gun)
  - Site (locking oneself from inside or going to secluded areas)
  - Amount of substance used (a single sip or consuming all the content available)
  - Prior planning

CONT-

(c) Accidents - are events that occur unexpectedly

- These may cause physical injuries, destructions of properties, loss of life or destructions of lifesyles or livelihood

(d) Death and bereavement

- Emotional and psychological processes linked to death crisis tend to be self limiting and usually never lasts more than six weeks
- NB-A crisis period must always be regarded as a form of medical or psychiatric emergency
- An unresolved situational crisis may lead to suicide, violence homicide, acute stress disorder or post tramatic stress disorder or adjustment disorder
- It, thus, calls for immediate action

OTHER SOURCES OF CRISIS

- Loss of a loved one or loss of possession or status
- Severely disabling accidents eg such as those causing paraplegia, amputation or severe disfigurement
- Natural or unnatural disasters eg bombblast ,floods, ethnic clashes, earthquakes
- Being diagnosed with a potentially fatal disease such as AIDS, inoperable cancers or being confronted by a life theatening situation eg being trapped in an aeroplane facing possibility of a crash
- Being raped
- Being arrested for a serious offence
- Breakups of a relationship eg divorce or termination of an engargement
- Forced retirement
- Separation or threatened separation of a child from its parents
- NB people experiences stressful events without undue effect but a series of such event have cumulative effect and eventaully one may experience a crisis

MANIFESTATION OF CRISIS

- People in crisis experiences varying features of anxiety, depression, shame, guilt, anger, problems with thinking and coping with ordinary day-today experience
- Other symptoms include-palpitations ,low appetite, insomnia, sweating and may tire easily
- Memory is impaired, one may begin to avoid social contant or ordinary activities or hobbies
- Guilt might develop and the person might blame himself or herself for the crisis
- Intense depressive feelings might develop along with suicidal feelings
- Feeling of unreality might develop with loss of pleasure feeling for social activies and one may isolate himself or herself

RISK FACTORS FOR SEVERE CRISIS

- Individual previous experiences and ability to handle stressful events have low risk of severe crisis
- Individual with a history of stressful experiences tend to suffer severe form of crisis than the average person
- Individual who have a personal or a family history of mental disorder are also vulnerable to severe crisis states
- lack of significant social support systems or
- The existence of significant family or marital discord

ASSESSMENT OF CRISIS STATE

- A crisis assessment is often difficult but necessary
- Elabolate assessment may be impossible in many crisis especially where life is in danger eg where the person is threatening to jump off a tall building, bridge or cliff or shoot or stab himself or may threaten the life of others
- Interventions must be given immediately, rapidly and tactifully
- Establishment of rapport with the pt is important
- Gentle and pleading persuasion away from danger is crucial
- As soon as the dangerous situation is averted data must be collected

LEVEL OF CRISIS ASSESSMENT

- Crisis assessment is essential in determining the nature of appropriate help that the affected person needs
- Assessment consist of two levels:

❑ LEVEL 1

- Concerned with the assessment of the risk of suicidal behavior,assault or homicidal threat
- Crisis may mostly involve personal harm, to the person concerned or others in the life of the individual
- Therefore level one assessment is very crucial

CONT-

- LEVEL 2
- This is concerned with the assessment of the impact of the crisis situation on the individual
- Defining the origin of the crisis situation
- Manifestation of the crisis situation on the individual
- What action the person might have taken to control the crisis
- What personal, family or interpersonal resources available
- The social and cultural atmospheres of the person crisis
- NB The primary objective of the crisis assessment process is crisis resolution

CRISIS RESOLUTION

- To do this emphasis is placed on the indetification of immediate problem that can be adressed
- History of persons usual problem solving skills and strategies should be obtained
- An assessment of available social support systems
- Evalution of the person emotional atmosphere
- The subjective experience and interpretation of the crisis situation should also be assessed as this will determine the risk of self destructive behaviours
- The crisis assessment process might need to be extended to the entire family or community as some crisis eg disasters involve the whole family or community

SIGNS AND SYMPTOMS OF PEOPLE WHO EXPERIENCE CRISIS

- PSYCHOLOGICAL

  -Unexplained fear (anxiety)

  -Irritability

  -Sadness, tearfulness and feeling of hopelessness

  -Labile mood (mood that changes rapidly)

  -Forgetfulness, misplacing items and poor recall

  -Brooding over the same issues for an endless period

  -Apathy (reduced interest in the sorrounding)

CONT-

- SOMATIC
  - Headaches, bodyaches and pains, fatigue
  - Pounding heart, missed heart beat, fear of heart stopping
  - Feeling as if one is short of air (air hunger)
  - Poor appetite

CONT-

- BEHAVIOURAL
  - Reduced level of activity, lack of energy
  - Overactivity and restlessness (inability to settle)
  - Poor, lack or too much sleep
  - Loss of regards for personal care, appearance and well being
  - Excessful alcohol consumption
  - Suicidal behaviour

CONT-

- INTERPERSONAL
  - Lack of pleasure for social contact
  - Inability to share emotions with others
  - Disagreement and arguements over trivial issues
  - Act of violence on flimsy reasons
  - Excessive dependence on others

TYPES OF COPING WITH CRISIS

- Two types

(1) Defensive Coping

(2) Direct Coping

DEFENSIVE COPING

- In defensive coping the individual either runs away from the problem and avoids going near the stress inducing situation or blocks it out of their mind and denies that the situation is stressful
- In defensive coping therefore, the individual uses emotion-reducing strategies such as-
  - -Avoidance (refusing to think, avoiding people or reminders)
  - -Positive re-appraisal (recognising the problem might have led to some good eg self betterment)
  - -Accepting or rejecting responsibility (recognising that one is at least partly responsible for the problem and can deal with it or that one is not responsible and need not react

CONT-

- Defensive coping
- Is often not adaptive (avoidance may delay attention to physical illness
- Maladaptive coping strategies reduce emotional response in the short term but lead to greater difficulties in the long term (eg use of alcohol or drug abuse or deliberate self harm and aggressive behaviour)
- The alcoholic anonymous (AA) recognise this fact in their prayer which says ‘’to be granted the courage to change what can be changed, the serenity to accept what cannot be changed and the wisdom to know the difference

DIRECT COPING

- Here the individual makes an objective analysis of the problem, how it came about and how one is responding
- Individual develops clear ideas of what they wish to achieve to solve the problems (goals) and come up with mental road maps or list of approaches to reach the desired end
- Individuals who employ a step by step approach in analysing the situation and choosing the best option for dealing with the problem are likely to cope better and learn from experience. This is a clear problem solving strategy
- OTHERS INCLUDE:

- Seek help from others
- Obtain information or advice
- Making and implementing plans to deal with the problem
- Confrontation- This is defending ones right or persuading another person to change their behaviour

THE END

- THANKS

EPILEPSY

- EPILEPSY- The most common neurological disease in the general population and affect about 1% of the population
- For psychitrist the major concern about epilepsy are

1) The consideration of epileptic diagnosis in psychiatric patient
2) The psychosocial ramification of a diagnosis of epilepsy for a patient and
3) The psychological and cognitive effects of commonly used anticovulsant drugs

-With regard to the 1st concern 30-50% of all person with epilepsy have psychiatric difficulties sometimes during the course of their illness

-The most common behavioural symptoms of epilepsy is a change in personality , psychosis and violence

CONT-

- SEIZURE - is defined as a transient paroxysmal pathophysiological disturbance of cerebral function caused by a spontanous excessive discharge of neurons
- Patient are said to have epilepsy if they have a chronic condition characterised by reccurent seizures
- The ictus or ictal event is the seizure itself
- The non ictal period are categorized as preictal, post ictal and interictal

CONT-

The symptoms during the ictal event are determined by the site of origin in the brain and the pattern of spread of seizure activity through the brain

Interictal symptoms are influenced by the ictal event and other neuropsychiatric and psychosocial factors such as co-existing psychitric or neurological disorder,the presence of psychosocial stressor and premorbid personality traits

CLASSIFICATION

- Two major categories of seizure

1) Partial
2) Generilised

Partial seizure involve epileptiform activity in localized brain region

Generalized involve the entire brain .A classification system for seizures internationally is as follows

CONT-

I PARTIAL SEIZURE(SEIZURE BEGINNING LOCALLY)

A partial seizure with elementary symptoms(generally without impairment of consciousness)

1)With motor symptoms

2) With sensory symptoms

3) With autonomic symptoms

4) Compound form

B Partial seizure with complex symptoms(generally with impairment of consciousness temporal lobe or psychomotor seizure)

1) with impairment of consciousness only

2) With cognitive symptoms

3) With affective symptoms

4) With psychosensory symptoms

5)With psychosensory symptoms (automatism)

6) Compoud forms

C Partial seizure secondarily generalized

CONT-

II Generalized seizures (bilaterally symmetrical and without local onset)

a) absences(petit mal)
b) Myoclonus
c) infantile spasms
d) clonic seizures
e) tonic seizures
f) Tonic-clonic seizure(grandmal)
g) Atonic seizures
h) Akinetic seizures

III unilateral seizures

IV unclassified seizures(because of incomplete data)

GENERALIZED SEIZURE

- Characterized by loss of consciouness, generilized tonic-clonic movement of the limbs ,tongue biting and incontinence
- The diagnosis of ictal period is straight forward but post ictal state is characterized by gradual recovery of consciouness and cognition which ranges from a few minutes to many hours
- The most common psychiatric problem associated with generalized seizure is helping the patient adjust to a chronic neurological disorder and assessing the cognitive or behaviour effects of anticonvulsant drugs

ABSENCE SEIZURE(PETIT MAL)

- A difficult type of generilized seizure to diagnose because the epileptic nature of the episode may go unrecognized and the motor and sensory characteristic of fit may be absent
- Petit mal epiepsy- begin in childhood between the ages of 5-7yrs and ceases by puberty
- Brief disruption of consciouness during which the patient suddently loses contact with the environment but patient has no true loss of consciouness and no convulsive movement during the episode
- In rare instances it may begin in adulthood characterized by sudden reccurent psychotic episodes or delirium that appear and disappear abruptly
- The symptoms may be accompanied by a history of falling or fainting spells

PARTIAL SEIZURES

- Partial seizures are classified as either simple(without alteration in consciouness)or complex(with alteration in consciouness

More than half of patient with partial seizures have complex type

Other terms used for complex partial seizure are temporal lobe epilepsy, psychomotor seizure and limbic epilepsy these term however are not accurate description of the clinical presentation

Complex partial epilepsy is the most common form of epilepsy in adults affect approximately 3 of 1000 persons

About 30% of patient with complex partial seizure have major mental illness such as depreession

SYMPTOMS

- PREICTAL SMPTOMS

Preictal events(auras) in complex partial seizure include autonomic sensetion(eg fullness in the stomach, blushing and changes in respiration) cognitive sensetion(eg , forced thinking, dreamy states)affective states(eg fear, panic, depression, elation) and automatism(eg lip smacking, rubbing, chewing)

CONT-

- ICTAL SYMPTOMS

Brief disorganized and uninhibited behaviour characterizes the ictal event

The cognitive symptoms includes amnesia of the seizure and a period of resolving delirium after the seizure

A seizure focus can be found on an EEG in 25-50% of patient

The use of sphenoidal or anterior temporal eletrodes and sleep deprived EEGs may increase the likelihood of finding an EEG abnormality

NB Muiltiple normal EEG are obtained for a patient with complex partial epilepsy therefore normal EEG cannot be used to exclude a diagnosis of complex partial epilepsy

The use of long term EEG recording (usually 24-72hours) can help the clinician detect a seizure focus in some patient

CONT-

- INTER ICTAL SYMPTOMS

Personality disturbance- is most common in patient with temporal lobe origin

The most common features are religiosity characterized by involvemet in religious activity, unusual concern about moral and ethical issues and preoccupation with right or wrong or

Heightened experience of emotions- noticeable in a pts conversation which is likely to be slow, serious and has non essential details and often circumstantial.The listerner may grow bored but be unableto find courteous and successful way to disengage from the conversation or

Changes in sexual behaviour - may be manifested by hypersexuality,deviation in sexual interest and most commonly hyposexuality

Psychotic symptoms- schizophrenia like episodes may occur in patient with epilepsy of temporal lobe origin

About 10% of all patient with complex partial seizures have psychotic symptoms . The risk factor for the symptoms includes female gender, left handedness, the onset of seizure during puberty and left sided lesion

The psychotic symptoms are more common in patient who have had epilepsy for a long time and the onset of psychotic symptoms are preceeded by personality changes the symptom includes hallucination and paranoid ideation/ delusion

CONT-

- VIOLENCE

Episodic violence has been a problem in some patient with epilepsy especially epilepsy of temporal and frontal lobe origin

Whether the violence is a manifestation of the seizure itself or is of inter ictal pychopathological origin is uncertain

CONT-

- MOOD DISORDER SYMPTOMS

mood disorder symptoms such as depression and mania are seen less often in epilepsy than are schizophrenia like symptoms

The symptoms are episodic and appear most often when the epileptic foci affect the temporal lobe of the non dorminant hemisphere

the importance of mood disorder symptoms may contribute to the increased incidence of attempted suicide in patient with epilepsy

DIAGNOSIS

- A diagnosis of epilepsy can be difficulty in patient who present with psychotic symptoms with no significant change in consciouness and cognitive abilities
- Patient who have previously received a diagnosis of epilepsy the appearance of new psychiatric symptoms should be considered as posible representaion of the epileptic symptoms and clinician should evaluate patient compliance with medication or advance effect of drugs (eg psychotic symptoms, mood disorder symptoms, personality change or symptom of anxiety(panic attacks)

CONT-

- In patient who have not received a diagnosis of epilepsy four characteristic should cause a clinician to be suspicious of the possibility

Abrupt onset of psychosis in a person previously considered psychologically healthy

The abrupt onset of delium without a recognized cause

A history of similar episodes with abrupt onset and spontaneous recovery and

History of previous unexplained falling or faintaing spells

TREATMENT

- PHARCOTHERAPY

I st line drug for generalized tonic-clonic seizure are valproate and phenyton

1st line drug for partial seizure includes carbamazepine , oxcarbamazepine and phenyton

ethosuximide and valproate are 1st line drugs for absence (petit mal) seizure

Carbamazepine and valproate are useful in controlling irritability and outburst of aggression as are the antipsychotic drugs

CONT-

- PSYCHOTHERAPY

Family therapy and group therapy may be useful in addressing the psychosocial issues associated with epilepsy

The clinician should be aware that many antiepiletic drugs cause mild to moderate cognitive impairment and an adjustment of the dosage or change in medication should be considered if symptoms of cognitive impairment are a problem in a patient with epilepsy

THE END

- THANKS

GERIATRIC PSYCHIATRY

GERIATRIC-Means the medical treament or healing of aged

-Branch of medicine concerned with prevention, diagnosis, and treament of physical and psychological disorders in the elderly

PSYCHIATRIC ASSESSMENT OF ELDERLY

- Psychiatric history and mental status assessment of the elderly follow the format that applies to young adult.
- But because of high prevelence of cognitive disorder in elderly patient, independent history should be obtained from a family member or caretaker

MENTAL DISORDER OF THE ELDERLY

- DEMENTIA (COGNITIVE DISORDER)
- DEPRESSION (RISK OF SUICIDE)
- PHOBIA (ANXIETY DISORDER)
- ALCOHOL USE

RISK FACTORS

- L OSS OF SOCIAL ROLE
- LOSS OF AUTONOMY
- DEATH OF SPOUSE/FRIENDS
- DECLINING HEALTH
- INCREASED ISOLATION
- FINANCIAL CONSTRAINS(Retirement benefits are below survival level and such benefits take time to come)
- DECREASED COGNITIVE FUNCTIONING

DEMENTIA

- A syndrome characterised by multiple impairment in cognitive functions,without impairment in consiousness.
- The cognitive function that are affected include-
- General intelligence
- Learning and memory
- Social abilities
- language
- Problem solving
- Orientation
- Perception
- Attention and concentration
- Judgement
- NB Patient persolity is also affected

- Also has behavioral disturbances which include; Agitation,restlessness,wandering,rage,violence, ,impulsiveness,sleep disturbance.social and sexual disinhibition

EPIDEMIOLOGY

- Dementia is essentially a disease of the aged
- In America-Those over 65yrs about 5% have severe denentia,15%mild dementia,those>80yrs 20%have severe dementia
- 50-60% of patient with dementia have dementia of Alzhermer,it is the most common type
- Risk factors include-age,female gender and family history
- 15-30%of patient with dementia have vascular dementia
- Risk factor include –male gender,hypertension,diabetes and cigarettes smoking
- Others causes of dementia represent 1-5%
- Include,head trauma,alcohol related,HIV,Pick's disease,Parkinson's disease,Huntington's disease,Creutzfeldt Jacob disease

CLASSIFICATION OF DEMENTIA

- CORTICAL
- SUDCORTICAL
- Depending on the site of cerebral lesion

CORTICAL DEMENTIA

- DEMENTIA OF ALZHERMER'S TYPE
- CREUTZFELDT-JACOB DISEASE
- PICK'DISEASE
- MANIFESTATION-
- (a)Multiple cognitive deficits such as memory impairment(impaired ability to learn new information and to recall previously learned information)
- (b)Aphasia –language disturbance
- (c)Apraxia-impaired ability to carry out motor activities despite intact motor function
- (d)Agnosia-failure to recognise or identify object despite intact sensory function

SUBCORTICAL DEMENTIA

- HUNTINGTON'S DISEASE
- PARKINSON'S DISEASE
- WILSON 'S DISEASE
- NORMAL PRESSURE HYDROCEPHALUS
- MANIFESTATION
- (a) movement disorder
- (b) gait apraxia
- (c) psychomotor retardation
- (d) apathy

DEMENTIA OF ALZHEIMER'S TYPE

- Account for 50-60% of all patient with dementia
- Affect 5% o fall person who reach 65yrs
- Affect15-25% those who reach 85yrs and above
- Prevelence-high in women than in men

CLINICAL FEATURES

- Gradual onset with progressive decline incognitive function.
- The general sequence of deficit is memory,language,visuospatial functions
- Memory-inability to learn or recall new informtion
- Language-impaired naming of object /people
- Visuospatial-inability to copy figures or write
- Personality changes includes-depression,obsessiveness and suspiciouness,outburst of anger,violent act and wandering
- Neurological defects(eventually appear) include
- (a)Aphasia-language disturbance
- (b)Apraxia-impaired ability to c arry out motor activity despite intact motor function
- (c)Agnosia-failure torecognise or identify object despite intact sensory function
- NB The dementia has insidious onset and is progressive,mean survival rate is 8yrs with a range of 1-20yrs

ETIOLOGY

- CAUSE-Unknown
- Neuropathology-gross anatomy there is diffuse atrophy of brain with flattened cortical sulci and enlarged ventricles.Reduced gyral volume in the frontal and temporal lobes
- Microscopic-senile plaques(amyloid plaques) composed of particular proteins B/A4 and astrocytes,--.Neurofibrillary tangles this are cytoskeletal element which are primary phosphorylated tau proteins
- NB-Blocking phosphorylation of tau protein is being explored as positive management intervention of dementia of Alzheimer's
- Neuronal loss

TREATMENT

- No known prevention or cure
- Treatment is palliative consisting of proper nutrition, exercises and supervision of daily activities
- Medication are useful in managing agitation and other behavioral disturbances. Drugs such as propanolol,sodium valproate, haloperidol may reduce agitation and aggression

VASCULAR DEMENTIA

- 2nd most common type of demetia (Alzhermer and vascular account for 75% of all dementia
- Characterised by same cognitive deficit of dementia of the Alzheimer's type but has focal neurological signs and symptoms such as
- (a)exaggeration of deep tendon reflexes
- (b)extensor plantar response
- (c)gait abnormality and weakness of an extremity
- Compaired to Alzhermer ;vascula dementia has an abrupt on set and a stepwise deterioting cause
- Vascular dementia may be prevented through the reduction of known risk factors such (1)Hypertension ,Diabetes,Cigarrettes smoking ,Heart arrhythmias

DIAGNOSIS

- CONFIRMED BY MAGNETIC RESONANCE IMAGING(MRI)
- CEREBRAL BLOOD FLOW STUDIES

DEMENTIA DUE TO PICK'S DISEASE

- Pick's disease cause a slowly progressing dementia
- It is associated with focal cortical lesions in the frontal lobe producing aphasia, apraxia and agnosia
- The disease last from 2-10yrs with an average duration of 5yrs
- Clinically Pick's disease is diffiult to diffentiate from Alzhermer's disease but in autopsy brains reveals (intraneuronal inclusion called Pick bodies which are different from neurofibrillary tangles seen in Alzhermer dementia
- Pick's disease is much rearer than Alzhermer's disease and no treatment is available

DEMENTIA DUE TO CREUTZFELDT JACOB DISEASE

- A diffuse degenerative diesase that affect the pyramidal and extrapyramidal system
- affect people in their 50s usual cause is 1yr
- it is associated with aging
- it incidence decrease after 60yrs
- It terminal stage is characterised by severe dementia generilised hypertonicity and profound speech disturbance
- it is caused by a slow growing infectious virus
- some cases have been traced to the transplantation of the cornea of an infected person to one previously uninfected

DEMENTIA DUE TO HUNTINGTON'S DISEASE

- A hereditary disease associated with progressive degeration of the basal ganglia and cerebral cortex
- It is transmitted as an outsomal dorminant gene(traced to the G8 fragment of chromosome 4)
- each offspring of an affected patient has a 50% chance of getting the disease
- Onset of the disease is between 35-50yrs sometimes later in rare cases
- it is characterised by progressive dementia, muscular hypertonicity and bizarre choreoform movement
- death usually occur 15-30 years after onset of disease
- no tretment is available

DEMENTIA DUE TO NORMAL PRESSURE HYDROCEPHALUS

- In elderly this condition cause gait disturbance(unstability)
- Urinary incontinence and dementia
- Enlargement of the ventricle with increased cerebrospinal fluid’s pressure is found
-

DEMENTIA DUE TO PARKINSON'S DISEASE

- Parkinson's disease is characterised primarily by motor dysfunction but cognitive disturbance including dementia may be part of the disorder
- Nearly ½ of affected patient are depressed making depression one of the most common mental disturbance in parkinson disease
- Patient also has increased risk of anxiety

DEPRESSIVE DISORDER

- Affect 15% of elderly community resident or nursing home patient
- Risk factors

-being windowed

- Lonelessness
- social isolation
- having a chronic medical illness

Clinical presentation

-reduced energy and loss of interest in daily activities

-poor concentration

-sleep problem(especially early morning awakening)

-decreased appetite

- weight loss
- Somatic complains(elderly pt with depression have more somatic complains as compared to young adults

PSEUDODEMENTIA

- A cognitive impairment in depressed elderly pt which can easily be confused with true dementia
- True dementia- intellectual impairment is global in nature and persistant
- In pseudo-dementia intellectual impairment is variable
- Pseudo-dementia occurs in 10% of depressed elderly pt while 25% of pt with dementia are depressed

BIPOLAR 1 DISORDER

Bipolar 1 disorder begins in middle adulthood

-1st episode of mania after age 65yrs is most likely due to psychological or organic cause eg side effect of medication or an early dementia

Signs and symptoms of mania in the elderly are similar to those in young adults and includes

- Elevated expansive or irritable mood
- Decreased need for sleep
- Destractibility
- Impulsivity and
- Often excessful alcohol intake

SCHIZOPHRENIA

- Schizophrenia- usually begin in late adolescence or young adulthood and persists throughout life
- Late onset type beginning after age 45yrs is called PARAPHENIA
- Common in women
- Paranoid schizophrenia has a greater prevelence late in life
- About 20% of schizophrenic person show no active symptoms,80% show varying degrees of impairment
- Aged person with schizophenia symptoms responds well to antipsychotic drugs
- Lower than usual dosages are often effective in the elderly

ANXIETY DISORDER

- Most common disorder are phobias 4-8%
- Panic disorder1%
- Anxiety disorder begin in early or middle adulthood but some cases may appear for the 1st time after age 60
- Other includes obsessive-compulsive disorder,generalised anxiety disorder,acute stress disorder and post traumatic stress disorder

SOMATOFORM DISORDER

- Psychological disorder characterised by physical symptoms resembling medical diseases
- Repeated physical examination are useful in reassuring pt that they don’t have a serious or fatal illness

ALCOHOL AND OTHER SUBSTANCE USE DISORDER

- Alcohol and other substance account for 10% of all emotional problems in the aged
- aged pt with alcohol dependent usually give a history of excessive drinking that begin in young or middle adulthood
- They are usually medically ill primarily with liver disease, are either divorced, windowed or men who are never married
- May have arrest records
- they constitute 20% of nursing home patient
- Elderly patient may abuse anxiolytics to allay anxiety or induce sleep

SLEEP DISORDER

- Sleep related problems in elderly pt includes
- Trouble sleeping
- Day time sleepness
- Day time napping
- use of hypnotics drugs

Other causes includes

-general medical condition associated with pain

sleep apnea

restless leg sydrome

nocturia

dyspnea

Heartburns

MANAGEMENT

- Use of pharmacological(drugs)
- Take care of nutrition
- manage physical illness
- psychotherapy include

- insight-orietated psychotherapy
- Cognitive therapy
- group therapy and family therapy

Institutional careof the aged(placement of the aged person in an institution is often viewed as a failure in management)

But it may the only alternative available

CONT

- HOMES

-Old age homes and boarding are voluntary non profit institution in which old person are expected to live together for the rest of their lives with no attempt to rehabilitate them for discharge

Nursing home and extended care facilities-are institution for the long term care of chronically ill or permanently impaired person

Day care centres and community center for the aged are places for the elderly person to congregate to enjoy,to socialize,to share experience and to deal with feeling of depression, anxiety,boredom and loneliness

THE END

- THANKS

PREVENTIVE,PROMOTIVE AND REHABILITIVE PSYCHIATRY

- What is mental health? WORLD HEALTH ORGANIZATION difinition

Defines mental health as a state of physical mental and spiritual well being in which the individual realises

-His or her own abilities

-Can cope with the normal stresses of life

- Able to make a contribution to their community

NB-Mental health and wellbeing is a combination of both positive feeling and positive functioning

MENTAL HEALTH PROMOTION AND PREVENTION

Incorporates any action taken to maximise mental health and well being

This is done among the population and at individual level

(A)POPULATION

At population level promotion influences the social and economical factors that dertemine mental health such as

ECONOMICAL FACTORS

-Income’; those with low income are prone to mental illness

-poverty; eradicating poverty

-employement ;creating employement

-housing ; provide safe housing

CONT-

- SOCIAL FACTORS

Enhance social factors that protect people against mental illness such as

- Prevent substance abuse
- Provide good antnatal care and safe delivery

-Overcome cultural/ religious barrier

CONT-

- INDIVIDUAL LEVEL

-Practical tips includes

(1)Make sure you are getting enough rest- sleep boosts your mental health

(2) Feel what you feel- don't worry about controlling or changing your feeling

Focus on expressing the feeling that you have rather than trying to feel a certain way

(3)Forgive yourself for past mistakes-messing up or making mistakes is part of life

Mental health requires understanding that and moving on

If there is a mistake or regret that eat at you let it go

(4)Exercise- regular exercise help to cut back stress in your life

Exercise release endorphins chemical in the brain that energize us

CONT-

(5)Eat healthy

-invest time to learning which kinds of food brings you up and which kinds brings you down

- Committing to a diet can make you feel good about yourself

Give you a sense of self improvement and

Boost your sense of accomplishment

CONT-

(6) Find a good support system

Whether family ,friends , a church or something else , find a group of people who are willing to love you for who you are

This boosts resilience and helps to provide hope in the midst of stress and pains

(7)Accassionally throw a party for yourself,cerebrate a recent accomplishment in your life by parting yourself on the back and rewarding yourself with a small gift

It is important to acknowledge successes – not just failures

(8)Stay away from drugs and alcohol

This affect your mental health by decreasing mental stability and giving you false positive emotions

Cont-

(9)Leave time for leisure

-Make sure you allow time in your schedule for whatever causes you to relax

-May be it is watching movies or completing crosswards puzzles or taking a walk or playing games

(10) Commit to helping others

-You can build self esteem and self worth by regularly pouring out your energy and talents to help others

- Volunteering is another activity that releases endorphins boosting your mood

(11) Learning something new

- Part of what makes us human is our tendency to challenge ourselves to learn something new- may be a new skill, sport, game or knowledge

CONT-

(12)Do things that requires discipline

Self control increases self worth as you feel like you can control aspect of your life

(13)Cut out late night TV and computer use

-Studies have shown that watching TV and using a computer late at night can cause depressive symptoms

(14) Stick to your friends

-Do what you can to intentionally keep in touch with a circle of friends

-Schedules lunches,dates or get togethers with you friends more often

-Deep friendships provide a sense of belonging

CONT-

(15)Make decision not to worry

-Worry will consume your mind if you let it

-But you can train yourself to avoid worries

-Choose a life without anxiety

-Ask God to help you not to worry

(16) Do things that engage your senses

-Each day perform one task that engage each of your sense, sight,touch, smell, sound and taste

- Engaging your senses helps you to live in the moment and focus on the present

(17)Leave time for nothing

- Make sure your schedule has a little room for free time that is unbadgeted

-Use that time for meditation, prayer ,relaxation or exercises

CONT-

(18)Work to understand what stresses you

- Understand your stressors and be able to recognise how you need to react
- Know your limit and stick to them
- Refuse to accept added responsibilities
- Learn how to say ‘’NO’’

(19) Give and receive compliments

-Find reasons to praise people and be willing to accept people praises of you

- This will help you to appreciate the good in those around you and recognise it in yourself

(20) Leave time to laugh

- Try to laugh hysterically every day

-Feed yourself funny things allowing your mind to decompress from time to time

CONT-

(21) Spend time with people every day

-Find people who are like you and who like you and don't forget them when you're depressed or down- interacting with people is part of the solution not problem

(22) Accept that there are things you cannot change

- Alot of anxiety stems from trying to change things beyond our control

- Recognizing that somethings are beyond our control is a key to a healthy anxiety free mind

(23) Engage in spirituarity on regular basis

- Make sure you're exercising not just your mind and your body but also your spirit

- Interact regularly with a spiritual community putting faith in GOD relieves stress on ourselves

CONT-

(24)Talk to GOD about where you're at

- Interact with God in prayer on daily basis and allow God to be part of your stress reduction strategy

- He's been doing it for thousands of years

- He's got a little more practice than you do or than most of us

PSYCHIATRIC REHABILITATION

- A process of minimising psychiatric impairment, social disadvatages and adverse personal reactions
- So that the psychiatric person is helped to use his talents
- To acquire confidence and self esteem and also experience success in social roles

CONT-

- What good mental health implies

A person who has good mental health should be able to

-Form meaningful relationship with others(including those outside of the family and with the opposite sex)

- Be flexible in response to a variety of situations even when events arise that are unexpected and not be thrown out of control
- Take criticism constructively and be able to give and take compliments
- Be able to work with a variety of people at different levels of authority
- Should be able to find pleasure in living and in daily events
- Find a range of activities interesting and worthwhile
- Recognise personal strengths and weakness and strive for improvements

PSYCHIATRIC DISABILITY

- Three terms used to describe the various forms of disability resulting from an illness

(1)Impairment – refer to a loss of function at the system or organ level

(2) Disability- this term operates at the level of the person and describes distubances in performing daily activities such as being unable to live a fulfilling life or perform a specific job

(3) Handicap-the term in psychiatry is applied to those people who have cognitive limitation

WHY IS REHABILITATION IMPORTANT

- It strives to achieve the highest level of an individual functioning whose benefit includes
- Increases a person self worth
- Incorporate a person back as an accepted member of the family
- Makes one a productive member of the community and society
- It helps in intergration of the individual into the family roles and community involvement

NB- Rehabilitation especially in severe condition eg schizophrenic pt help by both promoting a successful discharge from hospital and by reducing the need for re-hospitalization in the future

WHO PROVIDES REHABILITATION

- Varius professional need to work together

(1) PSYCHITRIST- Who provides appropriate diagnosis and psychotherapeutic as well as pharmacological interventions

(2) Nursing personnel- to administer medication and make observation of the patient while in the hospital

Nurses are responsible for creating a theurapeutic ward environment

when a patient needs to be followed up in the community for assessment and monitoring a visiting community nurse can provide this service

CONT-

(3)PSYCHOLOGISTS

They help to understands the ndividual patient and his particular problem and advice on adjustment

They perform psychological and intelligence test and also provide skilled psychotherapeutic intervention

(4) Social worker – to assist in the family concern and resettling of the client in the community particularly when it requires other services to be involved such as social welfare

CONT-

(5) OCCUPATIONAL THERAPISTS

- They assess the needs of a client and analyse which activities and tasks that would help person to achieve a higher level of functioning in a given area
- They plan a treatment or intervention program depending on the person capability strength and interest
- They also assess to observe if the pro gram has made an impact on the behaviour and function of the client

(6) TRADITIONAL HEALERS

- They play an important role and work with client in Africa
- It is a cultural component that should be included in treatment planning when it is an alternative that the client chooses

CONT-

(7) THE FAMILY

- It plays an important role in rehabilitation in a variety of ways ranging from changing their attitudes towards mental illnes and thus reducing stress on the ill member
- To support and attempts to reintegrate the sick person into meanful social role

(8) THE CLIENT

-Themselves are key participants in the rehabilitation process

-It has been demostrated that when a client is involved in planning his own goals- participation and compliance with treatment programs are improved

HOW IS REHABILITATION ACHIEVED

- 1ST STEP ASSESSMENT
- Assessment must be done in several areas for holistic treatment plan to be devised
- This includes

(1)Cognitive skill(ie how the individual is able to solve daily problems)

(2) Motor skills(eg difficulties in mobility which may interfere with daily activities)

(3) Communation skills eg ability to communicate one's need, express anger and other emotions

(4) Activies of daily living eg ability to organise and complete tasks of daily living such as personal hygiene

(5) Leisure eg how the person spends his leisure time

CONT-

(6) Interpersonal and social skills eg how the person interacts with other people such as family, friends or colleagues at work

(7) Vocational skills eg skills that are necessary for succesful employment

(8) The individual's own motivation and goals

CONT-

- 2ND STEP

-Determing a comprehesive set of goals of the rehabilitation program

- Goals may be focused on three main themes

(1) Enhancing skills and perfomance eg through education, practice or reinforcement of skill

(2) Improving self image and expression eg through social skills training

(3) Modifying the evironment eg through family intervention

REHABILITATIONS ACTIVITIES INCLUDES

- PRACTICAL ACTIVITIES

- This includes structured tasks such as woodwork, leather making and other craft skills

OUTING TO COMMUNITY

Which helps to develop awareness of mentally sick in the community and reinforces the need for providing opportunies that exist in community to mentally sick patient

TASKS-Related to daily living (eg planning and making meals, care of personal hygiene, mending clothing etc

STRESS MANAGEMENT-Includes techniques which train the client to maintain mental health through techniques such as relaxation and advice on healthy life styles

CONT-

(2)SOCIAL SKILLS TRAINING

-It aim to develop the person's ability to interact with others by practising assertiveness skills and becoming aware of others feelings and reactions

-Story telling to allow sharing of one''s experience with others and improve socilization

(3) CREATIVE ACTIVITIES

-This includes creative tasks such as painting- which allows the client to express what he is feeling and facilitate the expression of feeling which has not been expressed in other ways

WHERE DOES REHABILITATION TAKE PLACE

TWO AREAS

(a) Medical facilities eg hospitals

(b) Community based settings eg sheltered workshops and halfway houses

ACUTE HOSPILIZATION

- The purpose is to stabilise the patient and return him to his usual environment as soon as possible
- Patient often stay for a few days to a few weeks
- Patients symptoms have been reduced to a level at which they may reasonably co-operate and become participants in the program

LONG TERM HOSPITALIZATION

- This happen in pt with a chronic mental illness which requires a controlled environment
- Rehabilitation goals may include development ofskills in the areas of activities of daily living, work related skills and leisure time management

CONT-

- DAY TIME OR PARTIAL HOSPILIZATION

Day treatment or day hospilization is an option for people who no longer require the limit that hospital impose

Yet need structure of a treatment program to gain skills to function in their home environment

Skills that may be acqured includes

-Communication

- Social interaction and
- Work related skills

HALF WAY HOMES OR GROUP HOMES

-The facility is useful when the client needs a structured home environment

-This is often an option for those who are unable to live with their family for various reasons or

-For those who cannot live alone without some support

CONT-

SHELTERD WORK SHOPS

- There are several level to this concept

- Hospital that provide care over a long period of time often have ‘’workshop’’ or stations that will allow client to participate in some type of work
- Client are usually given a minimum wage for the work that they accomplish

COMMUNITY BASED AGENCIES

- Provides work for people with varius types of disability
- This kind of facility will allow the client who may not be able to work in a competative work environment
- Sometimes sheltered workshop are set up as training institutions
- This type of agency is not intended for permanent employment but rather as a place to teach work and work related skills to those client who would benefit from this type of service
- in Africa setting income generating projects activities may serve the same purpose

CONT-

- HOME BASED REHABILITATION

- Living situations may need to be altered to fit the needs of a client as well as the family which he lives with
- Often this will take the form of checklist that can be followed
- It is important for client to feel that he is part of the family and learn how to be a construtive part of the household

OTHER SETTINGS

Other settings where rehabilitation may occur includes

-Retirement or senior centers caring for the needs of the elderly

-Hospices which care for the needs of the dying

- Special schools-caring for children with special needs
- Correctional institutions with units for dealing with mentally ill offender

THE END

- THANKS

ROLE OF SERVICE PROVIDER IN DESTIGMATAZATION OF MENTAL ILLNESS

- The fate of those who suffer from mental illnesses is stigmatization
- Stigma creates a cycle of discrimination and social exclusion to those with mental illness and those associated with them
- Stigma more than illness

-Is the single most important barrier to the quality of life of people with mental disorder their family and friends

- It is also a major impediment to mental health reform and service development

-A major barrier to the appropriate treatment and rehabilitation of people with mental illness

NB Good mental health is the key to good physical health. Therefore elimination of stigma through partnership with public, whereby education and open discussion should be encouraged

EFFECT OF STIGMA

- AT COMMUNITY LEVEL

Majority of people with mental illness are now treated in the community where negative public opinion(stigma) can lead to

-Human right violations

-Discrimination

-Unemployment

-Lack of housing

-Diminished self esteem

-Disruptions in family relationships

-Reduced normal interactions

Therefore stigma pose major obstacles to recovery and promote psychiatric disability

CONT-

- GLOBALLY

Result of stigma are

-Lower priority for mental health services

-Difficulty in getting good staff to work in these services

-Continuing problem in finding employment and housing for people who have had an episode of mental disorder

-Social isolation of people with mental illness and their families

-Poorer quality of care for physical illnesses occuring in people diagnosed as having had psychiatric illnesses

NB The history of the stigmatization of mental illness is long but has become stronger in the past two centuries because of

-Urbanization

-Growing demands for skills and qualifications in almost all sectors of employment

PRINCIPLES GUILDING THE INTERVENTION

(1)Work with the patient and relatives to boost patient and their families self esteem and self respect

- This facilitates

- Patient socialization
- Their active participation in the treatment and rehabilitation process and
- Their motivation for better personal care

CONT-

(2)Work with members of health profession who can do a great deal to prevent or distigmatise mental illness by

- Helping pt maintain self esteem

-Developing and implementing the plan of treatment together

-Being constantly aware of the dangers of labeling which might harm the patients

-Ensuring that they have respected their patient priorities rather than placing their priorities below those of the health care systems

-Working with families-learning from their experience and providing them with practical and useful information

-Acting as advocates and models of tolerance and acceptance of people with mental illness

CONT-

(3)Work with health authorities

-Emphasis has been placed on the need to re-examine and improve legislations and procedures that govern the health system in order to avoid its stigmatization potential and ensure no violation of human rights for persons with mental illness

CONT-

(4)Work with journalist and other media professionals

-Journalist have been engaged in fighting stigma through better reporting about mental illness and about people with mental illness

(5)Work with public

-The focus here has been on a change in behaviour rather than only a change of attitudes

MAIN OBSTACLES/ CHALLENGES

- Change in behaviour and attitude take time
- Financial support have to be maintained continuosly
- Maintaining the motivation of all concerned over many years is very difficulty
- Maintaining a lasting involvement of all structures of the health system and other social services, who should see the fight against stigma as one of their permanent and essential tasks

BASIC PRINCIPALS

- 3 Basic principals should be kempt in mind when fighting stigma

(1) The fight against stigma is a priority because stigmatization is a major obstacle to any progress in the field of mental health

(2) Programs against stigma and discrimination should involve people with mental illness and their families

(3) Each of us whether part of a major program or alone can do something to diminish or avoid stigmatization of mental illness

NB It is just as important to ask what we ourselves can do to diminish stigmatization as it is to urge others to do something about it

THE END

- THANKS

THE MENTAL HEALTH ACT
CHAPTER 248

- Enacted by the parliament in 1989 to replace the 1949 mental treatment act
- Came into force on 1st may 1991
- Among other things it provides for:

(1) The procedure of reception of patient in mental hospitals
(2) The establishment and functions of the Kenya boards of mental health councils as institutions that implement the objective of the act
(3) The establishment of mental hospital for the treatment and care of persons with mental illnesses
(4) Management of estates of persons suffering from mental disorder and
(5) Offences that may be committed under the act and sanctions prescribed for such offences

RECEPTION OF A PATIENT

- The procedure of reception of a pt in mental hospital incudes:
- The procedure of receiving of voluntary patient into mental hospital and their care
- The procedure of receiving and managing of involuntary patients
- Emergency admission of pt suffering from mental disorder into mental hospital
- Admission of pt from foreign countries into our local health hospital
- Discharge and transfer of pts generally

THE KENYA BOARD OF MENTAL HEALTH

4 (I) A board is established under this act ''Kenya Board of mental health''

(II) The board consist of;

(a) A chairman, who shall be the director of medical services or a deputy director of medical services appointed by the minister

(b) One medical practitioner with specialization and exeperince in mental care appointed by the minister

(c) One clinical officer with training and exeperience in mental health care appointed by the minister

(d) One nurse with training and experience in mental health care appointed by the minister

(e) The commissioner for social services or where the commissioner cannot serve his nominee appointed by the minister

CONT-

(f) The director of education or when the director cannot serve his nominee appointed by the minister

(g) A representative of each of the province of Kenya being person resident in the province appointed by the minister

The members of the board appointed by the minister shall serve at the minister's pleasure for a period not exceeding three years and shall be eligible for re- appoinment

The board may co-opt any person whose skills ,knowledge or experience may be useful to the board or any other commitee of the board

The board may for any purpose or function establish commitee for board

FUNCTION OF THE BOARD

(a) Co-ordinate mental health care activies in Kenya
(b) To advice the government on the state of mental health care facilies in Kenya
(c) To approve the establishment of mental hospitals
(d) To inspect mental hospital to ensure that they meet prescribed standard
(e) To assist whenever necessary in the administration of any mental hospital
(f) To receive and investigate any matter refered to it by a patient or a relative of a patient concerning the treatment of the patient at a mental hospital and where necessary to take or recommend to the minister any remedial action
(g) To advice the government on the care of person suffering from mental subnormality without mental disorder
(h) To perform such other function as may be coferred upon it by or under this or any other written law

CONT-

- There shall be a director of mental health whose office shall be an office in the public service and who shall be the secretary and chief officer of the board
- The minister may in consultation with the board appoint district mental health council to perfom at the district level who should report to the board
- The district health council

(a) Shall consist of not less than five and not more than seven person including the district medical officer of health

(b) The members shall serve at minister pleasure for not more than three years at one time and shall be eligible for re-oppointment

PART IV MENTAL HEALTH HOSPITALS

- Mental hospitals are established under this act
- A hospital or part of a hospital may be authorised by the board by notice in the Kenya gazette to be a place for reception and treatment as inpaatient of two or more preson who are suffering from mental disorder
- The board may authorise places within prison to be places for reception and treatment for remand or convicted criminal prisoner

NB Every mental hospital shall have facilities for inpatient and autpatient treatment of person suffering from mental disorder

-There may be established public mental hospital operated and managed by government and private mental hospital operated and managed by person other than the government

PART V ;VOLUNTARY PATIENTS

- Any person who has attained the apparent age of sixteen years who desires to submit himself to treatment for mental disorder can make a writtern application in duplicate in the form pescribed to the person incharge of a mental hospital
- A person who has not attained the age of sixteen yrs a parent or guardian can make such an application to the person incharge of mental hospital
- Any person admitted voluntary under this section may leave the hospital after giving a severity two hours notice to the person incharge of the hospital
- If such a person dies or departs from a mental hospital such information shall be given by the person incharge to the district mental health council
- A voluntary pt who might become incapable of expressing himself shall not be retained for more than forty two days

PARTVI;INVOLUTARY PATIENTS

- A person who is suffering from a mental disorder and can benefit from treatment in a mental hospital but is incapable of expressing himself as willing or unwilling to receive treatment. A writtern application can be made and pt can be received as an involuntary patient
- An application can be made in the prescribed form to the person incharge and can be made

(a) By the husband or wife or by a relative of the person to whom it relate

(b) If there is no husband or wife or relative available or willing to make application any other person can make the application stating the reason, the connection with the patient and circumstances in which the application is made

CONT-

- The application shall be accompanied by a recommendation in duplicate in the pescribed form signed by a medical officer
- The medical practitioner who makes the recommendation must examine the pt specify the date and the ground on which recommendation is based
- A recommendation shall cease to have effect on expiration of fourteen days from the last date on which the person was examined by the medical practitioner
- A person received as an involuntary patient into a mental hospital may admitted in the hospital for a period not exceeding six months this period can be extended by the person incharge for a further period of not exceeding six months

CONT-

- NB . An involuntary patient shall not be admitted in a mental hospital for any continuous period exceeding twelve months
- If an involuntary patient under this section dies or departs from the mental hospital information of the reception, death or departure shall be given by the person incharge, to the district mental health council

PART VII; EMERGENCY ADMISSION

- Any police officer of or above the rank of an inspector, officer in charge of a police station, administative officer, chief or assistant chief may take or cause to be taken to custody
- -Any person who he/ she beliefs to be suffering from mental disorder and who is found within the limit of his/her jurisdiction
- -Any person who he believes is dangerous to himself or to others or who because of the mental disorder acts or is likely to act in a manner offensive to public decency
- Any person who he believes to be suffering from mental disorder and is not under proper care or control or is being cruelly treated or neglected by any raletive or other person having charge over them

CONT-

- Any person taken into such custody must be taken to a mental hospital within 24 hrs
- Such person should be admitted for a period not exceeding seventy-two hours for purposes of examination and making arrangement for his treatment and care
- The person incharge may, after examination can hand the person over to the care of any relative or detain the person in the hospital as an involuntary patient

ADMISSION AND DISCHARGE OF MEMBERS OF THE ARMED FORCES

- Any member of the armed forces may be admitted into a mental hospital for observation if a medical officer of the armed forces recommend through a letter addressed to the person incharge of the mental hospital
- The officer has to indicate he had examined the pt within forty eight hours before issuing the letter and feels he should be admitted for observation and treatment
- A member of the armed forces can be admitted for an intial period not exceeding 28days this period may be extended if two medical officers one of whom shall be a psychiatrist examine and recommend the extension
- A member of armed forces can be discharged from a mental hospital if two medical practitioners one of whom shall be a psychiatrist recommend through a letter to the person incharge

ADMISSION OF PATIENT FROM FOREIGN COUNTRIES

- Before a person from a foreign country is admitted into a mental hospital in Kenya the Kenya board of mental health must first approve such admission in writing
- An application of such approval is made either by the Government of that country or any other relevant authority on behalf of that patient
- In the application form it must be indicated that;

-The pt has been legally detained in that country for a period of not more than 2 months under the relevant law

CONT-

-The board authority must be accampanied by a warrant or some other such document from the foreign country authorising his dentention in and removal from the foreign country into Kenya

The person incharge of the hospital is required to examine him within 72hrs for the purposes of determining the extent of his mental disorder and the nature of treatment after which he must report to the board his findings

Such a patient shall not be detained in the hospital for more than two months without the approval of the board

REMOVAL OF PATIENTS FROM KENYA TO OTHER COUNTRIES

- For Kenyan seeking treatment in other countries the procedures to be adopted is as follows

-An appropriate application for approval of such removal is to be made to the Kenya board of mental health by a friend or a relative

If the board is sastified that the necessary arrangement are in place and the person can benefit from treatment in a foreign country a warrant is issued to the applicant

The board will issue the above warrant after being furnished with consent from the proper authorities in the foreign country to receive the patient

The cost of removal and maintance of such person must be clearly indicated either to be met by the government individual or insurance

DISCHARGE AND TRANSFER OF PATIENT

- The person responsible for the discharge of patients admitted in a mental hospital is the person in charge of the facility after receiving recommendation of the medical practitioner incharge of the person''s treatment stating that the person has recovered from mental disorder
- A person detained for trial shall not be discharged until his case have been completed
- A relative or a friend of a person admitted into a mental hospital may apply to the person incharge of a hospital to be given the custody and care of that person and the person incharge of hospital may grant such a request upon terms and conditions that he may fix
- The person may however be readmitted if it is established subsequently that his relative or friend is unable or unwilling to take care of him
- The law enpowers the director of medical services to tranfer any person detained in a Government mental hospital from one Government hospital to another in his absolute discretion

JUDICIAL POWER OVER PERSONS AND ESSTATE OF PERSON WITH MENTAL DISORDER

- The law cofers upon the High court of Kenya extensive power with regards to the management of both the person with mental disorder and their estate
- These power includes

- Power to make orders for the custody and guardianship of a person with mental disorder
- For the management of their estate by any relative or by any other person that the court finds suitable

CONT-

- For an order of management of the estate of a person suffering from mental disorder to be made the following situation must prevail

-The person must be found to be incapable of managing his affairs

-He must however be capable of managing himself

-He must not be dangerous to himself or to others

-There should be no likelihood that he will conduct himself in a manner that offends public decency

CONT-

- The order for management of his affairs shall incorporate an order for his maintance and that for maintance of his dependents
- It should be noted that where the court finds that the person is capable of managing himself no order for his custody is to be made
- The order of management would ordinarly be made in favour of a relative or suitable person but where none of these is available then the court may appoint the public trustee to manage the estate or to act as the guardian of such a person

OFFENCES

- Person other than medical practitioner signing certificate
- Assist escape of a person suffering from mental disoder
- Permitting pt to quit mental hospital unlawfully
- Ill treatment of person in mental hospital eg strikes ,abuses or any other form of ill treatment
- Dealing with patient eg sells, gives or bartes any articles or commodities whether inside or outside the grounds of the hospital
- General penalty-liable on convictions -

-A fine not exceeding ten thousands shillings or

-To imprisonment for a term not exceeding twelve months or both

PRESCRIBED OFFICIAL MOH FORMS

- MOH 614-Application for involuntary admission
- MOH 615- Recommedation for involuntary admission
- MOH 638- Application for emergency admission
- MOH 639- Report of death or departure
- MOH 613- Application for voluntary admission
- MOH 637- Application for voluntary admission for a child under 16yrs
- MOH 641- Application to extend the stay of a foreign patient to the institution
- MOH 616-Application for relative/guardian for care and custody of an involuntary patient
- MOH 617 An order directing delivery into care of relative or friend
- MOH 640- Warrent of removal of involuntary patient to other countries

THE END

- THANKS